



Foreword

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Dilemmas posed by medicine's new technologies continue to fascinate the general public and to challenge the legal system. The *U.C. Davis Law Review's* Symposium on health law topics reveals the breadth of issues that our culture and legal institutions are being called upon to confront as medical science expands its capacity to do good — and also, inevitably, incidental harm. This Symposium did not originate from the Editors' effort to orchestrate systematic coverage of a particular theme. Instead, as the Symposium's eclectic character reveals, the Editors supplemented some interesting voluntary submissions and two scheduled student works by soliciting a few additional contributions, thus filling out an entire issue aimed at the growing constituency of health lawyers. My function in introducing the Symposium is not to try to integrate these interesting and diverse contributions into a coherent whole but only to comment on some of the themes I see. These fine authors have themselves done an admirable job of integrating their papers into the larger health law scene, which is enriched by their efforts.

Medicine's central place in our modern culture has been explained by Michael Walzer as a corollary of the decline of religion:

In Europe during the Middle Ages, the cure of souls was public, the cure of bodies private. Today, in most European countries, the situation is reversed. The reversal is best explained in terms of a major shift in the common understanding of souls and bodies: we have lost confidence in the cure of souls, and we have come increasingly to believe [in], even to be obsessed with, the cure of bodies. . . . [A]s eternity receded in the popular consciousness, longevity moved to the fore. Among medieval Christians,

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eternity was a socially recognized need; and every effort was made to see that it was widely and equally distributed, that every Christian had an equal chance at salvation and eternal life

Among modern citizens, longevity is a socially recognized need; and increasingly every effort is made to see that it is widely and equally distributed, that every citizen has an equal chance at a long and healthy life¹

Unfortunately, medical technology is making it increasingly difficult to pursue a policy of sacrificing resources on the altar of medicine as a new secular religion. Indeed, the high cost and sometimes dehumanizing character of our expanded capacity “to maintain life after health”² are finally making us face the reality that longevity is not infinitely valuable and that, as with other good things, it is possible to have too much of it. Professor Smith’s monumental Article — inevitably the Symposium’s centerpiece because of the largeness of its theme and of its treatment — alerts us to another way in which medical technology is forcing us to rethink fundamental values. Our new power to extend life, we now know, should not always be used. Yet to withhold our aid when it is not wanted is to tolerate the voluntary surrender of life itself, further undermining our belief that longevity is an unalloyed good. Professor Smith’s contribution should help us, as a society, to come to grips with our increasing control over our own mortality.

Medical, legal, and ethical debates over death and dying have long struck me as scenes in a long-running morality play in which we collectively demonstrate and propagate our values. As the drama goes on, however, those values are gradually changing. Indeed, this “mortality play” is a means by which society is gradually reconciling itself to the fact that life is not only a gift but also a limited resource that we can have more of if, but only if, we decide to put our productive resources to that use. I find it helpful to invite students to look beyond the rhetoric of the immediate drama and the points being scored in the current debates and to try to visualize how these issues are likely to appear in another fifty years — when, incidentally, the students’ own mortality will be on the line. My guess is that, by that time, society’s collective views will have evolved into an acceptance of the limits that competing needs and scarce personal and societal resources impose on our pursuit of life at any cost. To say that life will have become by then a consumer as well as a merit good may be going too far, but I predict that

¹ Walzer, *Welfare, Membership and Need*, in *LIBERALISM AND ITS CRITICS* 200, 212-13 (M. Sandel ed. 1984).

² Starr, *A National Health Program: Organizing Diversity*, *HASTINGS CENTER REP.*, Feb. 1975, at 11, 13. Starr’s expression seems especially apt in this context.

decisions to consume more of it will frequently be influenced by personal choices based in part on cost and quality. Professor Smith's contribution to this issue provides just the kind of vantage point we need to look toward this future and to chart a more direct course to it.

One of the great imponderables in looking ahead to a future in which life-and-death choices are differently managed is the precise role that government will perform in the ongoing drama. Professor Blumstein's Article shows how public policy respecting medicine's most symbolic venture yet on the frontier between life and death — organ transplantation — has focused exclusively on strengthening government's regulatory role. It also reveals, however, some of the inconsistencies between the role currently being formulated for government in this field and a polity and economy based upon individual rights and decentralized institutions and decision making. Professor Blumstein and I have pondered together in the past (with Randall Bovbjerg) the policy implications of casting government — which, more than any other available actor, is given to the posturing and overdramatizing that characterize morality plays — as the final arbiter of "tragic choices."³ We expressed the view that society should also be auditioning private institutions to play roles in determining the availability of resources for life-saving ventures whenever our obligations as a society do not extend to providing life extension to all who want it. There remains to be faced, then, the question whether American society, which has always sought the separation of religious and secular matters, truly wants government to assume the role of giver (and withholder) of life itself. Again, how will American society manage these issues fifty years hence?

