CHAPTER

1

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 relative 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. Instead, it is a collection of harmonious facts, opinions, and sentiments drawn from varied perspectives, reviews of the literature, and the authors' personal experiences. 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 as it relates to healthcare administration.

PART 1: THE HISTORY OF LAW

After reading part 1 of this chapter, you will

- understand that US law comes from four basic sources;
- know that healthcare administration is subject to a complex, dynamic mix of federal and state law;
- appreciate the balance of power between the branches of government;
- know the basics of the state and federal court structures; and
- be familiar with basic aspects of legal procedure.

The Historical Foundation of the US Legal System

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

EXHIBIT 1.1
Code of Hammurabi

by King Hammurabi of Babylon. They were inscribed on an 8-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 (law of retaliation), under 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, and a surgeon who caused injury risked a hand amputation. 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 Hammurabi's reputation as a lawgiver, depictions of him can be found in several US government buildings, including the US Capitol and the US 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 political 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, people would be in a constant state of war and life would be "solitary, poor, nasty, brutish, and short."

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

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**.

Anglo-American law can be traced back more than a millennium, to the time when the Anglo-Saxon inhabitants of what was to become England tried to centralize their disparate kingships to ward off enemies

and maintain peace. In the process, they created a legal system that would eventually prevail throughout England—hence the term *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).

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, resolve disputes, and prevent anarchy. As retired US Supreme Court Justice Stephen Breyer explained, "Law . . . grows out of communities of people who have some problems they want to solve."[2] One valid critique of legal systems, including that of the United States, is that they often serve to maintain power structures and protect wealth at the expense of addressing problems in the broader community. This is one of the reasons for the push to include in lawmaking roles people with diverse backgrounds and experiences.

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

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. Law provides only general guidance; it is not an exact blueprint for living. It evolves over time, adapts to new circumstances, and can be highly fact dependent. As undesirable as hardening of the arteries, legal sclerosis would result in a debilitating lack of progress and innovation.

Viewed in proper light, therefore, 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, law moves seismically, as was the case in 2010 with the passage of a legislative temblor known as the **Affordable Care Act (ACA)**, sometimes referred to as "Obamacare."[3] Despite outcries from some segments of the political spectrum, dozens of attempts to repeal it, and countless court battles, the US Supreme Court has upheld the constitutionality of the central aspects of the law. Indeed, the ACA has survived three near-death experiences at the Supreme Court, setting important constitutional precedents in the process. Most of the ACA's key healthcare access reforms took effect in 2014, and the aftershocks of these and myriad other reforms will be felt for years. Until the dust settles completely, we will not know how much the act has altered the legal topography (see chapter 2 for more information about the ACA's access provisions).

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 access provisions are discussed more fully in chapter 2. Other aspects of the ACA are incorporated into other chapters.

Another earthquake shook the law and the country on June 24, 2022, when the US Supreme Court overruled *Roe v. Wade*, ending nearly 50 years of a constitutionally protected right to abortion. The decision, *Dobbs v. Jackson Women's Health Organization*,[4] allows states (and perhaps the federal

government) to ban, criminalize, reaffirm, or expand abortion access. The aftershocks began that same day as "trigger laws" went into effect in several states prohibiting most abortions.

A tsunami of legislation and litigation was expected to follow in short order. As of the summer of 2022, many questions remained unresolved: what exceptions are legally required or permitted; how providers might apply the exceptions given potential legal and licensure risks; what steps states can legally take to restrict medication abortions; whether a state can reach across its borders to criminally charge an abortion provider; what the restrictive laws mean for prenatal counseling, birth control access, and assisted reproduction procedures; and whether an individual can bring a cross-border civil lawsuit against those that facilitate abortion access. Healthcare providers, both institutional and individual, are likely to find themselves on unsteady ground as they navigate new state laws regardless of where in the country they practice. The *Dobbs* decision's potential effects on access to reproductive healthcare are explored most fully in chapter 15. Other issues raised by the decision are discussed later in this chapter and in many others.

The Vast, Complex, and Dynamic Field of Healthcare Law

The US healthcare system is vast, complex, and dynamic, so it should come as no surprise to learn that the relevant body of law shares these characteristics. 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 that are peculiar to healthcare. Historically the field was dominated by state law, but federal law has become increasingly dominant, starting with the adoption of Medicare and Medicaid in 1965 and accelerating with the many provisions set forth in the ACA of 2010.

Our goal is not to turn you into lawyers. (Though if you decide to go on to law school, we would not be disappointed.) Instead, whether you plan to be a healthcare administrator, regulator, or advocate, we aim to help you better appreciate the role of the law in shaping how medical care is delivered and paid for in the United States. In your future careers, we hope you will be able to identify legal issues when they arise, resolve them when possible, and recognize when you need to consult with a lawyer. With a solid overview of this fascinating area of law, you should be better prepared to manage healthcare entities effectively, thoughtfully, and nimbly. You should have a better understanding of the legal tools available to effectuate change. And you should be better equipped to comment thoughtfully on proposed healthcare laws or regulations. With those goals in mind, as you study the interrelated

topics included in this textbook, consider how the law helps or hinders efforts to create a more equitable, accessible, affordable, and quality healthcare system.

Major Sources of US Law and the Hierarchy of Authorities

There are four major sources of law in the United States. In rough order of hierarchy, they are constitutions, statutes, regulations, and judicial decisions. This hierarchal order is rough because judicial decisions, at the bottom of the list, are interpretations of the meaning of constitutions, which are at the pinnacle. Similarly, statutes can change judge-made common law, and judicial decisions can void improperly enacted regulations.

All four sources of law exist at both the federal and state levels. Federal law trumps conflicting state law. It is not always obvious, though, whether federal and state law are in direct conflict, or whether the laws of the different sovereigns can coexist, both to be followed by the regulated entity. You will learn about this sort of interpretive challenge, for example, when studying how the federal healthcare privacy and security statute (the Health Insurance Portability and Accountability Act of 1996) intersects with state law in this arena (see chapter 10).

State laws often vary and even conflict with one another. This feature of our federalist system—some might even say one of its great virtues—provides a "laboratory of the states" in which to test different approaches. If there is no conflict with federal law, this variability from state to state does not pose a problem for the legal system, but it can present challenges for multistate healthcare operations.

For example, one state might have a broad scope of practice for nurse practitioners, while its neighbor might limits what nurse practitioners can do. Similarly, some states require government-granted "certificates of need" for

Law in Action: Tips for Working with Attorneys

You are certain to interact with lawyers at different points in your career. Following are a few tips to keep in mind:

- An organization's lawyer represents the organization, not any individual who works for it. What an individual says to the attorney might need to be passed along to others in the organization.
- Always be truthful. Do not hide facts from your attorney if you want good advice. (Garbage in, garbage out.)
- The "attorney-client privilege" relates only to specific sorts of communications. A communication is not entitled to the privilege merely because someone stamps it so or copies a lawyer on the communication.
- Seek advice early. Lawyers would rather help clients avoid problems than deal with a situation after mistakes are made.
- The lawyer gives *legal* advice. The client uses that advice to make *business* decisions.
- "It depends" is a common answer. It is the rare legal question that has a simple yes/no answer. Often the answer depends on the specific facts and other variables and will live somewhere in a gray area. The individual's or organization's risk tolerance will usually guide the ultimate decision.
- Emails live forever. Before you send one, think how it would look as a headline in the local newspaper or as a trial exhibit.

expanded healthcare operations, while other states abandoned those requirements long ago. It will be your job as a healthcare executive to comply with the laws and regulations in your particular service area and to advocate for change when needed.

This aspect of federalism will be severely tested by the patchwork of conflicting state (and perhaps federal) laws going into effect in the wake of the *Dobbs* decision. One state might vigorously protect the right to abortion and those who facilitate it, while a neighboring state might criminalize abortion in most circumstances and aggressively prosecute those who facilitate it. And all sorts of novel legal issues are raised by "bounty hunter" state statutes that purport to allow their state residents to bring a civil lawsuit against a person or entity elsewhere in the United States who aids or abets a resident of their state in obtaining an abortion.

Experts predict that within a year of the Supreme Court's *Dobbs* decision, about half the states will prohibit or severely restrict abortion. During that time, the federal government may attempt to limit the impact of some of those laws—for example, regarding medication access, information privacy, or travel protections—and it is conceivable that one political party or the other in Congress might be able to pass a statute setting a national standard either legalizing or prohibiting abortion. One thing is certain, however: our federalist system will be strained by new political and legal battles among the states as well as between the states and the federal government.

Constitutions

The US Constitution is aptly called the "supreme law of the land" because it sets standards against which all other laws are judged. In other words, whether good, bad, or ugly, a law must be constitutional. With respect to the federal government, this means both that Congress must have the constitutionally grounded power to enact the law (e.g., its taxing and spending authority) and that the law must not violate any other constitutional protections (e.g., the protection for freedom of speech).

The US Constitution establishes the three branches of the US government: the executive branch, legislative branch, and judicial branch. It also grants specified powers to the federal government and guarantees essential individual rights. 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 and to regulate interstate commerce. Congress may also enact laws that are "necessary and proper" to carry out these express powers. Thus, the power to tax also includes the power to spend, such as expenditures in

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. Change regulations to cure defects

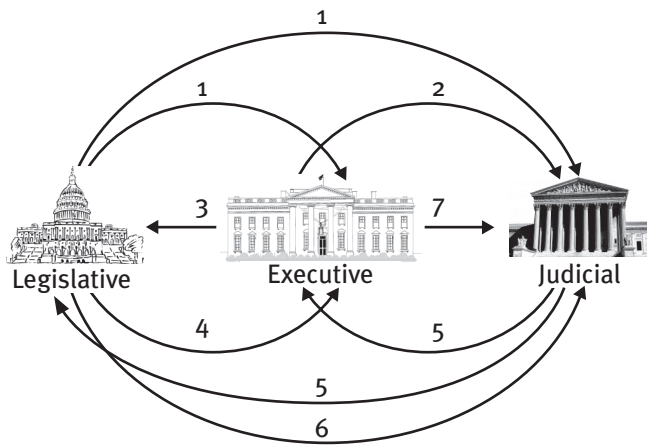

EXHIBIT 1.2
Checks and Balances

support of the Medicare program, and the power to regulate interstate commerce encompasses 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.

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

- freedom of religion, speech, and press;
- the rights of assembly and petition;
- the right to bear arms;
- protection against unreasonable searches and seizures;

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.

due process of law The administration of justice according to established rules and principles meant to ensure that a person is not unfairly deprived of life, liberty or property.

- rights in criminal and civil cases (e.g., jury trial, self-incrimination); and
- the right to substantive and procedural **due process of law**.

The Ninth Amendment specifies that "[t]he enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people." Among the unenumerated rights identified and upheld by the US Supreme Court are the right to travel and the right of privacy.

Of the 17 other amendments, two canceled each other: the Eighteenth Amendment, 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.

Read literally, the Bill of Rights applies only to the federal government. However, the US Supreme Court has held that most of the rights set forth in those ten amendments also apply to the states under the Fourteenth Amendment. (This is an example of judicial interpretation, which is discussed in greater detail in the following section on statutes.)

In addition to the US Constitution, each state has its own constitution. A state's constitution is the supreme law of that state, but it is subordinate to the federal Constitution. State and federal constitutions are similar, although state constitutions are more detailed and sometimes more protective of individual rights. Native American tribes also have constitutions, which are the supreme law in those jurisdictions.

A few states' constitutions include privacy protections, either explicitly or as interpreted by their courts. Less than a week after the US Supreme Court's 2022 decision that the US Constitution's unenumerated right of privacy does not include a right to abortion, a Florida court cited privacy protections in the Florida constitution to temporarily block that state's 15-week abortion ban, which sprang into effect when the *Dobbs* decision was handed down.[5] This will be one of many decisions concerning state constitutional protections in this arena. Efforts to amend state constitutions to explicitly protect the right to choose or, conversely, efforts to explicitly protect the unborn from the moment of conception, can also be expected.

