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While Abortion and Protection of the Human Fetus settles neither the moral question nor the more basic metaphysical issues at stake, as a result of the data presented, it clearly suggests the need for principled inquiry. The basic question remains: Is there any freedom which justifies such a large scale taking of human life?


Reviewed by George P. Smith, II*

I.

Although human anatomy and physiology are taken as the same worldwide, individual cultures differ in the basic organization and the delivery of health care services. Thus, while Americans are regarded as probably more health conscious than any other culture, it remains the only industrialized country (with the exception of South Africa) that has failed to create a system of national health insurance. The underlying rationale for this policy is said to be cost—this in spite of the fact that the Nation spends more than twelve percent of its Gross National Product on health care.1

While the traditional means for affording access to goods and services in a capitalistic economy is the free market system, Americans have been unwilling in the past for the most part—to either condone or accept financial ability as the central means for distributing health care. Responding to this attitude, or consensus, the United States Congress established both Medicare and Medicaid programs to deal with the commitment to provide health care services regardless of ability to pay.2 Recent surveys show, however, that while the American public is concerned about the idea or principle of providing health care for all who are in need, and catastrophic health care cov-

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verage for cancer and cardio-pulmonary problems and long-term care as well, "there is actually a significant limitation on their willingness to pay additional costs" outside of those provided for medical reimbursement coverage in their health insurance policies.

Even though the federal government does not control directly total health care delivery spending or, for that matter, hospital budgets, it can and does exercise considerable influence through funding of a multitude of health care programs. Today, the accepted norm in meeting health care costs is to invoke and implement the "Robin Hood Ethic" that forces the "rich" (or those covered by private insurance policies) to give to the "pool" (or the under and uninsured). Accordingly, the common practice designed to finance care for the Nation's some thirty-seven million uninsured—who generally come to the hospital through the emergency room facilities—is for the physicians and hospitals to inflate the bills they send to privately insured patients. All too often, another alternative to meeting soaring hospital costs is patient dumping.

II.

The system of national health insurance in Great Britain is an interesting study of how a system of budgetary constraints is applied to shape the availability of medical care. Under this system, all hospital expenditures are limited by a budget set by the national government. The individual hospitals receive funds through regional (and strict) disbursements. Budgetary limits, of necessity, introduce restraints on the availability of personnel and equipment—even though hospital administrators theoretically have discretion in allocating resources. Physicians in Great Britain are thus, in turn, forced to operate within those constraints, selecting some patients for treatment, while rejecting others.

A private medical care system is intertwined with the national health ser-

3. Callahan, Meeting Needs and Rationing Care, 16 LAW MED. & HEALTH CARE 261, 263 (1988); see also Danis, Patrick, Southerland & Green, Patients' and Families' Preferences for Medical Intensive Care, 260 J. A.M.A. 797 (1988); Donley, A Brave New World of Health Care, 2 J. CONTEMP. HEALTH L. & POL'Y 47 (1986).
4. Silver, supra note 2, at 1007.
6. Silver, supra note 2, at 1005.
vice and is not supported directly by the government. Patients are permitted to enter this private system at various points, with a few choosing to sign up initially with a private general practitioner. More often, patients elect to see a consultant privately, either directly, or after an initial referral by their national health service general practitioner. These private patients are given much greater access to health care resources simply because of their ability to pay extra for these services.

In the United States, direct federal governmental control of total spending on hospital budgets is not seen. The federal government nonetheless exercises great influence in health care maintenance by deciding those treatments for which reimbursement will be allowed and, at what level. The extent of government influence, however, extends well beyond its programs. Thus, should a hospital be given assurance that it will be reimbursed by Medicare for providing expensive technology (as with cardio-vascular surgeries and nuclear medicine), it will be more likely than not to undertake the capital investment necessary to provide for that very technology. The effect of cost containment on the allocation of scarce medical resources is seen dramatically in the case of kidney dialysis. In Britain, dialysis competes with other types of health care for government financing, while in the United States, Medicare reimburses the cost of treatment for everyone, and this includes coronary bypass surgeries. While there are no specific regulations restricting these latter surgical interventions—as well as various transplants—common medical sense would preclude coronary rehabilitation for Medicare patients of advanced age. Among the criteria used in Britain to select those suitable for dialysis are age, mental illness, and the presence of other medical diseases or physical handicaps. Because of the selection criteria and the competition for scarce hospital funding sources, the end result is that many patients denied treatment in England would in fact be treated in the United States.

III.

Health Law exists because health care is not a thing so much as it is a relationship between individuals: doctors and patients, patients and families,

9. Id. at 22.
10. Silver, supra note 2, at 1007, 1008.
11. Id.
13. Silver, supra note 2, at 1006.
14. Id. at 1005.
health care providers and health care institutions. Within this amalgam, joint decisions and conflicts arise. A major goal of Health Law should be to insure that health care is of acceptable quality for all citizens as well as to seek a reduction or elimination of medical error in the delivery of health care services.  