Two Articles in this volume relate to the AIDS disaster, a grim reminder that we cannot always guarantee a normal lifespan and must sometimes concentrate on optimizing our efforts, not to cure, but to care for those who are fatally or otherwise severely afflicted. The technical legal contexts of the McDonald Article and the student Comment on discrimination against persons handicapped by the HIV virus should not obscure their common focus on the legal system's role in structuring attitudes toward afflicted persons. Mr. McDonald focuses on the duties of health professionals, while the student Comment relates to the obligations of employers and other agents acting on behalf of the larger society. The questions that underlie these Articles include not only how

³ Havighurst, Blumstein & Bovbjerg, *Strategies in Underwriting the Costs of Catastrophic Disease*, LAW & CONTEMP. PROBS., Autumn 1976, at 122. The term "tragic choices" is, of course, Calabresi's. See G. CALABRESI & P. BOBBITT, TRAGIC CHOICES (1978).

to do better but also how much is enough for society to devote to the care of the sick when more might be done but diminishing returns and distributive issues have become salient.

Three Articles — those by Kinney & Wilder, Bovbjerg, and Jost — provide useful insights into the continuing problems of how to spur the health care delivery system to deliver good-quality care. Kinney & Wilder are concerned about establishing a rational standard of care to be enforced by malpractice courts, and they provide a useful catalog of clinical protocols that might serve plaintiffs as a sword, or defendants as a shield, in cases involving allegations of professional negligence. Efforts to improve the tort system's fact- and fault-finding capabilities are essential if the law is to assist in rationalizing health care spending, encouraging added attention when outcomes can be improved at reasonable cost without stimulating providers to waste resources in scattershot attempts to avert liability. Kinney & Wilder demonstrate how professional and other efforts to improve the quality of care can be used to make the malpractice system more dependable and predictable, thus helping it to serve societal objectives. Bovbjerg's Article adds further insights relative to the tort system's capacity to improve the medical industry's performance. The legislative reforms he considers, however, reflect too seldom an adequate appreciation of the policy significance of tort law and too often a political struggle between special interests — primarily potential tortfeasors and plaintiffs' lawyers.

Some questions to which my own thinking always returns in pondering the quality of medical care fall outside the scope of the Articles in this Symposium but remain provocative. I wonder, specifically, whether the legal system will ever shake itself loose from a conception of medical care that assumes the only issues involved in judging quality are technical ones, to be answered solely by scientific inquiry and medical experts and without appreciable or explicit regard to cost considerations. The malpractice system is founded, it would seem, on such a conventional view of the quality problem, reflecting in part the medical profession's ethical belief that ability or willingness to pay ought never to determine the treatment received. Regulatory mechanisms, such as Professor Jost's Article considers, generally feature the same one-right-way assumption. Regulation, like the tort system, might of course be viewed as merely setting socially determined minimum standards, below which no one's care should be permitted to fall. The question would then remain, however, whether and precisely how society can rationally define a minimum that is not also an ideal and can enforce claims to higher quality when that is what contracting parties have agreed to.

Finally, one student Comment observes some legal consequences of yet another technological breakthrough, a new scientific test of identity — DNA fingerprinting — which can be used as positive proof of paternity. Current methods of proving paternity in California rely to a large degree on forensic evidence that narrows the class of possible fathers to a small group of individuals. However, the tests cannot specifically link a child to a particular individual. In contrast, DNA fingerprinting can positively identify a particular individual as the father. Thus, use of the test will lead to more reliable findings of actual paternity.

These introductory ruminations may at least remind us that, however technical they may be, issues of health care law relate more often than not, in some way, to the large challenge of allocating scarce resources so that they will be used to increase the quantum of human welfare, suitably defined. It is possible, I think, to keep these issues in view without becoming a mere accountant/economist totting up benefits and costs. There is in fact a large externality (the term used by economists to keep larger implications in view) to be preserved by maintaining humanitarian values, which, together with our personal freedoms, allow us to take some pride in our civilization.