The Fourteenth Amendment was adopted after the Civil War. It is an important (and much-litigated) source of substantive and procedural rights. Its first section 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."

Statutes

At the federal level, Congress enacts statutes (written laws). After a bill has passed both the House of Representatives and the Senate, it becomes law if the president signs it. If the president vetoes the bill, Congress can override a veto with enough votes and the provision will become law despite the president's veto. Federal laws

are codified in the *United States Code* (abbreviated U.S.C.). A major law may have provisions found in many different sections of the *United States Code*. The ACA is a good example: its provisions are codified in several sections of the *United States Code*, including those that deal with taxes, with Medicaid, and with employment.

State legislatures enact statutes through similar processes and have similar codification systems (often readily available on state government websites). Local government authorities (including cities and counties) are also empowered to enact laws, which are sometimes known as *ordinances*. Enactments by federal, state, and local authorities all can apply simultaneously to a healthcare organization. For example, a not-for-profit hospital that wants to be exempt from taxes will strive to meet the exemption standards not only of the federal government, but also of the state government and perhaps a local taxing authority such as the city or county. The tax-exemption standards of these different jurisdictions are likely to be similar but not identical.

To further complicate matters, although statutes (and their implementing regulations) should be drafted so that they are clear enough for people to understand what is required and what is not, absolute clarity is rarely possible. Statutes are somewhat general, and questions almost always arise about their meaning or their application to a particular case, particularly in a novel situation. For this reason, courts (in the person of judges) are often called upon to engage in **judicial interpretation**—that is, to explain the meaning of the statutory language.

judicial interpretation The way the judiciary explains or clarifies the meaning of a legal provision and applies it to a specific case. Judicial interpretation can involve the meaning of language in a constitution, statute, or regulation; it can also involve the meaning of contracts, prior court decisions, or other writings pertinent to the issue at hand.

Rules of construction help judges interpret statutes. In some states, rules of construction are themselves the subject of a separate statute. Some of the more common rules of construction include the following:

- Absent a contrary definition in the statute, words must be given their plain, ordinary, and literal meaning, even if the legislative intent might suggest a different interpretation. (This is the *plain meaning rule*.)
- Despite the plain meaning rule, a statute should be internally consistent, so that the meaning of one provision is not divorced from the functioning of the rest of the law.
- Interpretation of a provision's meaning should be consistent with the stated intent of the legislature and should give effect to all the statute's key provisions.
- If a provision is unclear, the statute's purpose, the result to be attained, its legislative history, and the consequences of one interpretation over another are among the analytical factors that might be considered.

These "rules" are not inflexible, and judges often disagree about how to apply them, but the rules do help one to ascertain the meaning of statutory provisions and their application to individual cases. Consider these rules

when you read the US Supreme Court's discussion in *King v. Burwell* (see chapter 2) of what is meant by the ACA's phrase "established by the State."

Judicial interpretation, whether it involves constitutions, statutes, regulations, or other language, is the pulse of the law, and numerous examples can be found throughout this text. Readers should be alert for them and try to discern the different philosophies of interpretation reflected in the majority, concurring, and dissenting opinions.

Administrative Regulations

The third major source of law is particularly important in the healthcare arena: administrative regulations. At the federal level, Congress typically delegates to one or more federal agencies the job of fleshing out the practical specifics of a statute that it enacts. State legislatures do the same. If, as we often hear, "the devil is in the details," those details are found in agency-promulgated regulations and less formal pronouncements such as FAQs, guidance documents, and enforcement memoranda. These subregulatory materials do not quite have the force of law, but they provide key insights into how the agency views the legal requirements and its own responsibilities in enforcing them.

Administrative agencies are not mentioned in the US Constitution, but they are extremely important actors that have considerable power in what is sometimes termed our evolving "administrative state." Agencies have powers that are akin to the three branches of government. That is to say, they have quasi-legislative power when they write regulations; they have executive power when they conduct investigations and seek to enforce their rules; and they perform quasi-judicial functions when they adjudicate disputes over potential violations. On a day-to-day basis, healthcare personnel are typically far more concerned with the details of administrative regulations than they are with the legal principles found in constitutions, statutes, or judicial decisions.

administrative law The branch of law that concerns the creation and powers of administrative agencies, the rules and regulations those agencies make, and the relationships among the agencies and the public at large.

Administrative law is the type of public law that deals with the rules of government agencies, and it has greater scope and significance than some people realize. This fact was noted more than two centuries ago by the Irish and British statesman Edmund Burke (1729–1797), who, when writing about the government of England, stated,

> The laws reach but a very little way. Constitute government how you please, infinitely the greater part of it must depend upon the exercise of powers, which are left at large to the prudence and uprightness of ministers of state. [A]ll the use and potency of the laws depends upon them. Without them your commonwealth is no better than a scheme upon paper, and not a living, active, effective organization.

Administrative agencies exist at all levels of government: local, state, and federal. Well-known federal agencies that affect healthcare include the National Labor Relations Board (NLRB), Centers for Medicare & Medicaid

Services (CMS), Internal Revenue Service (IRS), US Department of Health and Human Services (HHS), Federal Trade Commission (FTC), and Food and Drug Administration (FDA). State-level administrative agencies include boards of professional licensure, Medicaid agencies, workers' compensation commissions, zoning boards, and numerous other agencies whose rules affect healthcare organizations.

Delegation of rulemaking authority puts this responsibility in the hands of experts, but the enabling legislation stipulates the standards to be followed by an administrative agency when it writes the regulations. At the federal level, the Administrative Procedure Act (5 U.S.C. §§ 551–559) specifies the processes that agencies must follow to enact regulations and the circumstances (e.g., public health emergencies) under which those rules can be waived or their timelines shortened. In general, to commence a rulemaking, a federal agency must publish in the *Federal Register* (in print and online) a *notice of proposed rulemaking* indicating what it intends to do and seeking public comment.

Anyone may submit comments, and as a healthcare administrator, you might well be tapped to help draft comments that will be submitted on behalf of your organization or a professional association. Public comments are also a way for healthcare advocates to elevate the voices of patients and others who may be affected by a proposed rulemaking. Absent an emergency, this process is rarely quick, and when there are many competing views or changes in executive branch leadership, it can drag out for quite some time. For example, it took 11 years for the first regulations to be issued to implement the federal Emergency Medical Treatment and Labor Act (EMTALA) of 1986.

When it publishes the final rule, the agency will include a preamble setting out its rationale for the regulatory decisions it made and how it accounted for the comments it received. The final rule will be published in the *Code of Federal Regulations* (abbreviated C.F.R.). States have similar procedures for rulemaking by their agencies and similar regulatory compilations. To survive a legal challenge, a

Legal Brief

Statutes are "no better than a scheme upon paper," to use a phrase from Edmund Burke (1729–1797), a British statesman, economist, and philosopher. Their effectiveness depends on the expertise of the personnel within the administrative agencies. Agency personnel are charged with putting meat on the statutory bones by drafting regulations, consistent with the Administrative Procedure Act, and publishing other interpretive and enforcement guidelines. Courts often defer to administrative regulations and interpretations, thus giving agencies significant power to interpret and enforce the laws.

The question of when judicial deference is appropriate has both legal and political implications, and at least two schools of thought have emerged. *Chevron deference*, a term coined after a US Supreme Court case involving the Chevron oil company, holds that if a statute is ambiguous, the courts should defer to an agency's interpretation so long as that interpretation is reasonable (*Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 [1984]).

On the other hand, *Skidmore deference*, so called for a 1944 Supreme Court case and

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revitalized in 2000, narrows the scope of *Chevron* deference. The *Skidmore* viewpoint holds that (1) an agency's policy statements, manuals, enforcement guidelines, and other subregulatory interpretations do not warrant deference and are "entitled to respect" only to the extent that they are persuasive; and (2) an agency's interpretation of its own regulation is warranted "only when the regulation's language is ambiguous" (*Christensen v. Harris County*, 529 U.S. 576, 588 [2000], citing *Skidmore v. Swift & Co.*, 323 U.S. 134 [1944]).

Aside from the *Chevron* and *Skidmore* approaches, the makeup of the US Supreme Court in June 2022 suggested a reluctance to give any deference to administrative agencies unless their actions were clearly authorized by Congress. For example, in *West Virginia v. Environmental Protection Agency* (597 U.S. ___ [2022]), a 6–3 majority of justices refused to defer to the Environmental Protection Agency's expertise in regulating carbon emissions from power plants, stating that, instead, there must be "clear congressional authorization" for the agency to regulate in the way intended.

This ruling and the philosophy behind it reflect skepticism toward the power of administrative agencies and a conservative approach that favors reducing the power of the administrative state.

regulation must be appropriately adopted, within the scope of the authorizing legislation, and constitutional.

Judicial Decisions

The final major source of law is judicial decisions, often derided as "judge-made law." And while it may seem undemocratic that one or a few members of the judiciary (or administrative law judges) can "make law," it is indisputable that to decide a case, it is often necessary to construe the meaning of constitutional, statutory, or regulatory language. For example, in 2020, the US Supreme Court had to decide whether the prohibition of "sex discrimination" in the Civil Rights Act of 1964 includes discrimination based on sexual orientation or transgender status. (Answer: *it does*. See chapter 4.).

At other times, judges must explain the meaning of relevant precedents set in earlier opinions. In doing so, they engage in common-law decision-making. For example, a court might be presented with the question of whether a provision in a gestational surrogacy agreement is "contrary to public policy" (see chapter 15). The **holding** in the case might make new law, or it might confirm earlier related precedent.

holding
The portion of a judicial decision that states how the law is being applied to the facts of the case. Many cases contain *dicta* (singular *dictum*, from Latin "to say"), which are side remarks that are not necessary for the decision and thus do not have precedential value.

Common-law decision-making is particularly important in what is known as *private law*, the type of law that predominantly concerns legal issues between individuals or private entities, in contrast with *public law*, which focuses on legal issues between an individual or entity and a government. Contracts and torts (including medical malpractice) are key areas of private law for healthcare organizations, as discussed in chapters 5 and 6.

The Power of Precedent

The common law produced two ancient 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. Although writs are significant in individual cases, we need not discuss them further here.

On the other hand, **stare decisis** is a fundamental principle that is key to understanding how the common law works. Stare decisis is essentially the concept of precedent. It requires that courts look to past disputes involving similar facts and similar legal principles when considering how to rule in a pending case. Unless there is good reason to abandon precedent, courts should ground their conclusions in the reasoning expressed in their own prior decisions and those of appellate courts above them. Key goals of this practice are to engender stability in the legal system and respect for the judicial process (see Legal Brief).

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.

writ
A court order commanding someone or an organization to perform or cease performing a particular act.

stare decisis
Latin for "to stand by things decided," stare decisis refers to the idea that appellate courts should stick to their prior precedents absent some compelling reason to the contrary. It also incorporates the directive that lower courts are bound to respect the precedents of higher courts within their jurisdiction when ruling on cases with similar facts.

Consider, for example, the opening sentence of the controlling opinion in *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[7] in which Justices Sandra Day O'Connor, Anthony Kennedy, and David Souter summed up stare decisis in nine memorable words: "Liberty finds no refuge in a jurisprudence of doubt."

