



Coggon, J. (2020). Studying Public Health Law: Principles, Politics, and Populations as Patients. In C. Dietz, M. Travis, & M. Thomson (Eds.), *A Jurisprudence of the Body* (1 ed., pp. 35-61). (Palgrave Socio-Legal Studies). Palgrave Macmillan.
https://doi.org/10.1007/978-3-030-42200-4_3

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Studying Public Health Law: Principles, Politics, and Populations as Patients

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This essay was published in Chris Dietz, Mitchell Travis, and Michael Thomson (eds.), A Jurisprudence of the Body, (London: Palgrave Macmillan, 2020).

Abstract

Public health law is firmly establishing itself as a crucial area of scholarly inquiry. Its vital importance has been sharply underscored following the outbreak of COVID-19, in response to which we have seen the institution of extreme legal measures—such as the UK’s Coronavirus Act 2020—in efforts to control and contain the spread of the disease. The pandemic has also starkly exposed the complex nature of the regulatory challenges, nationally, internationally, and globally, to which such public health problems give rise. In approaching these, and other questions concerning the public’s health, such as non-communicable disease, public health law, as a field, brings notable distinctive features: these include a practical focus on populations, institutions, the prevention of ill health, protection of good health, and the promotion of positive states of wellbeing; and concomitant critical approaches rooted in theories of social justice as contrasted with more narrow biomedical ethics. Such features make it in some senses atypical territory within the field of health law. Furthermore, the inherent role of political institutions places law conceptually within public health in a way that may be seen as distinguishable from law’s relationship with clinical medicine. This chapter explains how the broad reach and distinct features of public health require a commensurately broad approach to conceptualising public health law, and how distinct practical and theoretical features may be integrated into academic public health law. It also shows how public health law, with its distinct conceptualisations concerning ‘the body’ of medical jurisprudence, can both challenge and enrich medico-legal studies, and bring important perspectives within the broader field of health law.

1. Introduction

Works in legal scholarship commonly carry a time stamp as a *caveat* to guard against, or at least allow for, future changes. However, the allowance that such a *caveat* might give would be inadequate to capture, or to get past, the profundity of what has happened to perceptions and understandings of public health and law in the short time since this chapter was completed in 2019. Following the outbreak of COVID-19, the world has entered a public health emergency whose scale and impacts are yet unknown, but which has already led to governments instituting extraordinary legal measures in efforts to control the spread of the disease. Within the UK, Parliament has enacted the Coronavirus Act 2020, with provisions designed to limit transmission of the virus and protect healthcare and other services from being fatally overwhelmed. The Act operates alongside other legislative measures, including distinct Regulations to enforce ‘lockdown’ respectively in England, Northern Ireland, Scotland, and Wales. These public health laws provide (amongst other things) for extraordinary executive powers, extraordinary measures regarding the practice of medicine and other areas of health and social care, and the placing of enormous curbs on individual freedoms. The pandemic starkly demonstrates the depth of our interpersonal, social, and global interconnectedness: how even within framings made by reference to liberal state systems, we exist as “non-individuated individuals” (Coggon 2012a, chapter 10). In underscoring this, the crisis highlights realities whose critical implications are of

the highest importance for studies in the jurisprudence of the body, in medical jurisprudence, and in questions about the links between social justice and law.

In relation to jurisprudence of the body, public health emergencies, and public health more generally—as explained below—demonstrate how the ostensible physical boundaries of the human body do not straightforwardly track against the boundaries of persons either practically or normatively. At population levels too, global phenomena—including matters such as the spread of infectious disease but also questions such as global trade and its impacts—show how norms based on the idea of impervious or autonomous nation states are similarly not fit alone to serve our conceptual needs in global jurisprudential inquiry (Coggon 2014). The facts of our interconnectedness are marked in terms of how they impact our conceptions of bodily integrity and the nature of society and societies. In relation to medical jurisprudence, the conceptual abstraction of doctor/patient interactions is also challenged. It has long been accepted that, at least within a national healthcare system such as the NHS, ‘macro level’ questions inevitably bear on the provision of individual health care (Coggon 2016). However, following COVID-19, the vulnerability of the healthcare system and the complexities of the internal functioning of the NHS and its links with wider aspects of social care have much more radically emphasised the need to approach medical jurisprudence with attention to population and society-level concerns. And this in turn shines sharper light on questions about studies in health law and their relationships with ideas of social justice. The points about interconnectedness make clear how responsibilities for health, within and across nations, cannot be resolved without looking at collective obligations: narrow individualism is just inadequate (cf. Coggon 2012a; Marmot 2015; Venkatapuram 2010). The COVID-19 pandemic is laying bare, within nations as well as across nations, the gross failures in justice that are represented through health inequalities: that is, how health inequalities serve as indicators of points of deep social injustice through compounded, socially-determined disadvantage across multiple values including but stretching far beyond health (and thus matters that require to be addressed outside of the healthcare system).

The importance of understanding law as a determinant of health, as a mechanism for achieving greater social justice, as well as a source of constraint through, for example, human rights protection and adherence to the rule of law, could not be more clearly demonstrated. But we also need to recognise that these problems are not just ones that are limited to instances of public health emergency (see further Gostin et al. 2019). Therefore, beyond editorial constraints that tend against more thoroughgoing amendments, the following text is only lightly edited given the impacts of COVID-19. The pandemic has already radically changed the course of human history globally, and will likely lead to a much greater focus on public health law within university curricula and research agendas. But it is crucial to recognise that public health law is about so much more than control of infectious diseases or the use of law in times of emergency. I would therefore like to see the following arguments stand on their merits in the terms (only lightly further edited) in which I expressed them before public health and law were forced to the front of everyone’s minds by COVID-19. An upshot of the current global health emergency, with its overall personal and social implications, as well as those specifically facing healthcare and medical practice, shows, I would argue, the limitations of focusing on medical jurisprudence or questions of jurisprudence of the body without consideration of population-level, social, and political contexts. What follows aims to explain these limitations by looking at contexts that include but span far beyond the coordination of responses to a pandemic.

With those preliminary points made, it is useful to enter analysis of public health law as a field by considering how modern medico-legal studies and practice may be said to have emerged as a response to an absence of law, or at least to a failing in its reach. As the field was delineated,

there was profound influence from scholarship in individualistic modes of social philosophy and biomedical ethics (e.g. Illich 1976). These sought to identify the sources and dynamics of power and values within health care, and in particular to evaluate and critique the freedoms of physicians, and the forms of social, political, and legal deference that they enjoyed (see Kennedy 1991). At the heart of modern medical law, conceived both as an academic and as a practical agenda, was a predominant movement to reconfigure the relationships between patient and doctor, with a view to empowering the former and to separating the latter's professional, clinical expertise from her ability to give effect to personal moral or political value judgments.

Although the importance of public health has been a feature of key legal texts on health care for some time now (see e.g. Montgomery 1997), and has come to feature increasingly in newer editions of the leading medico-legal textbooks (contrast e.g. Jackson 2013, 2016; Mason et al. 2002; Mason and Laurie 2006), it has not been treated historically with the depth of attention given to questions such as, for example, an individual patient's informed consent to a remedial clinical intervention. This may be because public health is a truly multi-disciplinary field and—with its reach across sectors too—thus extends far beyond the narrower reach of 'medical' (see Guest et al. 2013). It may just be a question of authors' and tutors' judgments on topic selection, which will necessarily be exclusive given the range of practical areas that might feature in a textbook or teaching syllabus (cf. Jacob 1990). But whatever the reasons or their strengths, the inclusion of public health law within textbooks may generally be represented as a recent phenomenon (Farrell et al. 2017, chapter 1). And taken as a field in its own right, there is only a limited number of such books specifically on public health law (e.g. Gostin and Wiley 2016; Coggon et al. 2017).