The public’s interest in medical issues has risen in quantum leaps in recent times, while, professionals such as lawyers, philosophers, theologians and doctors themselves have begun the process of discussing and analyzing the problems and dilemmas that arise in the practice of modern medicine. Patients have also become more aware of their rights. As society becomes more consumer oriented it is understandable that complaints and grievances will arise and, in the absence of any better forum, patients will seek to resolve them in court. Doctors have not escaped the decline of the laissez-faire attitude which has been actively encouraged by the judiciary and consciously abetted by Parliament. Whether arising from the new freedom of choice and discernment exercised by today’s better educated and more sophisticated public or independently, patients have become more questioning and more anxious to be involved as equal partners in the doctor-patient relationship. When they are left out in the cold they become discontented and seek to question the doctor’s action. The increasing tendency to resort to the law, in what might be called doctor-patient disputes, is probably the direct effect of this.

The study of Health Law has become a growing, and indeed popular, aspect of curricular offerings in American law schools. Within the last ten years, eight major casebooks have been published under subsets of this broad topic.

15. Health Law Cases, supra note 1, at xvii.
When Great Britain's two foremost authorities in Law and Medicine combine their talents to produce their nation's first joint undertaking in print in this field, one could rightly hope that a high level of perfection would result. And this is exactly what has happened with the production by Butterworth's of MEDICAL LAW: TEXT AND MATERIALS. It is truly awesome in scope and coverage and has particularly strong comparative law sections interspersed throughout.

All the fifteen chapters are outstanding in their depth of scholarship; the comparative analysis among jurisdictions and the analysis of future direction for the law are most insightful.19 The discussion questions that appear throughout the chapters are thought-provoking and to-the-point. Chapter 4, entitled "Consent," was especially thorough and I also found Chapters 8 and 9 entitled "Facilitating Conception" and "Abortion," respectively, equally strong and balanced. For better continuity, however, I might have placed Chapter 11, entitled "Research," after the present Chapter 4 on "Consent," or even possibly move it to become Chapter 2. I also found Chapter 13 on problems of human tissue transplantation and Chapter 14 on treatment of the dying presented exceptionally well.22

I could (and will) use the Kennedy-Grubb book as an important reference tool. But, as a teacher, I would have difficulty in adopting it for the classroom because of the size of the print used.23 While I understand page size and print are often marketing decisions well beyond the control of the au-


19. I. KENNEDY & A. GRUBB, MEDICAL LAW: TEXT AND MATERIALS (1989) [hereinafter MEDICAL LAW]: ch. 1, The Doctor/Patient Relationship; ch. 2, The Parties to the Relationship; ch. 3, The Legal Framework of the Doctor/Patient Relationship; ch. 4, Consent; ch. 5, Medical Malpractice; ch. 6, Medical Records and Confidence; ch. 7, Contraception; ch. 8, Facilitating Conception; ch. 9, Abortion; ch. 10, Pre-natal Injury and Actions for Wrongful Life and Wrongful Birth; ch. 11, Research; ch. 12, Selective Treatment of Neonates; ch. 13, Donation and Transplantation of Human Tissue and Fluids; ch. 14, Treatment of the Dying and Treatment for Dying; ch. 15, Death.

20. MEDICAL LAW, supra note 19, at 633 passim (dealing with in vitro fertilization), 693 passim (surrogacy).

21. Id. at 796 passim (discussing reform proposals).

22. Id. at 1153 passim (evaluating the future directions of English Law in this problem area).

23. In a letter dated June 18, 1990, Mr. Dan Leissner, Editor of Textbooks at Butterworths, advised me that the normal text in the book is 10/11 pt., while the quoted material is smaller at 9/10 pt. The typeface for both is Times. In AMERICAN HEALTH LAW, supra note 18, published by Little Brown, the text is 10/12, and the quoted material is 9/11, with the typeface being Galliard. In HEALTH LAW CASES, supra note 1, published by West, the text is 10/12; the quoted material, author's notes, and problems are 9.5/11.5; the typeface is Century School Book.
thors, market capacity would be enhanced measurably if reader convenience were to be understood. Put simply, the size of the print in MEDICAL LAW places a strain on already poorly sighted individuals, such as this reviewer, and would threaten deterioration to those readers with good eyesight. Interestingly, a 1990 study by the Optical Manufacturers Association in Virginia showed sixty percent of all United States citizens wear prescription eyewear. But, the dilemma is: If the type face is made bolder, the size of the page would increase and thus would become larger, forcing the purchase price to increase as well. In cases such as this, perhaps the best strategy would be to market a book of the quality of MEDICAL LAW as a two volume book—thus educating the consumer that he would get more for his money and, at the same time, allowing him the enjoyment (instead of creating a task) of reading without eyestrain.

In the Preface to MEDICAL LAW: TEXT AND MATERIALS, the authors state the goal of their book to be that of presenting a forum for introducing “the student to the great range of the subject and to make available to the student and practitioner alike the wealth of material now available in common law jurisdictions.” In reality, this book not only meets this goal, but it serves as an invaluable tool for educating its readers to the ongoing complexities of Medical Law and recognizing the heavy responsibilities of decision making in this field; responsibilities that are often shaped and governed of necessity by inherent standards of ethics and morality.  