The *Casey* case, decided in 1992, hinged on whether to uphold or overturn *Roe v. Wade*, the 1973 decision that established a right to abortion grounded in the Constitution's protection of "liberty interests." The plurality opinion (aspects of which were joined by other justices) focused in part on the extent to which stare decisis requires upholding a prior decision even if the current justices might have decided the precedential case differently. As the court explained,

> [O]nly 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.[8]

By way of contrast, 30 years after *Casey*, a new set of justices applied a different philosophy about precedent and reached a stunningly different conclusion than the *Casey* court. Writing for the majority in *Dobbs*[9] (discussed earlier in this chapter), Justice Samuel Alito stated, "No Justice of this Court has ever argued that the Court should *never* overrule a constitutional decision, but overruling a

Justice O'Connor was the first woman appointed to the US Supreme Court and the only female justice at the time *Casey* was decided.

precedent is a serious matter. It is not a step that should be taken lightly." Alito went on to list "five factors [that] weigh strongly in favor of overruling *Roe* and *Casey*: the nature of their error, the quality of their reasoning, the 'workability' of the rules they imposed on the country, their disruptive effect on other areas of the law, and the absence of concrete reliance." After analyzing each of these factors at length and finding that they are not compelling, he concluded,

> *Stare decisis*, the doctrine on which *Casey*'s controlling opinion was based, does not compel unending adherence to *Roe*'s abuse of judicial authority. *Roe* was egregiously wrong from the start. Its reasoning was exceptionally weak, and the decision has had damaging consequences. And far from bringing about a national settlement of the abortion issue, *Roe* and *Casey* have enflamed debate and deepened division. It is time to heed the Constitution and return the issue of abortion to the people's elected representatives.

(*See* The Court Decides at the end of chapter 15 for a lengthy excerpt from the *Dobbs* opinions.)

As mentioned earlier, appellate courts (not trial courts) establish binding precedent, which applies internally and 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 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. For example, the California Supreme Court's decision in *Tarasoff v. Regents of the University of California* (discussed in more detail in chapters 5 and 10) is binding precedent only in California, but numerous other state courts have found its reasoning to be persuasive and adopted it as their own. Similarly, a federal trial court is bound by the decisions of the US 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 in Latin means "a thing or issue settled by judgment." 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 suing regarding the same matters.

Federal and State Court Systems

In a perfect world, we would not need courts and lawyers. This idea might have inspired William Shakespeare's famous line in *Henry VI,* "The first thing we do, let's kill all the lawyers."[10] 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, something he often did. Regardless of one's interpretation of the play, we do not live in Utopia, so we do need courts and lawyers.

There are more than 50 different 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; there are also tribal courts with their independent spheres of authority. 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 (and legislatures) adopt different approaches to a novel issue, the states can become a testing ground on which a preferred solution eventually might become apparent.

One relatively unique aspect of US federalism is the overlapping jurisdiction between the federal and the state courts. Our state courts are courts of general jurisdiction. That means they can rule on any legal issue except where a federal statute or the US Constitution grants exclusive jurisdiction to the federal courts.

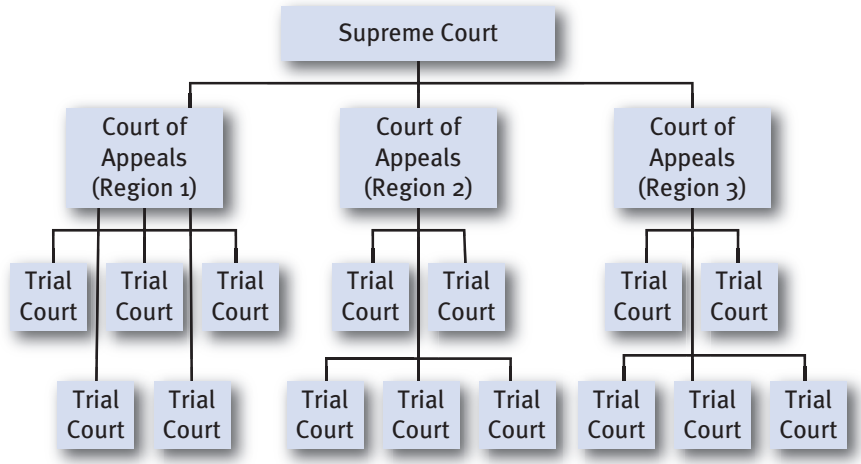
The federal courts are courts of limited jurisdiction, meaning that they can hear cases only as authorized by the US Constitution or federal statutes. Issues of purely state law do end up in the federal courts, though, particularly when the parties are from different states. As described later, this sort of *diversity jurisdiction* is one avenue for getting to federal court. The other avenue is *federal question jurisdiction*, in which the primary legal issue relates to a federal statute or the US Constitution.

Federal Courts

The federal court system is divided into three tiers: district courts, circuit courts, and the US Supreme Court (see exhibit 1.3). The judges on these courts are known as "Article III judges," after the section of the Constitution related to the judiciary. They are nominated by the president, confirmed by the Senate, and have lifetime tenure.

There are about 1,000 district court judges in 94 courts, each of which covers a particular geographic area. A district spans a portion of a state (or territory) or an entire state. Federal trials take place in district courts, either before a judge (referred to as a *bench trial*) or a jury. Cases involve both legal questions, which are for the judge to decide, and factual questions, which are decided by the "fact-finder"—the jury in a jury trial or the judge in a bench trial.

EXHIBIT 1.3
Model of a Typical Three-Tier Court Structure



As decreed by the relevant federal laws, the federal courts (beginning with the district courts) have *exclusive jurisdiction* over certain kinds of cases, including alleged violations of federal antitrust or securities laws, bankruptcy, and issues related to the Employee Retirement Income Security Act (ERISA). Federal and state courts have *concurrent jurisdiction* in cases arising under the US Constitution or 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.[11] These suits are called *diversity of citizenship* cases.

For example, although medical malpractice claims are almost always grounded in state law, if the injured patient and the allegedly negligent doctor reside in different states, the case may be brought in federal court. There is diversity of citizenship because the parties are from different states. There might be strategic reasons for filing a suit in federal court as opposed to state court. The federal district court hearing the case will apply the relevant state law on medical malpractice claims in deciding which party should prevail, and any appeal will go to the federal circuit court for that geographic area.

Concurrent jurisdiction also means that state courts may decide issues involving federal law (unless, as discussed earlier, the case involves an area of exclusive federal jurisdiction). For example, if a missed diagnosis in the emergency department caused injury to a patient, the patient might sue the hospital for medical malpractice ("negligent failure to diagnose") and for violating EMTALA ("failure to conduct an appropriate screening examination"). That case could be heard in state court or in federal court under federal question jurisdiction because EMTALA is a federal statute. In either situation, the trial court would need to determine both the facts and whether

those facts constitute liability under the different legal standards expressed in the state's medical malpractice law and in EMTALA. The hospital might be liable under either state law or federal law, both, or neither. Note that claims involving federal statutes and the US Constitution may also be tried in state court, depending on the situation.

The losing party in federal district court has a right to appeal to a US court of appeals, where the case is heard by a panel of three judges. In rare situations involving cases of exceptional importance, all the judges on the circuit court might consider a case after the initial panel has issued its ruling. In this case, the judges are said to be sitting *en banc*. There are 13 appeals courts, 12 of which are geographically organized and hear cases from the district courts in their respective regions.

The Court of Appeals for the Ninth Circuit covers the biggest geographic area and hears the most cases each year. The District of Columbia Circuit covers the smallest geographic area, but it is highly influential, partly because of the number and importance of the cases it hears involving federal regulations. The other federal appeals court is the US Court of Appeals for the Federal Circuit, which has subject-matter responsibilities rather than oversight of a given region. It hears appeals in specialized cases, such as those involving patent laws or specific statutes assigned to it by Congress (see exhibit 1.4).[12]

At the highest level of the federal court system, of course, sits the US Supreme Court, with its nine justices. Most litigants who lose at the court

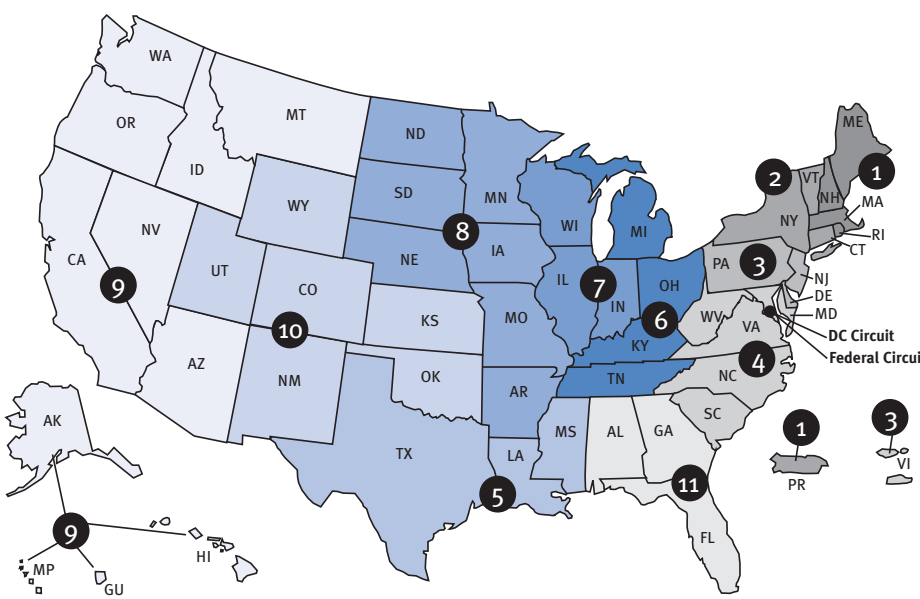


EXHIBIT 1.4
Map of US Courts of Appeals

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.

of appeals level do not have an absolute right to have their case heard by the US Supreme Court. Instead, they must petition for a **writ of certiorari**—an order to the lower court requiring that the case be sent to the high court for review—and they must persuade at least four of the nine justices that the issue merits the court's attention. The Supreme Court "grants cert" (i.e., grants certiorari) in about 80 cases per year from the 7,000 to 8,000 petitions it receives each year. If the court "denies cert," the lower court's decision stands. The Supreme Court is most likely to accept an appeal when a significant interpretation of federal statutory or constitutional law is at stake or when there is a "circuit split" (meaning that at least two circuit courts have come to different legal conclusions on the same issue).

As an example, consider the initial cases challenging the constitutionality of the ACA. Starting on the day that President Barack Obama signed the ACA into law in March 2010, challengers filed lawsuits in federal district courts across the country arguing that Congress did not have the constitutionally grounded authority to enact key provisions of the law, and therefore the entire law must go. Several circuit courts reached different conclusions about the constitutionality of the ACA, throwing into confusion the fate of the most consequential piece of healthcare legislation since the enactment of Medicare and Medicaid.

The Supreme Court could have denied cert, but because of the importance of the issues and the split among the circuit courts, there was little doubt that it would take the case. The result was *National Federation of Independent Businesses (NFIB) v. Sebelius*,[13] which spawned the longest Supreme Court oral argument in modern times. Argument took place for more than six hours over three days—typically, cases get just one hour for oral argument. This case also generated intense public interest and the most *amicus* (friend of the court) *briefs* ever. The Court's decision narrowly upheld the constitutionality of most of the ACA, excising only the requirement that states expand their Medicaid programs.

The *NFIB* decision was a landmark not only for the substance of healthcare law but also for issues of constitutional interpretation. It is now a staple of constitutional law textbooks, typically excerpted in more than one textbook section because the decision sets precedents relating to Congress's constitutional authority to regulate interstate commerce, to levy taxes, and to attach conditions to spending bills (for a more thorough discussion of this case, see chapter 2).

State Courts

As in the federal judiciary, state court systems are typically divided into three levels: trial courts, appeals courts, and a high court (usually called the state supreme court). 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, 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 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 examining the evidence from the trial court and to interpreting questions of law, not questions of fact. Appellate courts always have more than one judge and do not have juries.

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

Alternatives to the Court System

The primary alternatives to the court system are mediation and arbitration. Both forms of *alternative dispute resolution* are typically faster and less expensive than using the court process and may provide more confidentiality. In mediation, a neutral third party aims to help both sides come to an agreement. In arbitration, the neutral third party renders an opinion, which might or might not be binding.