At one level, we should be slow in criticising this. One of the defining points about studies in law and health is their rapid expansion and associated pluri-dimensionality. Inevitably, many interesting, important, and relevant points and approaches may—must—be missed within any given text or course curriculum. I will note here three such dimensions. First, because studies in health and law have an ultimate practical focus that is anchored to a particular value—good health, and the viable routes and limits to promoting this value—it invites analyses from across areas *within* law: laws that impact health span private law (including, but not limited to, torts), public law (including, but not limited to, administrative law and human rights), and criminal law (including, but not limited to, criminal regulation of medical malpractice), and they require understandings stratified across domestic, EU, and international legal systems. They also inevitably require understandings of regulation that emanates from non-legal sources (including, but not limited to, the remit of organisations such as the General Medical Council). Second, studies in health and law invite a wealth of critical and evaluative approaches from *without* the law itself. As emphasised in the following discussion, biomedical ethics consistently seems to claim a privileged place here, but it is just one of many methods of framing and analysing (see also Syrett 2019), alongside distinct methods of socio-legal scholarship and empirical bioethics, as well, for example, as different branches of feminist theory, and other areas of jurisprudence and legal philosophy. And to note a final dimension, the nature of the field is such that scholars have generated tremendous depths of expertise in law as applied to very specific individual areas or topics, as varied as dementia, euthanasia, genetics, human reproduction, and organ donation. Given even just these three dimensions and their potential points of intersection, we find a daunting propensity to breadth, depth, and super-specialisation for health law scholars, and it is accordingly easy for any given expert to profess the especial importance of her own research and teaching choices, whilst at the same time of necessity neglecting other, equally significant, areas.

However, whilst we should not be overly critical of omissions of public health from legal curricula and research agendas, there are important reasons to support its inclusion. At an

analytical level, the power of law is only partially represented when our focus is on its use as a shield to protect people who are unwell from undue intervention (undue because we see it as unjustifiable medical paternalism (cf *Montgomery v Lanarkshire Health Board* [2015] UKSC 11)) or—with much more limited reach—as a tool to demand a particular treatment (cf *R (Burke) v General Medical Council* [2005] EWCA Civ 1003). Public health law provides a focus on positive states of well-being, the relative enjoyment of health by persons and groups across society, and crucially looks to political (Coggon 2012a, chapter 11) and legal (Gostin et al. 2019) determinants of (ill) health. It thus goes far beyond the medical context, and looks at the whole of our social fabric and how—rightly or wrongly, and for better or worse—this influences our health outcomes and opportunities, balanced alongside other values and goals.

This chapter therefore aims to explain the distinguishing features of public health law and what might be achieved through its featuring in contemporary research and teaching agendas: not to promote its priority *over* other points of interest, but to show what is missed when it is omitted and gained by its incorporation. As a point of biographical more than academic note, it is perhaps worth stating that it was an area that I was initially drawn to because of its analytical distinctiveness; in particular, its natural invitation to critique law through a lens of political philosophy, which I generally find to be more interesting, and more usefully illuminating, than studies focused on law through ethical theories whose normative foundations are limited to unmediated concepts of interpersonal morality (Coggon 2010). The normative questions raised when we consider the public's health are not just a matter of individual right, or of what one person might expect of another: we are interested in what we owe to each other within society but also as members of a shared political community, how these things may be mediated through public institutions. And at a more basic level, it asks what we owe to the state and what it owes to us. We do not simply ask how and whether health ranks as a value alongside others, or focus on theoretically contained individual rights rooted in ethico-legal commitments to bodily integrity; we enter inquiry into the much bigger question 'what makes health public?' (Coggon 2012a). This question then informs the practical social, political, and legal question 'how can health be made public?' (Coggon and Gostin 2020).

Within the established principles—perhaps even dogmas (Dawson 2010)—that circumscribe or pre-analytically charge critical discussions of law and health, public health may be seen as an outlier area (Coggon and Laing 2019). Key concepts such as individual consent often cannot straightforwardly apply (Nuffield Council on Bioethics 2007). Concepts—in particular paternalism—that are treated as normatively loaded in a particular way cannot automatically be taken as they might be in a narrow, clinical context (Wilson 2011). And public health focuses not just on 'downstream' interventions; after the fact responses to remedy ill health. Rather, it looks to 'upstream' conditions within society to protect and promote good health and well-being (contrast Daniels 1985 and 2007). Public health engages questions of social justice and systemic factors that demonstrably impact the public's health (Venkatapuram 2011). It cannot, therefore, be understood or taught (well) with reference simply to principles, theories, frameworks, and approaches that apply to contexts of clinical medicine (Jennings 2003). In this chapter, I accordingly aim to assist understandings of public health law by, first, explaining what public health is about, before outlining the rationale that I and colleagues have taken to systematising the field within legal studies. I then outline briefly how a critical basis to studies in public health law might be founded, allowing consideration of ethical framings drawn from within public health, and offer some conclusions on the value of public health law's incorporation within the body of health-focused jurisprudence.

2. Public Health

The term ‘public health’ is remarkably open and fluid, often being used to mean quite different things even within a single document (including this chapter). Provided we are clear on our meaning in a given instance, this is not a problem. In an earlier conceptual analysis, surveying definitions and inferences that could be drawn given the implications of different uses of ‘public health,’ I have argued that we can see seven distinct ‘faces’—different clusters of ideas—that might be at play when we find the term used:

1. *Public health as a political tool*: in this sense ‘public health’ is used as an important end, denoting (supposedly) strong or compelling reasons for formulating policy. Here the term may be seen to imply a social mission, a social theory, or a naturally good concept. [...]
2. *Public health as government business*: as a function of government, public health may be understood narrowly as relating to the competence or responsibility of specific health agencies, widely as any governmental power that affects health, or somewhere between these extremes.
3. *Public health as the social infrastructure*: in this sense public health is taken to represent society’s organisation [...] in respect to [...] non-State responsibility for health that nevertheless may be described as public in character.
4. *Public health as a professional enterprise*: public health refers here to professional approaches [...] for example, to the scope of a professional’s practical competence [...], to the nature of expertise that a professional has, or to his work’s being health-related.
5. *Public health as blind benefit/harm*: public health may be used as a qualifier to represent probable benefits or harms within a population [...] to denote instances of certain harm where the specific identity of those harmed/[benefitted] is unclear [...], or instances where *ex ante* the ultimate beneficiaries are not known [...].
6. *Public health as conjoined beneficiaries*: here ‘the public’ has moral, ‘solidaristic’ connotations [...].
7. *Public health as the population’s health*: this [...] refers to the health of a population, either in aggregate or by reference to distribution. [...]. (Coggon 2012a, 46–47)

Each of these faces of public health calls for its own analysis; both conceptual and evaluative (see Coggon 2012a, chapter 3). Ultimately, I would reject calls for attempts to find or adopt *the* meaning of public health. But, as indicated by the above list, it is important when teaching or writing in this area to be clear within a given context about what is being covered, as distinct audiences can draw quite distinct interpretations of what an intended meaning might be. It is useful to begin a discussion of what public health is with this representation of the breadth of meanings that may be attributed to it, as this immediately exposes the ranging concerns and significances that it gives rise to.

However, having acknowledged this breadth and variety, it is of course necessary to gain some focus; again, a matter that whilst essential is inevitably exclusive. Within the context of public health law teaching, it is common to revert to and build on the most practically used and influential definitions of public health and to work from there (see e.g. the framings in Gostin and Wiley 2018, chapter 1). In doing this, two useful points of emphasis may be seen to arise, which can be related directly to the conceptual analysis of philosophers Angus Dawson and Marcel Verweij: the ‘public’ in ‘public health’ draws attention to methods of social coordination,

both governmental and through alternative social structures; and the reference to ‘public’ demands a focus on health at a population rather than an individual level (Verweij and Dawson 2009). These two points provide particularly useful ‘hooks’ for the study of public health law.

There are significant conceptual and practical distinctions to be drawn when we look to collective organised means to protect and promote health and conceive of ‘the population as patient’ (Gostin 2014). ‘Treating’ a population raises distinct questions about both rationales for and methods of intervention. Consequently, it also requires distinct analyses of how interventions may be legitimised. Our understanding of how we might properly ‘treat’ a body of persons will be impacted by analyses of how we may treat a person’s body. But our critiques can work in the other direction too and provide a more nuanced understanding of the practical scope and limits, and conceptual bounds, of the body—individually and within a social grouping—in health and law. As noted in the opening words of the introduction, since this chapter was completed and moved into production (towards the end of 2019), the importance of recognising these distinctions has been made stark by the necessity to control the spread of COVID-19; a crisis for people and governments globally. Even with national responses at their early stages, the fundamentality of human and social interconnectedness, the costs that may be carried in terms of individual liberty, and the weight and importance of values other than liberty are clear (see Coggon 2020a). Under and through the Coronavirus Act 2020 and associated and further legislative measures, the UK government and devolved administrations are exercising emergency powers in a way previously unheard of in peacetime. Other liberal democracies are acting similarly, and others again have followed quite different approaches. The questions of legitimacy in these circumstances bring to the fore how vital it is to retain checks on power, assure accountability, proportionality, and protection of human rights, approach public health law with a keen concern for equity, and adhere to a rigorous concept of the rule of law. They also emphasise the vulnerabilities of social institutions and infrastructures. And in relation to medical jurisprudence and medical practice, they show the fragility of assumptions based on analytically abstracted considerations just of an individual patient and doctor. By the time this chapter is published much legal scholarship will have been produced on the COVID-19 pandemic, and for sometime thereafter, crucial developments will emerge. The need for comprehension of public health law in ongoing analysis and practice will be essential.

However, the conceptual and analytical points that I aim to highlight at this stage of the chapter can be demonstrated in brief with reference to a less complex case study in public health ethics: the fluoridation of water supplies (see e.g. Nuffield Council on Bioethics 2007; Coggon and Viens 2017). A fundamental tenet of biomedical ethics and medical law, founded in the principles of respect for bodily integrity and respect for autonomy, provides that medical interventions may not be given to a person who has decision-making capacity, without her consent, if it is just for her own good (i.e. a paternalistic measure, as opposed, say, to a measure to protect others from harm) (see Mental Capacity Act 2005, section 1; *Re T* [1992] 4 All ER 649).¹ This consent requirement, if generalisable without qualification, would render water fluoridation illicit in the absence of informed and explicit agreement of everyone who uses the public water supply. At a general level, overall water treatment, through methods such as filtration and chlorination, which *clean* our water and make it drinkable, may be justified because clean drinking water is a basic necessity and water authorities would wrongfully be causing harm

¹ The notable exception to this fundamental of English medical law concerns compulsory treatment authorised under the Mental Health Act 1983. This chapter is not an appropriate place for consideration of that statute or the justifiability of the distinct points of law for mental health care, but for analysis that considers both mental health and public health as ‘outlier’ areas in health-focused legal studies, and how these areas might develop, see Coggon and Laing 2019. There are important questions too, of course, about determinations of incapacity under the Mental Capacity Act 2005, and consequent decision-making (see further the analysis in Coggon 2007, 2016).

if they provided us with untreated water. However, fluoridation is not rationalised by reference to making the water unharmed: it is an additional, *preventive* intervention to promote a health end (reduction of dental caries) that is dissociable from harms that might be caused by the water itself. The key rationales for fluoridating the public water supply is that it is a safe and effective means of preventing ill health and promoting good health across particular populations; in particular, children who are members of more disadvantaged socio-economic groups (Public Health England 2018). However, this treatment is essentially all or nothing: there can be no individual opt-in or opt-out. A decision has to be made, at a policy level, of whether a public as a whole will be treated paternalistically. The ‘treatment’ requires to be provided through general, coordinated means. Its effect anticipates, rather than reacts to, ill health. And its impact is on persons combined as an aggregate; as a public.

It is of course the case that many population-level health interventions may permit more nuance in their reach, and that rationales other than paternalism may be found for any given measure. For example, some vaccination programmes will be designed purely for the benefit of the individual who may be vaccinated, but others in order to protect third parties from harm or provide a general, ‘herd’ immunity. Others still will be a combination of these. In terms of implementation, furthermore, vaccination programmes may be unrolled at a general level whilst permitting individual opt-outs. Overall, public health activities span a broad range of functions. These include protection from environmental threats and prevention of the causes of incidence of disease. This may be through, for example, measures to assure food hygiene standards, clean air, refuse collection, a functioning sewerage system, or otherwise provide a sanitary environment. Or it may be through measures to prevent or respond effectively to enormous and imminent threats, such as an influenza pandemic. They also include the promotion of health and well-being through education, and the anticipation of causes of ill health. This may be through, for example, sex education, or through obesity reduction strategies to lessen the incidence of disease that is consequent to obesity.

In relation to legal studies, we can bring together the variety and range of public health activities and approaches and create a coherent body of analysis if we unify them through the two ‘publics’ in ‘public health’ presented by Verweij and Dawson. To reinforce the point, reflect on what is perhaps the most famous characterisation of public health, published a century ago by Charles-Edward A. Winslow:

Public health is the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health. (Winslow 1920, p. 30)

Contemporary definitions modify, but clearly draw a great deal from, Winslow’s definition (see the definitions reviewed in Verweij and Dawson 2009). Unsurprisingly, 100 years on from his representation of public health, we now see a strong focus on mental as well as physical health (albeit not one that is as well matched in practice as it is in expressed political commitment: Faculty of Public Health and Mental Health Foundation 2016; Coggon and Laing 2019). Equally, scientific understanding has progressed since Winslow’s time, leading to an increased understanding of the *social determinants* of health, and the need to consider *health in all policies* if we are to optimise protection and promotion of health and well-being (Davies et al. 2014). Twenty-first-century public health research, practice, and agendas are responsive to identifying different

populations with a keener understanding of the causes of compounding or clustering of disadvantage in society (Wolff and De-Shalit 2007) and overall a concern to address, through socially coordinated measures, unfair health inequalities (Marmot 2004, 2015).

Given this, one final practical point about public health bears making, before moving more squarely to the study of public health *law*. Beyond the conceptual and practical dimensions that arise when we ‘treat’ a population, there are important questions of deciding *which* populations to target. There are, of course, as explored below, challenging questions in political theory, for example, about the role of government in addressing inequalities (e.g. as opposed to asserting without argument that health-related decisions should just be a matter determined by personal responsibility). But at a practical level, we should also in particular be aware of what epidemiologist Geoffrey Rose identified as the ‘prevention paradox’ (Rose 1985). Rose’s analysis explains the differences between looking at, determining causation of, and responding to the manifestation of a disease in the case of an individual patient, and looking at the *incidence* of disease within a whole population and deriving understandings of what causes this and how it might be ameliorated. It is through the latter, for example, that we determine that smoking is a cause of lung cancer. We do not establish the causal link by studying individual cases, but rather by comparing two populations: smokers and non-smokers. Rose arrives at the idea of the ‘prevention paradox’ because, he explains, to reduce the incidence of disease in society, efforts require to be targeted at *low-risk* populations. In other words, to maximise public health interventions, we often achieve the greatest impact—for example, through measures to reduce salt consumption across a population—by targeting persons whose risk of ill health, taken individually, is low. Whilst for any given person there is low incentive to accept the intervention because of the probability of there being low gain, at a population level, the incidence of disease will be markedly impacted. This manner of complication adds a further challenge to the practical and normative considerations that define the study of public health law, the area to which this chapter now turns.