For certain types of cases or amounts in dispute, a court alternative might be required, at least as a preliminary matter. Parties to a medical malpractice lawsuit, for example, might be required to try mediation to see whether a settlement can be reached before trial. One party or the other might be more likely to settle having heard the assessment of a neutral, knowledgeable third party (e.g., a retired judge who acts as a mediator). However, the mediator cannot force a settlement.

It is increasingly common for contracts to require that disputes be handled through **arbitration**, which is usually but not always binding. Arbitration involves submission of a dispute for decision (binding or not) by a neutral third person or a panel of experts outside the judicial process; the decision is often binding. When mandatory arbitration is a bargained-for agreement between sophisticated parties, it can be a logical and time- and money-saving approach. Statutory law in most states favors voluntary binding arbitration and frequently provides that an agreement to arbitrate is

arbitration
An extrajudicial process of dispute resolution by one or more persons with subject-matter expertise chosen by mutual consent of the parties.

enforceable by the courts.[14] Particularly when one party is vulnerable or not in a position to bargain (a patient, say, or a nursing home transfer), mandatory arbitration clauses have been voided by courts as contrary to public policy, and they are an increasing focus of concern among legislators.

Litigation Process

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, specifies the 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.

Complaint, Answer, Reply

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

In response to the summons, the defendant files an answer to the complaint, admitting to, denying, or pleading ignorance of each allegation. The plaintiff then typically files a reply. 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.

Discovery Phase and Motions

In rare cases, the court's decision or a settlement agreement between the parties quickly follows the complaint and answer stages. Usually, however, several months (or even years) elapse between commencement of the action and settlement or trial. During this time, each party engages in *discovery*, an attempt to determine the facts and strength of the other party's case. Note that discovery might require action by a nonparty. For example, a physical therapy clinic might be required to produce healthcare records of a patient who is suing the driver of the car that allegedly hit and injured the patient.

During the discovery phase, parties may use any or all of the following techniques to uncover relevant facts and nonprivileged information (though

courts may impose limits on the number of each category of discovery that may be requested) and thereby assess 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 in some circumstances.
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. *Examination of property.* Rarely used in healthcare cases but could come up when the condition of premises or devices is at issue.
6. *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.

subpoena *duces tecum*
A request by one of the parties to a suit, that asks a witness or the opposing party to bring to court or to a deposition any relevant documents under the other's control.

Before trial, it is common for one or both parties to submit pretrial motions to limit the scope of issues to be tried or to dismiss the case altogether. A common type of pretrial motion is a motion for **summary judgment** as to one or more of the claims in the case. This helps narrow the issues to be decided and might speed up appeal of key legal questions. The trial court judge will grant a motion for summary judgment if, on viewing the facts in the light most favorable to the nonmoving party, there are no genuine issues of material fact, and the moving party is entitled to judgment as a matter of law.

summary judgment
An order by a court finding in favor of one party against the other without a trial. It can be 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, Fed. R. Civ. Proc.).

Many appellate court decisions are based on appeals from grants of summary judgment. The 2012 *NFIB* decision about the constitutionality of the ACA, for example, was decided at the district court level on summary judgment because, at its core, the case was one of constitutional interpretation that did not require much, if any, factual inquiry.

Settlement, Trial, Appeal

Most civil actions are dismissed or settled before trial. Part of the point of discovery is that all the evidence should be available to the parties before trial. Surprise witnesses and out-of-the-blue evidence make for good television but

COVID Connection

In both law and medicine, the COVID-19 pandemic spurred increased use of remote access technology, notably, telemedicine visits and Zoom hearings. With courthouse access limited, judges throughout the country heard motions, and even entire trials, with participants (including jurors) logging in from their homes or offices. The jury is still out on the overall success of this experiment. Nonetheless, some aspects of litigation practice seem well suited to the efficiencies of remote access. Zoom hearings related to scheduling and discovery questions, for example, might well continue beyond the public health emergency. For a humorous look at technology challenges, search online for the video of a hearing in which a lawyer stuck in a Zoom filter reassures the judge that "I am not a cat."

inefficient dispute resolution. With all the evidence at hand, and a sense of the financial and other risks of proceeding to trial, parties commonly engage in settlement negotiations. If they reach an agreement, the case is dismissed by mutual consent or with the court's approval, if required (e.g., when a child's interests are involved).

A trial begins with the selection of a jury if either party has requested a jury trial and it is an option for that type of case. After jury selection, each attorney makes an opening statement that explains matters to be proven during the trial. The plaintiff's attorney then calls witnesses and presents other evidence; the defense has an opportunity to cross-examine each witness. Then the defendant's attorney calls witnesses and presents its evidence, subject to cross-examination by the other side. Finally, there might be rebuttal witnesses and evidence. A party may ask the court for a **directed verdict**. They judge 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; however, such motions are rarely granted.

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.

Before the jury begins its deliberations, the judge gives the jurors instructions concerning applicable law. The jury retires to deliberate until it reaches a verdict (or declares that it is unable to do so, a rare circumstance known as a "hung jury"). 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 of 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. Note that attorneys will often request a directed verdict or judgment NOV simply to preserve their right to appeal the case. Without bringing these motions, a party might be deemed to have forfeited the right to appeal.

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.

The judge and the jury each play a key role in the trial. The judge decides whether evidence is admissible and instructs 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 NOV. The

jury decides the facts and determines whether the plaintiff has proven the allegations by the appropriate standard. In civil cases, that standard is usually a preponderance of the evidence, which means more likely than not. This is quite different from the "beyond a reasonable doubt" standard used in criminal cases. In rare cases, the outcome suggests that the jury finds the application of the legal standard unjust and decides the case accordingly. This phenomenon is known as *jury nullification*.

The next stage in litigation is often an appeal. For a variety of reasons (e.g., satisfaction with the verdict, unwillingness to incur further expense), not all cases go to an appellate court. In the event that a case does move to a higher court, the party that brings the appeal (the losing party in the trial court) is usually called the *appellant*, and the other party is the *appellee*. Thus, 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).

An appellate court's 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's decision, modify or reverse the decision, or reverse it and remand (send back) the case for a new trial.

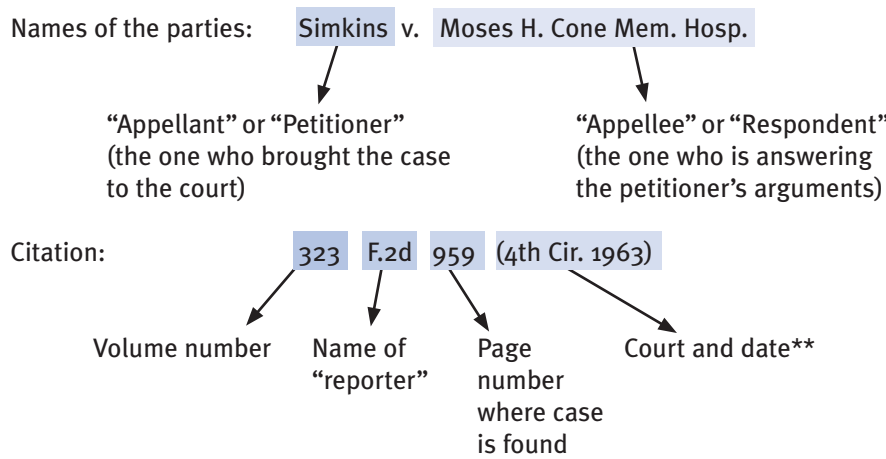
A Turning Point in the Quest for Healthcare Justice

Students of healthcare administration should know something about the law's role in maintaining and then in dismantling formal racial segregation in hospitals. This history informs current efforts to address healthcare disparities. It also highlights many of the types of law discussed in this chapter, as well as litigation processes. As you read the following section, consider what shades of difference may exist from time to time between moral standards, public policy, and legal requirements. Also note the judiciary's role as an interpreter of the Constitution's meaning, the uses of litigation compared with legislation, and the role of statutes in expressing societal norms.

As discussed earlier, the Fourteenth Amendment to the US Constitution was one of three amendments adopted in the wake of the Civil War. It requires states to extend due process and equal protection of the law to all their citizens, thus mirroring the Fifth Amendment's requirements of the federal government. (The other two Reconstruction Era amendments were the Thirteenth, which outlawed slavery, and the Fifteenth, which granted the right to vote to Black men.) The post–Civil War Reconstruction Era did not last long, as efforts to integrate newly freed people gave way to efforts to limit their rights through intimidation, violence, and law. "Jim Crow laws," enacted throughout the South, legalized racial segregation, including in the

EXHIBIT 1.5
Legal Citation System

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



All US Supreme Court decisions are published, as are roughly a quarter of circuit court decisions and an even smaller percentage of district court decisions. Of course, many of these unpublished decisions are now available on the internet, even though they may be marked "not for publication." State and federal court decisions are published in the National Reporter System (NRS) of West Publishing, a subsidiary of Thomson Reuters. The NRS is organized by level and location of the courts.

Even though advance copies of decision are often issued, only the printed, bound volume of the National Reporter System contains the official version of a court's decision. The volume number is generally known before pagination; thus, a blank space will be given after the name of the report when citing to a case that has not yet been published in final form. For example, see the citation to *West Virginia v. Environmental Protection Agency*, 597 U.S. ___ (2022), discussed in a Legal Brief earlier in this chapter.

provision of healthcare. Healthcare segregation in the North was less likely to be based on law, and more commonly grounded in hospital and medical association policy. And, of course, the racialized decisions of individuals—healthcare providers, administrators, and board members—permeated the system.

In one of its more shameful decisions, the US Supreme Court in 1896 upheld Jim Crow laws as constitutional under the Fourteenth Amendment. This decision, *Plessy v. Ferguson*,[15] involved a challenge to a state law that required racially segregated railroad cars. The court ruled that this "separate but equal" state law was not a violation of the Constitution's equal protection clause, and it did not require any assessment of the actual similarity of

the racially separate but supposedly "equal" facilities. The court's often-criticized opinion reasoned that the Fourteenth Amendment "could not have been intended to abolish distinctions based upon color, or to enforce . . . a commingling of the two races."

A prominent federal healthcare law explicitly supported and codified the Jim Crow regime in hospitals. The 1946 Hill-Burton Act[16] authorized vast federal funding in support of state plans to expand hospital capacity throughout the country. Hill-Burton nominally prohibited racial discrimination, but, in deference to Southern states (where most hospitals were either fully or partially segregated by race), it contained a sweeping exception for "cases where separate hospital facilities are provided for separate population groups."[17] The implementing regulations tracked this language and thus authorized funding for hospitals that excluded or segregated Black patients, staff, and providers if that was part of the state's plan.

Nearly a decade later, the US Supreme Court ruled unanimously in *Brown v. Board of Education* (1954) that "separate but equal" public schools are inherently unequal and violate the Fourteenth Amendment's equal protection clause.[18] The court then ordered public schools to desegregate "with all deliberate speed," a directive that, in practice, led to decades of delays and opposition and attempts at legal "workarounds." Although the *Brown* decision concerned only elementary schools, the rationale behind this new precedent should clearly have applied to all government programs. However, it was nearly another decade before separate but equal was addressed in the context of Hill-Burton.

In 1963, the US Court of Appeals for the Fourth Circuit heard a case that has been called "the *Brown v. Board of Education* for hospitals."[19] Dentist George Simkins, the head of the local chapter of the National Association for the Advancement of Colored People, and several Black doctors and patients sued two private, not-for-profit hospitals in Greensboro, North Carolina, arguing that their segregationist practices violated the US Constitution. Both hospitals had received Hill-Burton funds pursuant to North Carolina's plan for hospital expansion (as had the town's other hospital, the smallest of the three, which served Black patients and had Black physicians on staff). The federal district court dismissed the case on summary judgment, holding that the US Constitution's equal protection requirements did not apply to these private businesses. The plaintiffs appealed (see The Court Decides at the end of this chapter).