3. Public Health Law

Following the preliminary framings of this chapter, and the discussion of public health in the previous section, we may now consider how *public health law* might be conceived as a field of research and educational interest. The contrasting area of study and practice that I am referring to in this chapter as ‘modern medical law’ emerged towards the end of the 1970s, and achieved notable velocity following the interest stimulated by Ian Kennedy’s Reith lectures *Unmasking Medicine* (Kennedy 1981). As noted in the introduction, in concert with the broad multi-disciplinary field of bioethics within which it sits, early medical law of this era assumed a predominant focus on medical practice, leading to a disregard of the wider features of the healthcare system (including organisational structures) and of the non-physician actors within it (including other healthcare professions such as dentists, midwives, and nurses, and, e.g. managers and administrative decision-makers) (Montgomery 1997). Margaret Brazier and Jonathan Montgomery have recently challenged the wisdom of assuming or accepting the suppositions and framings of ‘modern medical law’ without regard for a much longer view of its historical context and possible futures (Brazier and Montgomery 2019). However, dominant norms in modern medical law have challenged a medical paternalism that was enshrined in the second half of the last century as a professional ethic, and supported through legal structures developed at common law by a largely deferential judiciary (cf Lord Woolf 2001). Equally, they have provided a partial account of social interactions—the clinical encounter between doctor and patient—and allowed patient autonomy to become a value of such predominant importance that even in wider contexts it is given undue (and often unquestioned) weight (cf Brazier 2006; Coggon 2012b). As a starting point, studies of public health law require attention to the entire social context: any

given scholar may *end up* at the view that individual autonomy ought always to triumph over wider questions of welfare or inequalities, but we must *start* with a clean slate rather than inherit the norms of the practically and analytically contained studies of ‘modern medical law’ (Coggon 2012a).

This question of wider context also invites recognition of the different actors that will be the subjects of analysis. As well as conceiving of persons in society generally, rather than ‘patients,’ we need to look to relevant institutional actors and the norms that ought to govern their practices: public health laws ultimately impact on individual persons, but we are interested in a collective ‘body’ (or ‘bodies’) of persons, and in the roles and responsibilities too of corporate (in particular, but not only, governmental) ‘bodies.’ This last sense of ‘bodies’ brings us again to Verweij and Dawson’s first idea of ‘public’ in ‘public health’: the organised community effort and use of social machinery in order to assure better conditions for the protection and promotion of the public’s health. Here we find natural links to the importance of legal studies for public health (Coggon 2018a). This is not least because law necessarily assumes a role as being a *part of* public health. At the ‘thicker’ end of this, there are governmental responsibilities to protect and promote the public’s health, as introduced in England, for example, through sections 11 and 12 of the Health and Social Care Act 2012 (the former relating to the Secretary of State, the latter to Local Authorities as well as the Secretary of State) or as provided under the Public Health (Control of Disease) Act 1984 (and extraordinarily, of course, through powers conferred under the Coronavirus Act 2020). Relevant here are the functions of executive agencies such as Public Health England, as well as organisations such as the NHS and the National Institute for Health and Care Excellence. But this also includes government responsibilities that may not be expressly or obviously designated as relating to ‘public health’, or exclusively based on policy concerns for the public’s health, yet which are nevertheless of relevance to determining how our environments impact our health (e.g. laws governing consumer protection, education, environmental protection, housing, urban planning, taxation). In a perhaps ‘thinner’ sense, we might also relate this idea of community effort and social machinery to the coordination and governance roles of non-governmental actors that nevertheless serve—or aim to serve—the public’s health (e.g. organisations such as the UK Faculty of Public Health). And we should look as well at the impact of powerful private organisations, whose practices may affect health at a population level for better or worse (e.g. supermarkets through their pricing policies on alcoholic drinks or their placing within the shop of sweets) (see further Coggon et al. 2017, chapter 9).

Given the wide reach of public health, as shown in the previous section, and the breadth of legal and governance approaches that are relevant to its proper understanding, delineating the field of public health law risks problems of (what might be perceived to be) overreach (for arguments supportive of such a position, contrast, for example the discussion of delimiting the definitions of ‘public health,’ respectively, by Richard Epstein (Epstein 2004) and Mark Rothstein (Rothstein 2002)). Nevertheless, Keith Syrett, A.M. Viens, and I have indeed promoted public health law as an area of study that is well characterised by the extensiveness indicated up to this point, characterising it as:

A field of study and practice that concerns those aspects of law, policy, and regulation that advance or place constraints upon the protection and promotion of the health (howsoever understood) within, between, and across populations. (Coggon et al. 2017, p. 72)

This definition is the product of a review of the nature and scope of contemporary public health agendas, the reach and points of engagement of public health ethics, and an analysis of the history of British law and public health (see Coggon et al. 2017, Part I). In contemporary literatures, we draw in particular from the approaches of UK scholars—especially Robyn Martin

and Richard Coker (see e.g. Martin 2006, 2007; Martin and Coker 2006a, b)—and pioneers of public health law in the United States—notably Lawrence Gostin and Lindsay Wiley (see e.g. Gostin and Wiley 2016)—and Australia—in particular Roger Magnusson (see e.g. Magnusson 2007) (Coggon et al. 2017, chapter 4). In developing and explaining our manner of understanding UK public health law, we are keen to emphasise the importance of being open-minded about substantive content, and firmer in our characterisation by reference to regulatory rationales and approaches than limited topics or points of jurisdiction (see also Bennett et al. 2009). That is, rather than delimiting the field by reference, say, to laws that define themselves as concerning ‘public health’ (e.g. laws about notifiable diseases or specifically designated state powers), or by reference to particular areas of practical concern (e.g. pandemic preparedness or obesity), we look to the broad interrelationships between law, governance, and the impacts of different phenomena—for better or worse—on the public’s health. For the reasons summarised in the current chapter, the study and analysis of public health and law would otherwise arbitrarily miss too much.

In chapter 4 of our textbook, where we present and explain our characterisation of the field, we present in summary form the key points of emphasis to be taken. We write that:

[S]uch a definition provides the different necessary conditions for the study and practice of public health law. Our definition:

- Covers the very broad, but necessary, embrace that is claimed by contemporary public health activity, which includes the provision of a health care system, public health infrastructure, and measures that respond to social determinants of ill health.
- Provides a breadth in its concept of law: we are not simply focussed on ‘hard law’ measures but look also to social policy broadly conceived to include the governance roles of public and private actors and institutions.
- Embraces different legal and regulatory measures and approaches and reaches across sectors.
- Emphasises the role of law and governance both as means to promote public health agendas and as means to limit what may be done in the name of public health.
- Permits an open interpretation of ‘health’ allowing analysis of measures that bear not simply on, for example, disease, but also on broader, positive states such as wellbeing.
- Is open to engagement from disciplines outside of legal studies: for example [...], the field should be informed by public health ethics. Our definition of public health law is also compatible, for example, with study informed by disciplines such as anthropology, sociology, psychology, history, and economics. (Coggon et al. 2017, 72)

The combination of these points creates the necessary drivers of studies in public health law. But it should be immediately obvious that, barring possibly a degree qualification specifically in the field, a single teaching curriculum will not be able to cover everything that might be included. As such, a defining feature of a given course in public health law will—as in medico-legal studies be a matter of exclusive selection. In line with the pluri-dimensionality raised in the introduction to this chapter, this applies across points of legal approach and jurisdiction, across critical methods of understanding and analysis, and across possible practical subjects or topics of study. My view is that this is inevitable, and that it should be treated as a strength. There are various reasons for this, but one—which we emphasise in our approach to drafting the more applied, UK and international/global-focused chapters of our textbook (see Coggon et al. 2017, chapters 5–9)—is that a solid aim of public health law is the development of *transferable* understanding (for a wider survey and discussion of rationales for different approaches to framing the study of public health ethics and law in educational contexts, see Syrett and Quick 2009; Dawson and Upshur 2013;

Miller 2015; Doudenkova et al. 2017). In the next section of this chapter, I therefore consider it valuable to outline some key *critical* and *analytical* concerns that arise in relation to public health and law, and which can inform the sorts of debates that this volume aims to address.

4. Biomedical Ethics, Political Morality, and Social Justice

4.1 The Socio-Political Context of Public Health Law

The defining features of public health law, at least as I have presented them in this chapter, by their nature present an area whose paradigms demand a move away from what have become the standardised approaches, framings, and received socio-ethical wisdoms of modern medical law. In public health law, we are not able to abstract individual encounters between doctor and patient from a wider social context and theorise on the basis of that. Like critical medical lawyers, public health law scholars are interested in questions of power imbalances, the proper scope of freedoms, and the contours of our rights in relation to health and welfare. Of necessity, the study of these requires more nuance and variety than that found in ‘textbook’ clinical encounters (see also Farrell et al. 2017, chapter 3). We find ourselves having to move beyond an apparent assumption that the best way for law to serve an individual is by ensuring that she is adequately informed and by that fact able to decide for herself. Rather than identify just the more powerful and the more disempowered party (respectively, the doctor and the patient), we look across society at persons, agencies, and institutions, as well as distinct layers of concentration of power, opportunity, advantage, disempowerment, and disadvantage. When looking at public health, we are raising distinguishable practical questions, including ones focused on promoting positive states of well-being, rather than just the avoidance, remediation, or palliative control of disease. And accordingly, the question of values and (enforceable) obligations is pervasive, rather than focused overwhelmingly on one party (i.e. in modern medical law, the doctor). We look at the responsibilities that everyone does and should owe to each other, and the obligations between persons and communities and institutions of government. These are studied not by reference to the uniform idealisation of the ‘autonomous patient’ but in a contextualised account of empirical social conditions and structures and real politics. Within public health law, therefore, different (albeit at times overlapping and, in principle, complementary) conceptual and critical approaches and lenses require to be taken to those that are familiar in medical law. These are needed, for example, in order to demonstrate the distinct possibilities for analysis of social inequalities and the consequent contours of social justice. And they lead to distinctive implications for the limits that might be placed on, or qualifications given to, rights and responsibilities, and the presumptive and ultimate conclusion on questions of justifying, for example, interventions that are paternalistic in nature, that call for trade-offs between values across society, or that promote redistribution of resources.

It should be clear from this that our critical focus in public health is properly framed by reference to a political, rather than a purely interpersonal, morality (Coggon 2012a). This insight is not new (see e.g. Jennings 2003; Nuffield Council on Bioethics 2007), but it is something that can get lost in medicolegal scholarship and education that often obscure the places of institutional actors and the relationships between persons as citizens, between persons and the state, and the place, rights, and responsibilities of other (e.g. commercial) organisations. The importance of politics and political context has long been apparent to those working in public health (Mackenbach 2009). But there can be a tendency—given that the same teachers and researchers tend to look at medical law and public health law—to allow paradigms from the former to pervade and even predominate the latter. Within public health research itself, there is an increasing and welcome movement to expose and engage in analyses in political science (see e.g. Bambra et al. 2005; Kickbusch 2013; Bekker et al. 2018). However, a full analysis

requires engagement both with the more empirically situated concerns of political science, *and* with the more philosophically oriented inquiry of political philosophy (Coggon 2012a, 2019; Coggon and Gostin 2020). I would encourage colleagues and students to approach their critical understanding of public health law within such framings. Whilst doing so may, in a way that is consistent with the discussions in the previous section, lead to a very broad teaching agenda, some practical ‘narrowing’ is possible if we focus our points of inquiry around the moral drivers of public health practice.

Although there is legitimate scope for disagreement on how to approach this, one point of critical departure may be the ethics of public health itself. There is something of a consensus that if we look to the ethical agendas espoused within public health, we can identify two ‘moral mandates’ on which practice—and ultimately interventions—rest (Coggon and Viens 2017). In doing this, we recognise that whatever moral legitimacy public health may claim, at the heart of our inquiry is the use of state power (including through law) to effect public health aims (Thomas et al. 2002). The first mandate that members of the public health community tend to identify is the protection of health, both through preventing ill health and through protecting and promoting good health and well-being; the second is the amelioration of unfair health inequalities. Given these professed ethical imperatives, and the points in the previous paragraphs about framing, the following two subsections of this chapter briefly engage with two heads of critical analysis and inquiry that might accordingly feature in—even underpin—teaching agendas in public health law: first, the question of health improvement and the magnetism of ‘nanny state’ accusations; and second, the critical focus of redistributive justice.

4.2 The First Moral Mandate of Public Health: Promoting Health Under the Shadow of Paternalism Objections

The first, and perhaps most obvious, concern in public health is the prevention of ill health and promotion of good health. This can find itself quickly related to a utilitarian ethic that often (and often too simplistically) becomes associated with public health ethics. By its nature, such imputed association suggests a focus on optimising the aggregate good with little direct regard for persons’ rights (or indeed values other than health). Additionally, both within a broad scheme of political morality, and within an area of study that can be beholden to the norms of medical law, we find an ethical reference point that rests on paternalistic ideas and ideals. And as is widely recognised, rightly or wrongly, paternalism has become an automatic indicator of illegitimacy in medico-legal studies.

These sources of tension are a good entry point for critical discussions of the proper role, purpose, and limits of law in the context of population health, and permits tutors to draw from ranging critical perspectives (see Coggon 2012a, chapters 7 and 8; 2018b). Health is a powerful value: whatever a person’s political leanings, it is hard to argue that health and well-being are not important. But what can be harder to argue is whether and why these things are a concern of government; a *public* matter. Within the ethico-legal literatures on public health, we find theorists such as Lawrence Gostin (Gostin 2008) and Jennifer Ruger (Ruger 2009), who argue for the special, fundamental importance of health. It is presented as *the* foundational value for political communities. At the other extreme, we find theorists such as Petr Skrabanek (Skrabanek 1994), who espouse a commitment to profound value pluralism, and who shun the idea that health might legitimately stand at all as a value that should direct policy. And there are then many positions that sit in between these extremes, for example, holding that health is important but that government-led public health policies create inefficiencies and conduce overall to poor health outcomes (see e.g. Epstein 2004), or that health is important but as just one of a plurality of basic values (see e.g. Powers and Faden 2008). There are crucial questions for (public) health

law students to examine on how health might be the value that motivates and justifies a policy intervention, and how discussions of this may be associated with fundamental characterisations of political morality and legal legitimacy (cf Latham 2015).

Accordingly, the ‘hook’ provided by the aims of prevention of ill health, protection of good health, and promotion of better health is a strong one. It invites debates about the legitimate aims of legislative and other forms of governance for health. But crucially, it also prompts discussion of *methods* of regulation, with perhaps inevitable reference within this to the ‘nanny state’ (Coggon 2018b). When exploring different sorts of intervention, it is instructive to evaluate ideas about normative distinctions between ‘harder’ and ‘softer’ measures. These include a focus on the vogue of ‘nudge’ as a (putatively: see Coggon 2020b) benign, or philosophically and politically more straightforward, method of achieving healthier publics (cf Sunstein and Thaler 2003; Thaler and Sunstein 2009; Sunstein 2014, 2016; contrast also the approach and analysis in Davies et al. 2014). Such a focus also allows the analysis of how the legitimacy of interventions might be scrutinised in terms of effectiveness, respect for basic rights and proportionality, equality, and the rule of law, or tempered by reference to the nature of the particular population being targeted (e.g. children; members of particular socio-economic groups) (cf Gostin et al. 2019).