The appeal was unusual in at least two respects. First, the appellate court decided on its own to hear the case en banc—that is, with all the court's judges, not just the usual panel of three. Second, in an action that is rare and was perhaps unprecedented at the time, the US government intervened (joined the lawsuit) on the side of the plaintiffs to challenge the

constitutionality of a law that had been passed by Congress. The Department of Justice did so during the thick of the 1960s Civil Rights Movement, a prominent aspect of which was the push for healthcare justice, including hospital desegregation.

In a 3–2 decision, the Fourth Circuit held in late 1963 that the hospitals' involvement with the Hill-Burton program provided the requisite "state action" to bring them within the Constitution's equal protection requirements. As a result, they were required to desegregate. The court also ruled unconstitutional the Hill-Burton Act's "separate but equal" provision. The hospitals (with the explicit support of the American Medical Association and the American Hospital Association) petitioned the US Supreme Court to take the case, seeking to reverse this decision. The Supreme Court, with unusual speed, denied cert; this meant that the *Simkins v. Moses H. Cone Memorial Hospital*[20] decision stood as binding precedent.

At the same time, across the street from the Supreme Court, Congress was debating the Civil Rights Act, including a provision (Title VI) that would bar racial discrimination by any recipient of federal funds. Proponents of this provision highlighted the *Simkins* ruling, and the Civil Rights Act passed in 1964 with Title VI left intact. Future recipients of Hill-Burton funds could not racially discriminate; and *Simkins*-style lawsuits could be brought to force desegregation of private hospitals that had received this federal funding in the past.

In 1965, advocates of healthcare justice gained a more powerful legal tool when Congress established the vast Medicare and Medicaid programs (see chapter 2). Medicare was set to go live on July 1, 1966, covering all citizens over age 65, and any hospital that wanted to participate and receive Medicare payments could not overtly discriminate based on race in its admitting, privileging, or employment practices. The Lyndon B. Johnson administration, pressed by civil rights advocates, decided that mere "intent" to comply would be insufficient, and it tasked the newly created Office of Equal Health Opportunity (OEHO, now the HHS Office for Civil Rights) with visiting hospitals and documenting actual desegregation. When the OEHO began its work, "[m]ore than four thousand hospitals were clearly out of compliance, many resistant to becoming compliant."[21] Although the OEHO faced obstructionist tactics from powerful hospital leaders and board members, these bureaucrats, and the community members they worked with succeeded in ending overt racial segregation in hospitals throughout the country, and Medicare successfully launched.

The *Simkins* decision is not widely known. On its face, the Civil Rights Act is not healthcare legislation. And Medicare is not, per se, a civil rights law. But taken together, they were crucial factors in the ongoing quest for healthcare justice. They highlight the power of legal tools to advance efforts

to achieve equitable access to high-quality, affordable healthcare. As Martin Luther King Jr. said in an often-quoted March 1966 speech, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

Discussion Questions for Part 1

1. Identify a current problem that has healthcare implications. In your view, have constitutional, statutory, case law, or regulatory standards helped or hindered its appropriate resolution? Which branch of government is best suited to address it? Is it more a state or a federal issue?
2. Consider the term "Obamacare" as it is used in your community. Does it have positive or negative connotations? Is support for or opposition to the ACA a campaign issue in your community?
3. Have you ever been involved in litigation, arbitration, or mediation, either as a party, a witness, or a juror? What were your impressions of the legal system? Do you think the parties were adequately heard and that justice was done?
4. Go to Oyez.org and listen to a recent US Supreme Court oral argument in a case that interests you. Are you able to understand the legal issues? Is this what you expected from a Supreme Court hearing?
5. Have you ever reviewed a regulation or submitted comments about a proposed regulation? On what sort of regulations do you think a healthcare administrator might usefully offer an opinion?
6. Do you think it matters whether members of the judicial, executive, and legislative branches include people with diverse backgrounds? Why or why not?
7. What are the purposes of discovery? How might healthcare providers, whether institutional or individual, be involved in responding to a discovery request?

The Court Decides

Simkins v. Moses H. Cone Memorial Hospital
323 F.2d 959 (4th Cir. 1963) (en banc)

Sobeloff, Chief Judge

The threshold question in this appeal is whether the activities of the two defendants, Moses H. Cone Memorial Hospital and Wesley Long Community Hospital, of Greensboro, North Carolina, which participated in the Hill-Burton program, are sufficiently imbued with "state action" to bring them within the Fifth and Fourteenth Amendment prohibitions against racial discrimination. Beyond this initial inquiry lies the question of the constitutionality of a portion of the Hill-Burton Act. . . . Because of the importance of these questions the court, on its own motion, has heard the appeal en banc. *[This means that the appeal was considered by all the judges on the Fourth Circuit, not the usual three-judge panel.]*

The plaintiffs are Negro physicians, dentists and patients suing on behalf of themselves and other Negro citizens similarly situated. . . . The basis of their complaint is that the defendants have discriminated, and continue to discriminate, against them because of their race in violation of the Fifth and Fourteenth Amendments to the United States Constitution. The plaintiffs seek an injunction restraining the defendants from continuing to deny Negro physicians and dentists the use of staff facilities on the ground of race; an injunction restraining the defendants from continuing to deny and abridge admission of patients on the basis of race, . . . and a judgment declaring unconstitutional [the portions of the Hill-Burton Act and its implementing regulations] which authorize the construction of hospital facilities . . . on a 'separate-but-equal' basis. . . .

[Because the complaint challenges the constitutionality of a federal statute and affects the public interest, the United States moved to intervene (requested to participate) in the proceeding.] Its motion for intervention was granted and throughout the proceedings the [Federal] Government, unusually enough, has joined the plaintiffs. . . .

. . . .

Factual Background

. . . .

The claims of racial discrimination were, as the District Court found, "clearly established." In fact the hospitals' applications for federal grants for construction projects openly stated, as was permitted by [the Hill-Burton] statute, and regulation, . . . that 'certain persons in the area will be denied admission to the proposed facilities as patients because of race, creed or color.' These applications were approved by the North Carolina Medical Care Commission, a state agency, and the Surgeon General of the United States under his statutory authorization.

. . . .

When this action was commenced, the United States had appropriated $1,269,950.00 to the Cone Hospital and $1,948,800.00 to the Long Hospital. . . . These appropriations for the most part were after the Supreme Court's landmark decisions in Brown v. Board of Education *[the 1954 and 1955 US Supreme Court decision that overruled its prior precedent and unanimously held that the Fourteenth Amendment prohibits states from segregating students by race]* . . . .

. . . .

The point of present interest is not the equality or lack of equality in "separate-but-equal," but the degree of participation by the national and state governments. *[Though, in a footnote, the court cited a 1962 report finding that in North Carolina the hospitals "available to nonwhites were both inferior to those available to whites and more limited."]*

THE LEGAL ISSUE

In our view the initial question is . . . whether the state or the federal government, or both, have become so involved in the conduct of these otherwise private bodies that their activities are also the activities of these governments and performed under their aegis without the private body necessarily becoming either their instrumentality or their agent in a strict sense. . . .

[The court recognizes that purely private action would not violate the Constitution, but concludes that there is state action here, pointing to the "massive use of public funds and extensive state-federal sharing in the common plan" inherent in the Hill-Burton program's functioning. The test for what constitutes "state action" is different now; this is discussed further in chapter 14.]

. . . .

Moreover, the [Federal] Government's argument stresses the fact that the challenged discrimination has been affirmatively sanctioned by both the state and the federal government pursuant to federal law and regulation. . . . These federal provisions undertaking to authorize segregation by state-connected institutions are unconstitutional. . . . Unconstitutional as well under the Due Process Clause of the Fifth Amendment and the Equal Protection Clause of the Fourteenth are the relevant regulations implementing this passage in the statute.

[The court discusses the hospitals' counterarguments and dismisses them.] Not only does the Constitution stand in the way of the [defendant hospitals'] claimed immunity but there are powerful countervailing equities in favor of the plaintiffs. Racial discrimination by hospitals visits severe consequences upon Negro physicians and their patients. *[In a footnote, the court supports this statement by noting that "[r]acial discrimination in medical facilities is at least partly responsible for the fact that in North Carolina the rate of Negro infant mortality is twice the rate for whites and maternal deaths are five times greater." Furthermore "[e]xclusion of Negro physicians from practice in hospitals on account of their race denies them opportunities for professional improvement and has discouraged Negro physicians from practicing in the cities of the South."]*

Giving recognition to its responsibilities for public health, the state elected not to build publicly owned hospitals, which concededly could not have avoided a legal requirement against discrimination. Instead it adopted and the defendants participated in a plan for meeting those responsibilities by permitting its share of Hill-Burton funds to go to existing private institutions. The appropriation of such funds to the Cone and Long Hospitals effectively limits Hill-Burton funds available in the future to create nonsegregated facilities in the Greensboro area. In these circumstances, the plaintiffs can have no effective remedy unless the constitutional discrimination complained of is forbidden.

The order of the District Court is reversed. *[Two judges joined the chief judge's opinion, forming a narrow majority; two judges dissented, "[b]believing the majority both unprecedented and unwarranted."]*

Note: Internal citations have been omitted from this and all other The Court Decides excerpts. ■

(continued)

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Discussion Questions

1. Why has this case been called "the *Brown v. Board of Education* decision for hospitals"? How is it similar to *Brown*? How is it different?
2. This was the first case in which the federal government intervened to argue that a federal statute was unconstitutional. Noting particularly the date of this case, consider what factors might have influenced the US Department of Justice to intervene in this case, advocating for the plaintiffs' position.
3. The dissent noted that in August 1963, just a couple of months before this decision was handed down, "the Senate rejected a proposal that henceforth grants in aid to hospitals under the Hill-Burton Act be restricted to hospitals which are desegregated, and which practice no discrimination on account of race." Does that surprise you?
4. The US Supreme Court "denied cert" in this case. What does that mean? What is the practical consequence of that action?

~ ~

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. Therefore, let us review some history of how our health system came to be the peculiar creature it is.[22]

Appendix 1.1 at the end of this chapter provides 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. 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 shamanism and similar practices persist in many cultures today including those of some Native American tribes, the Hmong of Southeast Asia (see Shamanism: The Ancient Meets the Modern), certain African tribes, and practitioners of traditional Chinese medicine.

The ancient Egyptians were relatively advanced in terms of their medical knowledge.[23] They were familiar with anatomy (perhaps because of their embalming practices), they were aware of the connection between the pulse and the heart, they could diagnose and treat a few diseases, and they were adept at simple surgery and orthopedics. Magic and mysticism were prevalent nevertheless, and some of their medical practices were ineffective—even harmful.[24] 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.[25] 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 2,000 Years of Medical Practice

Being ignorant of the concepts and practices developed in Asia, the Middle East,

Shamanism: The Ancient Meets the Modern

A particularly striking example of the contrast between scientific medicine and traditional beliefs can be 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, Straus and Giroux 1997). The book tells the story of a severely epileptic Hmong child in California whose parents' beliefs in shamanistic animism severely challenged her physicians, caseworkers, and local officials. The book is sympathetic to both sides of the cultural divide, but the child's tragic end—she was in a persistent vegetative state for 26 years before dying at the age of 30 in 2012—highlights the problems caused by a lack of cultural competency.

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

and elsewhere, Greek and Roman physicians such as Hippocrates (ca. 460–370 BCE) and Claudius Galenus (known as Galen, ca. 131–201 CE) practiced *humoralism,* the belief that the body consisted of four basic substances (called *humors*) that determined one's state of health. According to this theory, an imbalance in the 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 often did more harm than good. For example, several twentieth-century scholars surmised that President George Washington, who died in December 1799 at age 84, succumbed to acute inflammatory edema of the larynx (which resulted in 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.[26]

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 patients 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 foundational developments started the process that gradually led to what we can call "modern medicine."