4.3 The Second Moral Mandate of Public Health: Addressing Inequalities Under the Shadow of Arguments for Pure Individual Responsibility

The second key normative concern in public health is addressing unfair health inequalities. This clearly is not founded in anything like utilitarian ideas of justice, drawing considerations not just about the aggregate health within a public, but looking as well to distribution. Health inequalities generally are exemplified with reference to statistics concerning systemic causes and distributions of relative health outcomes for different populations but may also be related to the distribution of opportunity to live in good health. It is well recognised that for an inequality to be an inequity, some criterion or principle of fairness is needed. And people of course radically disagree on what is meant by *unfair* inequality. Additionally, public health (ethics) literatures explore how challenging it is to establish how we might index and, through policy, address measures of disadvantage (Braveman and Gruskin 2003; see also Wolff 2009).

Howsoever they may be understood and measured, unfair inequalities in health outcomes and opportunities are directly linked to wider socio-economic inequalities; questions of socio-structural (dis)advantage and (in)opportunity, rather than matters that can in practice just be addressed by persons individually (Marmot 2004, 2015; Venkatapuram 2011). They also require to be addressed by looking across sectors and areas of policy; we cannot just focus on health care (Daniels 2007). As such, when considering public health ethics and law with reference to inequalities, we find ourselves focusing on questions of *redistributive* justice, within a political framing that—with reference to scientific evidence—denies libertarian ideas that people can fairly be held responsible, on their own, for their health.

Amongst the complexities in understanding and evaluating health inequalities as a matter of justice are questions of whether we take health inequalities as themselves to be problematic, or whether we should treat them as indicators of injustice. Furthermore, there is the point that, unlike goods that might be redistributed within a social system (e.g. financial wealth), health itself is not something that can be redistributed (Ashcroft 2015). Within teaching and research agendas concerning public health, we are therefore required to look at and consider distinct theories of social justice (cf Coggon 2012a, chapters 7 and 8). We do this with a view to normative questions of whether and by what means governments might be mandated to redistribute wealth and other

goods (e.g. to assure optimal conditions for health in the early years of life), and how governments might be empowered to limit general or commercial freedoms (e.g. through minimum pricing schemes on alcohol) in order to remediate disproportionate health harms amongst less well-off socio-economic groups. Necessarily, we must also do this with a view to evidence bases about how different such measures might practically serve to ameliorate health (and other) inequalities. But in exploring such questions, we should not take it that philosophical debates on competing ideas of justice can be sidelined: health inequalities may be identified through scientific methodologies, but inequities are established by reference to political-philosophical reason.

Within public health discourses, and of course more generally in society, there are plural, competing accounts of how fairness should be understood in relation to health inequalities. A focus on health inequalities, like one on health promotion, allows studies in public health law to engage with divergent practical questions and contexts, elucidating the pulls and drawbacks of different ideas of justice, and overall permitting depth of critical understanding of the possibilities and limitations of law and governance as mechanisms to effect better population health. As discussed in the next section, they do so in a way that can lend fascinating extra dimensions to our understandings of the body in—and of—medical and health jurisprudence.

4.4 Public Health Law: Challenging and Enriching the Body in (and of) Biomedical and Health Jurisprudence

A.M. Viens has explained how the ‘population approach’ of public health challenges theorists to ‘tame’ the individualism of liberal and republican political theory (Viens 2016; see also the discussions of liberalism, republicanism, individualism, and agency, in the paper to which Viens’ paper responds: Weinstock 2016). The influence of such theory, in particular political liberalism, has been marked in the formation of medical law in the UK and beyond. The field’s received ethical and jurisprudential wisdoms have been developed by theorists who have espoused individualism, and thus promoted highly individualised concepts of ‘the patient.’ The atomisation of ‘the patient’ has led to a heavy emphasis on the presumptive value of individually oriented values: notably, decision-making autonomy, and liberty in the sense of ‘negative freedom’ from unwanted state interference (including interference by health professionals). Such orientations have meant that even when bioethical works purport to question the reach of liberal individualism’s impact from biomedical ethics—for example, the Nuffield Council on Bioethics’ report on public health ethics (Nuffield Council on Bioethics 2007)—they have been criticised for producing prescriptions that ‘double count’ liberty as a value when assessing the legitimacy of mandates for governmental interventions (see e.g. Dawson 2016). Equally, I have criticised that same report, suggesting that the nature of individualism associated with liberal theories can be, and in the Nuffield Council’s report was, problematically accepted and overemphasised (Coggon 2008) (see also Baldwin, Brownsword, and Schmidt 2009).

As medical law has expanded through healthcare law to *health law*, ranging critiques of the overinflated value of autonomy have become of increasing salience (Farrell et al. 2017, chapter 3). These include empirical studies that challenge the reductive simplification of a singular and—when informed—empowered patient given that, in reality, we find plural levels of diversity in persons’ lived experiences, vulnerabilities, and capabilities, leading to corresponding varieties in what is to be a patient. And they include critical perspectives from, for example, feminist theories, that challenge the normative validity of individual moralities in the face of relational realities.

Studies in public health law bring further challenges in the ways discussed in this chapter: notably, in looking at health opportunities and outcomes by reference to population-level understandings, and by looking at distributions of these opportunities and outcomes in manners that raise questions about social justice. Crucially, this is not just about people as patients, but people in the course of their lives in general. As Sridhar Venkatapuram has forcefully argued, when we are faced with evidence of the health impacts of institutional structures and the forms and effects of how communities are organised, and thereby recognise how an individual's health cannot be determined by the individual on her own, we are faced with evidence that impacts how we think about what makes a fair society. He writes:

Importantly, social epidemiological research not only explodes outward the classic model of epidemiology, but the research findings also militate against various social consequences of applying the biomedical model. Some of these social consequences include the narrow focus on providing health care and behavior change as the primary avenues to improve health; being inattentive to social group inequalities in health; exaggerating individual volition in health outcomes; and focusing on the material poverty of the most disadvantaged while ignoring psychosocial environments producing ill health in the entire population. (Venkatapuram 2010, p. 124)

Venkatapuram's concerns directly—and very forcefully—undermine excesses of individualism in debates on how we analyse questions about health-related rights, freedoms, obligations, and opportunities. He makes clear how, at both national and global levels, we cannot reduce analysis to individualised models, or limit our practical arena of concern to the sphere of health care.

In the context of 'a jurisprudence of the body,' these challenges offer excellent scope for enhancing our overall critical understandings of law and medicine, and law and health more widely. Public health law approaches can enhance and enrich studies in medical law in its narrower instantiations, as well as throw open the practical social and governmental reach of our inquiry in societal (including legal) engagement with health as a value. Lindsay Wiley has shown well how public health concerns draw together legal understandings with public health science and questions of social justice in a way that significantly challenges legal framings and responses that are rooted in individualistic values (Wiley 2012, 2014). Questions of the scope and limits of concepts such as autonomy and bodily integrity, and the boundaries—physical and in principle—of the body, are thrown into fresh relief when we consider how our social interactions and institutions are determinants of the health that we may—or may not—enjoy. The practical contexts and normative framings of public health outlined in this chapter must be taken seriously, howsoever a critical scholar may ultimately respond to them in terms of normative conclusions on conceptual and analytical questions within jurisprudence. In the ever-burgeoning field of law and health, public health law may be seen to bring particular insights and approaches that radically change our understandings and analyses for the better.

5. Conclusions

The importance of law and governance to the achievement of public health goals is not a new insight (Coggon et al. 2017, chapter 3). However, the study of public health law has, for whatever reason, been relatively limited when compared with other areas of health and jurisprudence. Given the inevitable place for law and regulation within public health, and the enormous breadth of socio-political and ethical concerns that are raised by the idea of governance for the public's health, I have sought to show in this chapter how public health law can bring very distinctive, interesting, and important components to health law and to debates on a jurisprudence of the body. Although as a field of study it concerns much more than control of infectious disease, the

COVID-19 pandemic and powers such as those granted through the Coronavirus Act 2020 underscore the great significance of public health law. This crisis has also drawn to the fore the social inequities that demand the critical attention of legal scholars, and which are not captured within the analytical framings of ‘mainstream’ medical law. Studies in public health law put social structures and embedded systems and inequalities into sharp focus. They also provide crucial opportunities for analysis—from many disciplinary perspectives—of the scope, limits, and legitimacy of law and other methods of regulation in achieving fairer societies. By explaining and contextualising public health within and against the wider body of medical and health law, I hope to have shown how inclusion of this often-neglected field can bring a critical dynamism, and broad—potentially global—reach to studies in health and law.

References

- Ashcroft, R. (2015). Ethics and Global Health Inequalities. In J. Coggon & S. Gola (Eds.), *Global Health and International Community—Ethical, Political and Regulatory Challenges*. London: Bloomsbury.
- Baldwin, T., Brownsword, R., Schmidt, H. (2009). Stewardship, Paternalism, and Public Health: Further Thoughts. *Public Health Ethics*, 2(1), 113–116.
- Bambra, C., Fox, D., & Scott-Samuel, A. (2005). Towards a Politics of Health. *Health Promotion International*, 20(2), 187–193.
- Bekker, M. P. M., Greer, S. L., Azzopardi-Muscat, N., & McKee, M. (2018). Public Health and Politics: How Political Science Can Help us Move Forward. *European Journal of Public Health*, 28(S3), 1–2.
- Bennett, B., Gostin, L. O., Magnusson, R., & Martin, R. (2009). Health Governance: Law, Regulation and Policy. *Public Health*, 123, 207.
- Braveman, P., & Gruskin, S. (2003). Defining Equity in Health. *Journal of Epidemiology and Community Health*, 57(4), 254–258.
- Brazier, M. (2006). Do no Harm—Do Patients Have Responsibilities Too? *Cambridge Law Journal*, 65(2), 397–422.
- Brazier, M., & Montgomery, J. (2019). Whence and Wither ‘Modern Medical Law’? *Northern Ireland Legal Quarterly*, 70(1), 5–30.
- Coggon, J. (2007). Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism? *Health Care Analysis*, 15(3), 235–255.
- Coggon, J. (2008). Harmful Rights-Doing? The Perceived Problem of Liberal Paradigms and Public Health. *Journal of Medical Ethics*, 34(11), 798–801.
- Coggon, J. (2010). Assisted Dying and the Context of Debate: ‘Medical Law’ versus ‘End-of-Life Law’. *Medical Law Review*, 18(4), 541–563.
- Coggon, J. (2012a). *What Makes Health Public? A Critical Evaluation of Moral, Legal, and Political Claims in Public Health*. Cambridge: Cambridge University Press.

- Coggon, J. (2012b). Would Responsible Medical Lawyers Lose their Patients? *Medical Law Review*, 20(1), 130–149.
- Coggon, J. (2014). Global Health, Law, and Ethics: Fragmented Sovereignty and the Limits of Universal Theory. In M. Freeman, S. Hawkes & B. Bennett (Eds.), *Law and Global Health*. Oxford: Oxford University Press.
- Coggon, J. (2016). Mental Capacity Law, Autonomy, and Best Interests: An Argument for Conceptual and Practical Clarity in the Court of Protection. *Medical Law Review*, 24(3), 396–414.
- Coggon, J. (2018a). Law. In S. Venkatapuram & J. Bibby (Eds.), *A Recipe for Action: Using Wider Evidence for a Healthier UK: A Collection of Essays Exploring Why We Need Trans-Disciplinary Approaches to Improve the Public's Health*. London: Health Foundation.
- Coggon, J. (2018b). *The Nanny State Debate: A Place Where Words Don't Do Justice*. London: Faculty of Public Health.
- Coggon, J. (2020a). Beyond Liberty: Social Values and Public Health Ethics in Responses to COVID-19. Nuffield Council on Bioethics Blog (26th March, 2020) Available at <https://www.nuffieldbioethics.org/blog/beyond-liberty-social-values-and-public-health-ethics-in-responses-to-covid-19>, (last accessed 30th March, 2020).
- Coggon, J. (2020b). Smoke Free? Public Health Policy, 'Coercive Paternalism', and the Ethics of Long-Game Regulation. *Journal of Law and Society*, 47(1), 121–148.
- Coggon, J., & Gostin, L. O. (2020). The Two Most Important Questions for Ethical Public Health. *Journal of Public Health*, 42(1), 198–202.
- Coggon, J., & Laing, J. (2019). Exploring New Paradigms in Mental Health and Capacity Law: Persons, Populations, and Parity of Esteem. *Northern Ireland Legal Quarterly*, 70(1), 31–52.
- Coggon, J., Syrett, K., & Viens, A. M. (2017). *Public Health Law—Ethics, Governance, and Regulation*. Abingdon: Routledge.
- Coggon, J., & Viens, A. M. (2017). *Public Health Ethics in Practice: An Overview of Public Health Ethics for the UK Public Health Skills and Knowledge Framework*. London: Public Health England.
- Daniels, N. (1985). *Just Health Care*. Cambridge: Cambridge University Press.
- Daniels, N. (2007). *Just Health*. Cambridge: Cambridge University Press.
- Davies, S. C., Winpenny, E., Ball, S., Fowler, T., Rubin, J., & Nolte, E. (2014). For Debate: A New Wave in Public Health Improvement. *The Lancet*, 384(9957), 1889–1895.
- Dawson, A. (2010). The Future of Bioethics: Three Dogmas and a Cup of Hemlock. *Bioethics*, 24(5), 218–225.
- Dawson, A. (2016). Snakes and Ladders: State Interventions and the Place of Liberty in Public Health Policy. *Journal of Medical Ethics*, 42(8), 510–513.

Dawson, A., & Upshur, R. (2013). A Model Curriculum for Public Health Ethics. In D. Strech, I. Hirschberg, & G. Marckmann (Eds.), *Ethics in Public Health and Health Policy: Concepts, Methods, Case Studies*. Dordrecht: Springer.

Doudenkova, V., Bélisle-Pipon, J.-C., Ringuette, L., Ravitsky, V., & Williams-Jones, B. (2017). Ethics Education in Public Health: Where Are we Now and Where Are We Going? *International Journal of Ethics Education*, 2(2), 109–124.

Epstein, R. (2004). In Defense of the ‘Old’ Public Health. *Brooklyn Law Review*, 69(4), 1421–1470.

Faculty of Public Health and Mental Health Foundation. (2016). *Better Mental Health for all: A Public Health Approach to Mental Health Improvement*. London: Faculty of Public Health and Mental Health Foundation.

Farrell, A.-M., Devereux, J., Karpin, I., & Weller, P. (2017). *Health Law—Frameworks and Context*. Cambridge: Cambridge University Press.

Gostin, L. O. (2008). Meeting Basic Survival Needs of the World’s Least Healthy People: Toward a Framework Convention on Global Health. *Georgetown Law Journal*, 96(2), 331–392.