Anesthesia

One of these developments occurred in 1846 when physician John C. Warren (1778–1856), and dentist William T. G. Morton (1819–1868) performed the first significant public demonstration of the use of anesthesia at Massachusetts General Hospital. Using diethyl ether, and with Morton as his anesthetist, 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."[27] The era of painless surgery and dentistry

EXHIBIT 1.7
The Doctor, Sir Luke Fildes (1891)

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

had officially begun in the Western world (see Anesthesia: A Brief History).

Germ Theory and Vaccines

Use of anesthesia was followed in the 1860s by Louis Pasteur's (1822–1895) germ theory, the scientific principle 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 techniques and handwashing in obstetrical clinics, but he was roundly ridiculed until Pasteur provided scientific proof of this proposition.[28]

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]). 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 343 [1962]). Morton and Warren were unaware of Long's success when they performed their operation in 1846.

The term *anesthesia* (or *anaesthesia*), from the Greek meaning "absence of sensation," was coined by the American neurologist Oliver Wendell Holmes, father of the famed US Supreme Court Justice (Aidan O'Donnell, Anaesthesia: A Very Short Introduction [2012]).

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, as 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*, http://ushistoryscene.com/article/second-industrial-revolution [https://perma.cc/S6WU-UE5U] [last accessed Dec. 7, 2018]).

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,[29] 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 began around the end of the US Civil War (see 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.[30]

What Is Public Health?

Public health is the science of protecting and improving the health of people and their communities. This work is achieved by promoting healthy lifestyles; researching disease and injury prevention; and detecting, preventing, and responding to infectious diseases. Overall, public health is concerned with protecting the health of entire populations. These populations can be as small as a local neighborhood, or as big as an entire country or region of the world (*Public Health in Action*, CDC Found., https://www.cdcfoundation.org/what-public-health [https://perma.cc/HB9R-48VW]).

The Public Health System

As medical science began to advance, so, too, did greater awareness of preventive measures that would improve the health of entire populations.

In the 1850s—before the adoption of modern plumbing and public sanitation measures—the English physician John Snow (1813–1858) determined that a cholera epidemic in London had been caused by contaminated drinking water. His findings were disputed at the time, as most physicians held to the belief that the disease was caused by airborne "miasmas," but Snow was later proven to be correct,

and the offending bacterium was identified as *Vibrio cholerae*. Although cholera is still present in low- and lower-middle-income countries, water purification systems prevent its recurrence in most of the world today, and Snow is now considered to be the "father of modern epidemiology."[31]

The growing acceptance of epidemiology, germ theory, the value of vaccines, and other scientific advances in the mid- to late 1800s led to what we now recognize as the field of "public health," which has enabled the eradication of smallpox and vast decreases in the incidence of polio, diphtheria, measles, whooping cough, and other diseases. Public health measures have also worked to address noncommunicable health conditions such as obesity, diabetes, and tobacco- and mental health–related ailments. These efforts—especially the elimination of childhood diseases—were the main reason why average life expectancy at birth increased from about 40 years in 1850 to over 75 by 2000.[32]

In short, while the medical profession aims to cure, public health aims to prevent. As the American Public Health Association (APHA, founded 1872) states, "We champion prevention as both an effective and cost-efficient path to improved health and wellness."[33]

Each public health measure is met with resistance from entrenched groups, of course. For example, fluoridation of drinking water continues to be controversial in some areas even though it is an inexpensive and highly effective means of preventing dental cavities. Likewise, the use of iodized salt is highly effective in reducing iodine-deficiency disorders such as alopecia and goiter, but these diseases persist in many parts of the world.

Recently and most dramatically, COVID-19 vaccinations, mask mandates, and social-distancing requirements led to angry demonstrations, disinformation on social and mass media, and political obstruction. The US Surgeon General and other experts labeled this opposition a threat to the nation's health,[34] but it continued throughout the pandemic. Such phenomena illustrate the challenges that public health professionals face from conservative political elements, vested interests, and a skeptical public that feels empowered by social media to spread misinformation.

Public health activities are carried out through many hundreds of federal, state, and local agencies as well as nongovernmental organizations. As stated by the National Academy of Sciences,

> In the United States, government responsibility to protect the public's health is represented by public health agencies, state and local health departments, and by the federal Department of Health and Human Services. The public health system in the United States includes a wide array of other public agencies, such as environmental, occupational safety, mental health, developmental disability, and social service agencies at national, state, and local levels. It also includes national,

> state, and local private organizations and providers, such as health professional associations, citizen advocacy groups, the media, community health centers, and research foundations. Together, these participants in the system fulfill the mission of public health. The public health agencies, as the governmental representative of public health, focus this mission.[35]

A full review of the public health system is well beyond the scope of this text or any single course in healthcare administration. Accredited master of healthcare administration programs include courses that relate to public health (e.g., epidemiology, statistics). In addition, there are nearly 200 post-graduate degree (master of public health) programs that focus entirely on the subject. The topic is mentioned here simply to remind readers that promotion of health is not only the calling of physicians, nurses, midwives, and other care providers but also a social responsibility, a duty of individuals and organizations to act in the best interests of society as a whole.

The Nursing Profession

Coincident with scientific advances came improvements in the practice of nursing. The primary meaning of *to nurse* is "to feed at the breast" or "to suckle"[36]—thus, it is no coincidence that nursing was long considered solely "women's work." For centuries, much of nursing care was provided by religious women: 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 more than 90 percent female.[37]

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 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 other 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.[38] Because of her fame and her influential books *Notes on Hospitals* (1858) and *Notes on Nursing* (1859), Nightingale (known as "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."[39]

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).

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."[40]

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's 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 fate 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.[41]

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."[42]

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, the quality of education remained "highly variable and frequently inadequate."[43] It was presented in one of three ways: through apprenticeships with local practitioners, in proprietary schools owned by other physicians, or at the few universities that provided a combination of didactic and clinical training.

The few university-affiliated schools that existed taught diverse types of medicine, such as scientific, osteopathic, homeopathic, chiropractic, eclectic, physiotherapy, botanical, and Thomsonianism (which used herbs and application of different 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.[44]

It should be noted, of course, that alternative treatment modalities such as physical therapy, herbal remedies, and chiropractic have many followers today and can provide therapeutic benefit.

While all medical education at the time was disorganized, the situation for Black medical students was even more confused. The first Black physician in the United States, James McCune Smith (1813–1865), had to travel to Scotland to obtain his medical degree. No Black woman graduated from a medical school until Rebecca Lee Crumpler obtained her MD degree in 1864.

Nineteen Black medical schools opened after the Civil War. One author, writing in the journal of the National Medical Association (an organization for Black physicians), described their situation as follows:

> Before the turn of the 20 century, medical education for African Americans was haphazard, inconsistent, and of uneven quality. Black medical schools were either

> church-related missionary institutions or proprietary operations. . . . That some proprietary schools were pure commercial endeavors and little more than diploma mills further complicated and compromised the medical education of African Americans.[45]

As one might expect, given the racial attitudes that have persisted throughout our history, that it was virtually impossible for persons of color to gain admission to most medical schools well into the twentieth century In fact, "for more than 100 years, the AMA [American Medical Association] actively reinforced or passively accepted racial inequalities and the exclusion of African-American physicians."[46] The association has since formally apologized for its policies that excluded Black physicians from AMA membership and barred them from some state and local medical societies.[47]

Reform of the medical education 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 [B]lacks 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.[48]

The Early Twentieth Century

Physician education reform continued in 1904 when the 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*).[49] This document, issued in 1910, proposed new standards for medical schools and helped increase physicians' professional stature. In the wake of the *Flexner Report*, the number of medical schools was reduced and the quality of teaching improved. Only two of the Black schools survived, however: Howard University College of Medicine in Washington, DC, and Meharry Medical College in Nashville, Tennessee. Only two other historically Black medical schools have since been founded: Charles R. Drew University of Medicine and Science in Los Angeles (established in 1966) and Morehouse Medical College in Atlanta (established in 1975).[50]

In conjunction with the National Conference of Catholic Bishops, the CHA has for many years published *Ethical and Religious Directives for Catholic Health Care Services*. This publication contains guidance for Catholic healthcare institutions on moral issues including abortion, euthanasia, assisted suicide, sterilization, and collaborative arrangements with non-Catholic organizations. In some situations, the *Directives* present challenges for mergers, joint ventures, and similar corporate arrangements. They may also make compliance with state laws concerning availability of services difficult.

In 1914, the AMA council set the first standards for hospital internship programs and identified the few hospitals that met them. Concurrent with these efforts, the Catholic Hospital Association (now the Catholic Health Association of the United States, or CHA) was established in 1915. The number of Catholic hospitals was growing, and the new association said it wanted to respond to technological advances while ensuring that its hospitals' Catholic mission, identity, and values "would not be derailed by this new movement [for healthcare standardization]."[51] In 1920, CHA began publishing an official journal, *Hospital Progress* (now *Health Progress*), to further promote quality in inpatient healthcare.

Around the same time, the newly established American College of Surgeons (ACS) developed a set of minimum standards for hospitals and began on-site inspections of facilities. It found that fewer than 15 percent of hospitals met the standards. In 1951, the ACS joined the AMA, the American Hospital Association (established in 1899), and other groups to form the Joint Commission on Accreditation of Hospitals. Now known as The Joint Commission, it publishes *Standards for Hospital Accreditation*, a document cited frequently to establish the standard of care in negligence cases (see the discussion of the *Darling* case in chapter 7).

By the third decade of the twentieth century, hospitals were becoming high-quality organizations with state-of-the-art diagnostic and treatment methodologies. Use of X-rays (discovered in 1895) was common, as was administration of penicillin (discovered accidentally by Sir Alexander Fleming in 1928). Laboratory and other equipment became more sophisticated, not to mention more expensive. As hospitals became operationally more complex, they needed trained staff to handle personnel issues, billing, purchasing, medical records maintenance, fundraising, and similar corporate functions. Thus, a division of labor occurred: patient care was left to physicians, nurses, and other clinicians, whereas business activities were carried out by salaried administrative personnel.

Some hospital administrators were physicians, but many were nurses (and, in Catholic hospitals, often nuns) by training. Their quaint titles ("superintendent" or "nurse matron") reflected the old paradigm of hospital qua asylum. These titles eventually changed as hospital administration became a recognized profession. Like any good profession, it needed an

association, so the American College of Hospital Administrators (now the American College of Healthcare Executives) was established in 1933. At that time, there were more than 6,000 hospitals in the country—there had been fewer than 200 after the Civil War—and they needed professionals to run them.

What developed was a "peculiar bureaucracy" (Starr's expression)[52] with two lines of operational authority—one clinical and the other administrative. The former often considered hospitals merely to be "doctors' workshops," created for their benefit; the latter tended to see hospitals as dedicated to serving the broader needs of the community. Adding to the anomalous situation was the fact that most hospitals were ultimately governed by a board of trustees representing local religious, business, professional, philanthropic, or other community interests. The trustees were charged with making major policy and strategic decisions that management and (presumably) providers were expected to implement.

This odd governance and operating structure led to hospitals being described as resting on a "three-legged stool" of physicians, administrators, and governing board members. Few self-respecting sociologists or management consultants would recommend such a confounding arrangement, but it is what it is: a product of historical coincidence and practical considerations (see A Wry Definition).

A Wry Definition

A colleague at Washington University School of Medicine used to describe a hospital as "a collection of individual fiefdoms connected by a common heating, ventilating, and air-conditioning system." To what extent does the professor's point about individual fiefdoms remain valid now that most hospitals are no longer single buildings with a common HVAC system?

Other Health-Related Professions

As modern medicine advanced in the twentieth century, new types of professionals began providing services to complement the work of physicians and nurses. These included anesthesiology assistants, athletic trainers, audiologists, dietitians, dental hygienists, emergency medical technicians, medical assistants, nuclear medicine technicians, nurse practitioners, pharmacists, physical and occupational therapists, physician assistants, radiology technicians, respiratory therapists, speech-language pathologists, and others. It has been estimated that these *allied health professionals* (AHPs) now constitute nearly 60 percent of the healthcare workforce.[53]

Like physicians and nurses, AHPs are now subject to licensing and regulatory standards intended to protect the public and exclude unqualified persons. Of course, this legal regime can also inappropriately protect economic interests, as discussed in chapter 14 regarding legal prohibitions on anticompetitive behavior. These regulatory schemes vary from state to state, and

payment for AHP services varies depending on the patient's insurance coverage. Federal law does not license or regulate AHPs directly, but, of course, it now determines provider eligibility under Medicare and Medicaid, and federal policy positions can influence state licensing boards' regulatory activities.

World War II to the Present

As shown in appendix 1.1, most miraculous advances in healthcare—the "wonders of modern medicine"—have appeared within the past 100 years. These include more effective treatments for cancer, coronary artery bypass surgery and cardiac pacemakers, vaccines for polio and influenza, organ transplantation, and gene therapy. When used in the modern hospital by well-trained physicians, nurses, and allied health professionals, these wondrous and relatively new practices constitute the best healthcare the world has ever known.

These developments underscore the sagacity of Starr's comment that few institutions have changed as much in their recent history as have hospitals. Barely 200 years ago, they were horrid cesspools of suffering, infected by ignorance and medieval—even ancient—belief systems. Even as recently as 100 years ago, they were generally to be avoided. Today, just four or five generations later, the prospect of a hospital stay may cause some anxiety but is far less likely to inspire dread. In fact, hospital care is much more likely to be a cause for hope, recovery, and celebration of life.

As significant as these changes have been, however, consider what may happen in the next few decades. Universal insurance coverage (perhaps), improved disease prevention, better wellness programs, genetic and stem cell therapies, better information systems, high-tech tools, online doctor visits, a team approach to care, concierge medicine for all, greater use of complementary and alternative medicine, and competition among providers on the basis of value rather than cost—these developments and others not yet imagined will make the medicine of today seem as cumbersome to future generations as Civil War medicine appears to us.

Discussion Questions for Part 2

1. In your opinion, what was the most important development in the history of medicine? Be prepared to defend your position.
2. Define when "modern medicine" began and explain why you chose that moment in history.
3. Do you believe that people of all races and genders now have equal access to medical school, residencies, and medical staff privileges? If not, what barriers do you perceive, and what, if anything, can the law do about that?

4. Before reading this chapter, had you heard of the *Ethical and Religious Directives for Catholic Health Care Services*? If so, what was the context?
5. Describe what you think the healthcare system of the future should look like. Would it require different educational pathways for healthcare providers? Is it shaped by new medical discoveries or technological advances?

Chapter Summary

Part 1

Part 1 of this chapter discussed the following topics:

- The history and sources of law
- The relationships among the three branches of government
- The basic structure of the federal and state court systems
- Some basics of legal procedure in civil cases (the procedures followed in criminal cases are somewhat different and beyond the scope of this text)
- The quest for racial justice in healthcare

Part 2

Part 2 of this chapter discussed the following topics:

- The history of medicine
- "Modern medicine" as a relatively new phenomenon
- Major advances in medicine developed after the Civil War (e.g., anesthesia, vaccines)
- The differences between hospitals as we know them today and those a century ago

Vocabulary

administrative law
Affordable Care Act (ACA)
arbitration
common law
directed verdict
due process of law

holding
judgment NOV
judicial interpretation
law
stare decisis
subpoena *duces tecum*
summary judgment
writ
writ of certiorari

Notes

1. *See, e.g.,* Michelle J. Benton, *An Overview of Natural Law*, The Moral Liberal (Jan. 29, 2012), http://www.themoralliberal.com/2012/01/29/an-overview-of-natural-law [https://perma.cc/5SP9-PCX5].
2. Pete Williams, *Justice Stephen Breyer to Retire from Supreme Court, Paving Way for Biden Appointment*, NBC News (Jan. 26, 2022), https://www.nbcnews.com/politics/supreme-court/justice-stephen-breyer-retire-supreme-court-paving-way-biden-appointment-n1288042 [https://perma.cc/3TKX-2JPM].
3. Pub. L. No. 111-148, 124 Stat. 119, codified as amended at various titles and sections of the *United States Code*.
4. *Dobbs* v. *Jackson Women's Health Organization*, 597 U.S. ___ (2022).
5. Patricia Mazzei, *Florida Judge Will Temporarily Block 15-Week Abortion Ban*, N.Y. Times (June 30, 2022), https://www.nytimes.com/2022/06/30/us/florida-abortion-ban-blocked.html [https://perma.cc/M3TV-6WSW].
6. Quoted in Woodrow Wilson, Congressional Government: A Study in American Politics 1 (1885).
7. Planned Parenthood of S.E. Pennsylvania v. Casey, 505 U.S. 833 (1992).
8. *Id.* at 867.
9. *Supra* note 4.
10. William Shakespeare, Henry VI (act 4, scene 2).
11. 28 U.S.C. § 1332—Diversity of citizenship; amount in controversy; costs.
12. *See generally*, United States Courts, *About Federal Courts*, http://www.uscourts.gov/about-federal-courts [https://perma.cc/UE46-LDXC] (last visited Dec. 10, 2018).

13. National Federation of Independent Businesses v. Sebelius, 567 U.S. 519 (2012).
14. *See*, *e.g.*, Ohio Rev. Code Ann. § 2711.03, http://codes.ohio.gov/orc/2711.03 [https://perma.cc/4FLK-8ENL].
15. Plessy v. Ferguson, 163 U.S. 537, 544 (1886).
16. Hospital Survey and Construction Act, 42 U.S.C.. § 291—Congressional declaration of purpose.
17. 42 U.S.C.A. §291(e)—Projects for construction or modernization.
18. Brown v. Bd. of Educ., 347 U.S. 483, 495 (1954) (declaring segregated public schools unconstitutional), supplemented, 349 U.S. 294 (1955).
19. P. Preston Reynolds, *Professional and Hospital Discrimination and the US Court of Appeals Fourth Circuit 1956–1967*, 94 Am. J. Pub. Health 710, 712 (2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448322/pdf/0940710.pdf [https://perma.cc/AN5K-R3V5].
20. Simkins v. Moses H. Cone Memorial Hospital, 323 F.2d 959 (4th Cir. 1963) (en banc).
21. David Barton Smith, The Power to Heal: Civil Rights, Medicare, and the Struggle to Transform America's Health Care System 112 (Vanderbilt Univ. Press 2016). *See also* the documentary film The Power to Heal: Medicare and the Civil Rights Revolution (Bullfrog Films 2019).
22. Part 2 is synthetic historiography culled from many sources. Primary among them are Charles Singer & E. Ashworth Underwood, A Short History of Medicine (Oxford Univ. Press 1962); Paul Starr, The Social Transformation of American Medicine (Basic Books 1982); and American College of Healthcare Executives, Coming of Age: The 75-Year History of the American College of Healthcare Executives (Health Admin. Press 2008).
23. *See generally*, John F. Nunn, Ancient Egyptian Medicine (Red Rover Books 2002).
24. *See*, *e.g.*, Michael D. Parkins, *Pharmacological Practices of Ancient Egypt*, *in* Proceedings of the 10th Annual History of Medicine Days (W. A. Whitelaw ed., 2001).
25. *See*, *e.g.*, Health and Fitness History, *Ancient Babylonian Medicine*, HealthAndFitnessHistory.com, https://healthandfitnesshistory.com/ancient-medicine/babylonian-medicine/ [https://perma.cc/5X8N-88CE] (last visited July 17, 2019).
26. *See* Fielding O. Lewis, *Washington's Last Illness*, 4 Annals Med. Hist. 245–48 (1932); Creighton Barker, *A Case Report*, 9 Yale J. Biology & Med. 185–87 (1936); S. L. Shapiro, *Clinic-of-the-Month: General*

Washington's Last Illness, 54 Eye Ear Nose & Throat Monthly 164–66 (1975).

27. Cristin O'Keefe Aptowicz, *The Dawn of Modern Anesthesia*, The Atlantic (Sept. 4, 2014), http://www.theatlantic.com/health/archive/2014/09/dr-mutters-marvels/378688/ [https://perma.cc/FF2B-SVSJ].
28. *See* Semmelweis Society International, *Dr. Semmelweis's Biography*, at https://semmelweis.org/?s=biography [https://perma.cc/NYR5-YHWU] (last visited Oct. 10, 2019); O. Hanninen, M. Farago, & E. Monos, *Ignaz Philipp Semmelweis, the Prophet of Bacteriology*, 4 Infection Control 367 (1983).
29. Joseph Lister, *On the Antiseptic Principle in the Practice of Surgery*, 90 Brit. Med. J. (1867). For Lister's life generally, *see* Encyclopedia of World Biography, *Joseph Lister Biography*, https://www.notablebiographies.com/Ki-Lo/Lister-Joseph.html [https://perma.cc/X954-9NB9] (last visited Dec. 20, 2012).
30. Michael R. Gilchrist, *Disease & Infection in the American Civil War*, 60 Am. Biology Tchr. 258 (1998), www.jstor.org/pss/4450468 [https://perma.cc/H8CY-X4YP].
31. *See*, *e.g.*, David Vachon, *Doctor John Snow Blames Water Pollution for Cholera Epidemic*, UCLA Department of Epidemiology (2005), http://www.ph.ucla.edu/epi/snow/fatherofepidemiology.html [https://perma.cc/7EHX-S3A2]
32. *See*, *e.g.*, *Life Expectancy Graphs*, Mapping Hist., https://mappinghistory.uoregon.edu/english/US/US39-01.html [https://perma.cc/X8VG-6KEM] (last visited Sept. 12, 2021).
33. *Our Work*, Am. Pub. Health Ass'n, https://www.apha.org/About-APHA/Our-Work [https://perma.cc/E47N-ZC8G] (last visited Sept. 7, 2021).
34. Jacqueline Yao, *Misinformation Harming US Health, Surgeon General Says*, Pub. Health. Newswire (July 19, 2021 5:01 PM), http://publichealthnewswire.org/?p=surgeon-general-advisory [https://perma.cc/VXK7-ET25] (last visited Sept. 7, 2021).
35. Institute of Medicine, The Future of Public Health (National Academies Press 1998), https://doi.org/10.17226/1091.
36. *See*, *e.g.*, Am. Heritage Dictionary of the English Language (5th ed., 2011).
37. *See*, *e.g.*, Richard A. Smiley, et al., *The 2020 National Nursing Workforce Survey*, 12(1) J. Nursing Reg. Supplement S1, S12 Table 3, https://doi.org/10.1016/S2155-8256(21)00027-2.

38. *See* King's College London, *Florence Nightingale Faculty of Nursing and Midwifery*, https://www.kcl.ac.uk/nmpc [https://perma.cc/94SK-SPF5] (last visited July 14, 2016).
39. Jean C. Whelan, *American Nursing: An Introduction to the Past*, Univ. Penn. Sch. Nursing (2017), https://www.nursing.upenn.edu/nhhc/american-nursing-an-introduction-to-the-past/ [https://perma.cc/EMV3-6T65] (last visited July 17, 2019).
40. *Id.*
41. Paul Starr, The Social Transformation of American Medicine 145 (1982).
42. *Id.* at 123.
43. Andrew H. Beck, *The Flexner Report and the Standardization of American Medical Education*, 291 J. Am. Med. Ass'n. 2139 (2004), http://jama.jamanetwork.com/article.aspx?articleid=198677 [https://perma.cc/3ZC3-TNQB].
44. *Id.*
45. Earl H. Harley, *The Forgotten History of Defunct Black Medical Schools in the 19th and 20th Centuries and the Impact of the Flexner Report*, 98 J. Nat. Med. Ass'n. 1425 (2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2569729/pdf/jnma00196-0027.pdf [https://perma.cc/44FW-3V4M].
46. *The History of African Americans and Organized Medicine*, AMA History, https://www.ama-assn.org/about/ama-history/history-african-americans-and-organized-medicine [https://perma.cc/UD5L-Q3ZZ] (last visited Jan. 26, 2022).
47. *Id.*
48. Starr, *supra* note 41, at 123–24.
49. *See* Thomas P. Duffy, *The Flexner Report—100 Years Later*, 84 Yale J. Biol. Med. 269 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3178858/ [https://perma.cc/59FZ-KGJ5].
50. Harley, *supra* note 45, at 1428.
51. *Our History*, Cath. Health Ass'n U.S., https://www.chausa.org/about/about/our-history [https://perma.cc/5HEU-BDB5] (last visited July 14, 2016).
52. Starr, *supra* note 41 at 177.
53. David H. Demo, et al., *A Call for Action: Advocating for Increased Funding for the Allied Health Professions*, 44(1) J. Allied Health 57 (2015), https://static1.squarespace.com/static/57a64a023e00beb95af13929/t/58000c2e8419c2e2686c7365/1476398127700/A-Call-for-Action-Advocating-for-Increased-Funding.pdf [https://perma.cc/S6C9-ZY3S].