Gostin, L. O. (2014). Public Health: The ‘Population’ as Patient. In C. DeAngelis (Ed.), *Patient Care and Professionalism*. New York, NY: Oxford University Press.

Gostin, L. O., Monahan, J. T., Kaldor, J., et al. (2019). The Legal Determinants of Health: Harnessing the Power of Law for Global Health and Sustainable Development. *The Lancet*, 393(10183), 1857–1910.

Gostin, L. O., & Wiley, L. F. (2016). *Public Health Law—Power, Duty, Restraint* (3rd ed.). Berkeley: University of California Press.

Gostin, L. O., & Wiley, L. F. (2018). *Public Health Law and Ethics—A Reader* (3rd ed.). Berkeley: University of California Press.

Guest, C., Ricciardi, W., Kawachi, I., & Lang, I. (Eds.). (2013). *The Oxford Handbook of Public Health Practice* (3rd ed.). Oxford: Oxford University Press.

Illich, I. (1976). *Limits to Medicine—Medical Nemesis: The Expropriation of Health*. London: Marion Boyars.

Jackson, E. (2013). *Medical Law—Text, Cases, and Materials* (3rd ed.). Oxford: Oxford University Press.

Jackson, E. (2016). *Medical Law—Text, Cases, and Materials* (4th ed.). Oxford: Oxford University Press.

Jacob, J. (1990). Reviews. *Modern Law Review*, 53(2), 280–282.

Jennings, B. (2003). Frameworks for Ethics in Public Health. *Acta Bioethica*, 9(2), 165–176.

Kennedy, I. (1981). *The Unmasking of Medicine*. London: George Allen and Unwin.

- Kennedy, I. (1991). *Treat Me Right: Essays in Medical Law and Ethics*. Oxford: Oxford University Press.
- Kickbusch, I. (2013). Foreword: We Need to Build a Health Political Science. In C. Clavier & E. De Leeuw (Eds.), *Health Promotion and the Policy Process*. Oxford, Oxford University Press.
- Latham, S. (2015). On some Difficulties for Any Theory of Global Health Justice. In J. Coggon & S. Gola (Eds.), *Global Health and International Community—Ethical, Political and Regulatory Challenges*. London: Bloomsbury.
- Mackenbach, J. P. (2009). Politics Is Nothing but Medicine at a Larger Scale: Reflections on Public health's Biggest Idea. *Journal of Epidemiology and Community Health*, 63(3), 181–184.
- Magnusson, R. (2007). Mapping the Scope and Opportunities for Public Health Law in Liberal Democracies. *Journal of Law, Medicine and Ethics*, 35(4), 571–587.
- Marmot, M. (2004). *Status Syndrome: How Your Social Standing Directly Affects your Health* (Vol. 1, p. 150). London: Bloomsbury.
- Marmot, M. (2015). *The Health Gap: The Challenge of an Unequal World*. London: Bloomsbury.
- Martin, R. (2006). The Limits of Law in the Protection of Public Health and the Role of Public Health Ethics. *Public Health*, 120(Supp 1), 71–77.
- Martin, R. (2007). Law as a Tool in Promoting and Protecting Public Health: Always in our Best Interests? *Public Health*, 121(11), 846–853.
- Martin, R., & Coker, R. (2006a). Introduction: The Importance of Law for Public Health Policy and Practice. *Public Health*, 120(Supp 1), 2–7.
- Martin, R., & Coker, R. (2006b). Conclusion: Where Next? *Public Health*, 120(Supp 1), 81–87.
- Mason, J. K., McCall-Smith, R. A., & Laurie, G. T. (2002). *Law and Medical Ethics* (6th ed.). London: LexisNexis Butterworths.
- Mason, J. K., & Laurie, G. T. (2006). *Mason and McCall Smith's Law and Medical Ethics* (7th ed.). Oxford: Oxford University Press.
- Miller, F. H. (2015). Teaching Public Health Law: Time for a Status Upgrade. *Journal of Law, Medicine and Ethics JLME, Supplement*, 5–6.
- Montgomery, J. (1997). *Health Care Law*. Oxford: Oxford University Press.
- Nuffield Council on Bioethics. (2007). *Public Health—Ethical Issues*. London: Nuffield Council on Bioethics.
- Powers, M., & Faden, R. (2008). *Social Justice: The Moral Foundations of Public Health and Health Policy*. Oxford: Oxford University Press.
- Public Health England. (2018). *Water Fluoridation—Health Monitoring Report for England 2018*. London: Public Health England.

- Rose, G. (1985). Sick Individuals and Sick Populations. *International Journal of Epidemiology*, 14(1), 32–38.
- Rothstein, M. (2002). Rethinking the Meaning of Public Health. *Journal of Law, Medicine and Ethics*, 30, 144–149.
- Ruger, J. P. (2009). *Health and Social Justice*. Oxford: Oxford University Press.
- Skrabanek, P. (1994). *The Death of Humane Medicine and the Rise of Coercive Healthism*. London: Social Affairs Unit.
- Sunstein, C. (2014). *Why Nudge?* New Haven: Yale University Press.
- Sunstein, C. (2016). *The Ethics of Influence: Government in the Age of Behavioral Science*. Cambridge: Cambridge University Press.
- Sunstein, C., & Thaler, R. (2003). Libertarian Paternalism Is Not an Oxymoron. *The University of Chicago Law Review*, 70, 1159–1202.
- Syrett, K. (2019). Healthcare Resource Allocation in the English Courts: A Systems Theory Perspective. *Northern Ireland Legal Quarterly*, 70(1), 111–130.
- Syrett, K., & Quick, O. (2009). Pedagogical Promise and Problems: Teaching Public Health Law. *Public Health*, 123(3), 222–231.
- Thaler, R., & Sunstein, C. (2009). *Nudge: Improving Decisions about Health, Wealth, and Happiness*. London: Penguin.
- Thomas, J., Sage, M., Dillenberg, J., et al. (2002). Editorial—A Code of Ethics for Public Health. *American Journal of Public Health*, 92(7), 1057–1059.
- Venkatapuram, S. (2010). Global Justice and the Social Determinants of Health. *Ethics and International Affairs*, 24(2), 119–130.
- Venkatapuram, S. (2011). *Health Justice: An Argument from the Capabilities Approach*. Cambridge: Polity Press.
- Verweij, M., & Dawson, A. (2009). The Meaning of ‘Public’ in ‘Public Health’. In A. Dawson & M. Verweij (Eds.), *Ethics, Prevention, and Public Health*. Oxford: Oxford University Press.
- Viens, A. M. (2016). Public Health and Political Theory: The Importance of Taming Individualism. *Public Health Ethics*, 9(2), 136–138.
- Weinstock, D. (2016). Can Republicanism Tame Public Health? *Public Health Ethics*, 9(2), 123–133.
- Wiley, L. F. (2012). Rethinking the New Public Health. *Washington and Lee Law Review*, 69(1), 207–272.

Wiley, L. F. (2014). Health Law as Social Justice. *Cornell Journal of Law and Public Policy*, 24, 47–105.

Wilson, J. (2011). Why it's Time to Stop Worrying About Paternalism in Health Policy. *Public Health Ethics*, 4(3), 269–279.

Winslow, C.-E. A. (1920). The Untilled Fields of Public Health. *Science*, 51(1306), 23–33.

Wolff, J. (2009). Disadvantage, Risk and the Social Determinants of Health. *Public Health Ethics*, 2(3), 213–223.

Wolff, J., & De-Shalit, A. (2007). *Disadvantage*. Oxford: Oxford University Press.

Woolf. (2001). Are the Courts Excessively Deferential to the Medical Profession? *Medical Law Review*, 9(1), 1–16.