Appendix 1.1: A Select Timeline of the History of Medicine

Date	Key Events
Third millennium BCE	Imhotep describes the diagnosis and treatment of 200 diseases (ca. 2600 BCE). He and others use trepanation surgery for unknown purposes. Spirits and supernatural forces are thought to be the cause of disease.
Second millennium BCE	Code of Hammurabi is inscribed (ca. 1790 BCE).
Fifth century BCE	Hippocrates, the "father of Western medicine," uses observation of the body as a basis for medical knowledge. He recommends changes in diet, rudimentary drugs, and keeping the body "in balance" (humoralism) rather than prayer and sacrifice to divinities.
Fourth century BCE	Aristotle codifies known science. First known anatomy book appears (ca. 300 BCE), but religion still dominates medicine. Hippocratic Oath appears.
Second century BCE	Galen becomes physician to Roman emperor Marcus Aurelius and builds on Hippocrates's theories of the humors but supports observation and reasoning in medical science.
Fifth to tenth century	Western Europe experiences decreasing population and trade; a flood of migrants and invaders; and a paucity of literary, cultural, and scientific output. Culture continues to flourish in the Byzantine (Eastern Roman) Empire.
Eighth century	Baghdad becomes "a veritable seedbed of medical learning, cross-fertilized by Persian-Mesopotamian, Byzantine-Greek, and Indian traditions" (NLM and NIH 2006). The recent introduction of paper enables knowledge to be more easily recorded and published.
Tenth century	Rhazes—considered the greatest physician and practitioner of Islamic medicine during the Middle Ages—revolutionizes Islamic medicine by using careful clinical observation and notation, writes scientific treatise on infectious disease, identifies smallpox, and publishes *The Comprehensive Book on Medicine* (the Hawi).
Eleventh century	Persian polymath Avicenna (Ibn Sina) builds on Rhazes's work and publishes *The Canon of Medicine*, an encyclopedic book dealing with pharmacology, the nature of contagious diseases, experimental and evidence-based medicine, and many other topics. It is consulted for centuries thereafter in some parts of the world.
Thirteenth century	Roger Bacon invents spectacles (1249).
Fourteenth century	Bubonic plague, believed by many to be a punishment from God, kills millions in Europe.
Fifteenth century	Leonardo da Vinci and others study anatomy by dissecting corpses, much to the displeasure of the Catholic Church. Printing press is invented (1454), enabling knowledge to be recorded and transmitted more freely.

Date	Key Events
Sixteenth century	New drugs such as quinine and laudanum (an opiate) are discovered. Royal College of Physicians is formed in London (1518). Paracelsus (1493–1541) rejects ancient texts, emphasizes natural sciences, and founds the fields of toxicology and psychology. Zacharias Janssen invents the microscope (1590).
Seventeenth century	William Harvey publishes *An Anatomical Study of the Motion of the Heart and of the Blood in Animals* (1628). The book forms the basis for future research on blood vessels, arteries, and the heart. Sir Christopher Wren experiments with canine blood transfusions (1656). Anton van Leeuwenhoek improves the microscope, discovers blood cells, and later observes bacteria (1670).
Eighteenth century	Based on the work of Edward Jenner and others, smallpox inoculations gain acceptance in England and America. (They had long been practiced in Africa, India, and China, but this was not well known in the West.) James Lind discovers that citrus fruit prevents scurvy. First successful appendectomy is performed.
Early nineteenth century	Royal College of Surgeons is formed (1800). Rene Laennec invents the stethoscope. First successful human blood transfusion is performed. Ether and nitrous oxide are used as general anesthetics. Benjamin Rush (1746–1813)—signatory of the Declaration of Independence, founder of Dickinson College, professor of medicine at the University of Pennsylvania, and proponent of bloodletting and similar therapies—is considered the "father of American psychiatry." Syringe is invented.
Mid- to late nineteenth century	The Home for the Colored Aged (later the Colored Home and Hospital and now part of NYC Health + Hospitals) opens in New York City in 1839 to serve former enslaved persons. American Medical Association is founded (1847). Louis Pasteur identifies germs as cause of disease; antiseptic techniques begin. Florence Nightingale lays the foundations for professional nursing and modernization of hospitals. Joseph Lister develops antiseptic surgical techniques. Vaccines developed for cholera, anthrax, rabies, tetanus, diphtheria, typhoid fever, and bubonic plague. New England Female Medical College (NEFMC)is founded, becoming the first US medical school for women (1848). It merged with Boston University School of Medicine in 1873. Rebecca Lee Crumpler (1831–1895) becomes the first Black woman to earn an MD degree, graduating from NEFMC in 1864.

(continued)

Date	Key Events
	Sir William Osler (1849–1919), the "father of modern medicine" and cofounder of Johns Hopkins Hospital, establishes the first medical residency program to involve medical students in bedside clinical training ("grand rounds").
	Howard University, traditionally an all-Black institution, is established (1867).
	American Public Health Association is formed (1872). Clara Barton promotes public support for a national society to work with the International Red Cross. The American Red Cross is founded (1881).
	X-rays are discovered, rather accidentally, by Wilhelm Roentgen (1895).
	National Medical Association, a pioneering organization of Black physicians, is formed (1895).
	Association of Hospital Superintendents, forerunner of the American Hospital Association, is founded (1899).
Early twentieth century	Karl Landsteiner introduces blood classification system (types A, B, AB, and O).
	Charles R. Drew (1904–1950), prominent Black surgeon and researcher, develops improved techniques for blood storage and helps develop large-scale blood banks.
	William Montague Cobb (1904–1990), Black physician and the first Black PhD in anthropology, studies and teaches the idea of race as having a negative impact on communities of color.
	X-ray technology becomes available.
	US Pure Food and Drug Act is enacted (1906).
	Tuberculosis skin test is introduced (1907).
	The *Flexner Report* on medical education is published (1910).
	Solomon Carter Fuller (1872–1953), Black psychiatrist and neurologist and professor at Boston University, makes major contributions to research on Alzheimer's disease.
	American College of Surgeons, first of the American medical specialty colleges, is founded (1913).
	Catholic Hospital Association (now Catholic Health Association of the United States) is founded (1915).
	Paul Dudley White develops the electrocardiogram.
	Polio epidemics break out in New York and Boston (1916) and continue elsewhere for years.
	Influenza pandemic kills 15 million worldwide (1918–1919).
	Edward Mellanby discovers vitamin D connection with rickets (1921). Sheppard-Towner Act establishes child and maternal health centers; insulin is first used to treat diabetes (1922).
	Vaccines are developed for whooping cough, tuberculosis, and yellow fever.
	Medical Group Management Association is founded (1926).

Date	Key Events
	American Health Information Management Association is founded (1928).
	Penicillin is discovered (1928).
	American College of Hospital Administrators (now American College of Healthcare Executives) is founded (1933).
	Vitamins A, B1, B2, and B3 are identified.
	First blood bank opens in Chicago (1937).
	National Cancer Institute is founded (1937).
Mid-twentieth century	Ultrasound is developed (1942).
	Chemotherapy is developed for cancer treatment (1942).
	Healthcare Financial Management Association is founded (1946). Association of University Programs in Health Administration is founded (1948).
	Sydenham Hospital, in the Harlem neighborhood of New York City, becomes the nation's first hospital to have a fully desegrated staff at all levels (including trustees and physicians), and hires Jean Murray Smith as the first Black hospital administrator at a nonsegregated facility.
	Influenza vaccines and streptomycin are developed.
	First cardiac pacemaker is invented (1950).
	Joint Commission on Accreditation of Hospitals (now The Joint Commission) is established (1951).
	Polio vaccine is used widely (1950s).
	James Watson and Francis Crick describe the structure of the DNA molecule (1953).
	First kidney transplant is performed (1954).
	Vaccines for measles, mumps, rubella, chicken pox, pneumonia, and meningitis are developed.
	Health Information and Management Systems Society (founded as Hospital Management Systems Society) is established (1961).
	Nursing home administrators form an association (now American College of Health Care Administrators) (1962).
	Medicare and Medicaid are enacted (1965).
	Federation of American Hospitals (for-profit hospitals) is established (1966). American Organization of Nurse Executives is founded (1967).
	First heart transplant and coronary bypass operations are performed (1967).
	Health Maintenance Organization Act is passed (1973).
	Black physician Patricia E. Bath (1942–2019), the first woman ophthalmologist appointed to the faculty of University of California, Los Angeles medical school; she goes on to invent a new device for laser cataract surgery (1986).
	American Association for Physician Leadership is founded (1975); it was previously called American Academy of Medical Directors and American College of Physician Executives.

(continued)

Date	Key Events
Late twentieth century	World Health Organization declares smallpox eradicated (1980).
	HIV, the virus that causes AIDS, is identified (1983).
	Artificial kidney dialysis machine is invented (1985).
	Consolidated Omnibus Budget Reconciliation Act is passed to allow for the continuation of group health coverage after a job loss (1985).
	Emergency Medical Treatment and Active Labor Act is passed to prohibit patient dumping (1986).
	Hepatitis A vaccine is developed (1992).
	Dolly the sheep is the first cloned mammal (1996).
	Health Insurance Portability and Accountability Act is passed to provide insurance portability and new privacy standards (1996).
	State Children's Health Insurance Program and Medicare+Choice (later Medicare Advantage) are established (1997).
	Balanced Budget Act is enacted to cut Medicare spending and provide beneficiaries with additional choices through private health plans (1997).
Early twenty-first century	Healthcare costs continue to rise in the United States; total healthcare spending makes up more than 17.3 percent of the gross domestic product ($2.7 trillion).
	The Human Genome Project is completed (2003), and the entire sequence of nearly 40,000 human genes is documented.
	Medicare Part D (drug benefit) begins (2006).
	Affordable Care Act (ACA) is signed into law (2010) and upheld by the US Supreme Court (2012), but Medicaid expansion is optional.
	Thirty-nine states and District of Columbia expand Medicaid per ACA (by early 2022).

Sources

See generally, US National Library of Medicine, History of Medicine at https://www.nlm.nih.gov/hmd/index.html [https://perma.cc/5KLZ-2QVU] (last visited July 9, 2019).

Drew Altman & William Frist, *Medicare and Medicaid at 50 Years*, 314 J. Amer. Med. Ass'n. 384 (2015).

American College of Healthcare Executives, Coming of Age: The 75-Year History of the American College of Healthcare Executives (Health Administration Press 2008).

History of Medicine Timeline, DatesAndEvents.org, http://www.datesandevents.org/eventstimelines/10-history-of-medicine-timeline.htm [https://perma.cc/9HQJ-HRQ4] (last visited July 9, 2019).

The 1619 Project, chs. 12, 15 (Nikole Hannah-Jones, ed., 2021).