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# Health Law 2005: An Agenda

*Peter D. Jacobson*

In 2004, the journal *Health Matrix* published a very interesting symposium volume titled “The Field of Health Law: Its Past and Future.”<sup>1</sup> As the title implies, the various commentators took both a retrospective and a prospective look at past trends and future prospects in health law. Some, including Clark Havighurst,<sup>2</sup> Skip Rosoff,<sup>3</sup> and Walter Wadlington,<sup>4</sup> wrote thoughtful essays on the development of health law over time and the implications of those trends. Others, including Rob Schwartz,<sup>5</sup> Jim Blumstein,<sup>6</sup> Rand Rosenblatt,<sup>7</sup> and Mark Hall and Carl Schneider,<sup>8</sup> wrote equally thoughtful essays that reflected on the past but focused more on future directions and prospects. And one, Ken Wing, wrote a semi-dyspeptic essay debunking the entire field of health law.<sup>9</sup>

Taken together, these essays present a comprehensive view of how health law has developed so far and where its future might lie. Four themes emerge from the collected writings. First, there is considerable agreement on how and why health law has developed, but little agreement on where it is headed. Second, there is considerable concern as to health law’s place as a compelling discipline within the law school curriculum. Many of the essays might therefore be read as self-reflective attempts to assess the field and the authors’ collective contributions to it. Third, many of the articles take a position on the desirability of markets versus professional norms or social justice in defining the role of law in the delivery of medical care.

Fourth, the volume implicitly (and explicitly in Ken Wing’s contribution) raises questions about the field’s current dynamism. In this context, consider the following observation from Mark Hall and Carl Schneider: “We suspect there is no grand organizing principle for medical law because there cannot be. Medical law deals with medical activities in too many settings and must borrow from too many areas of law....We propose an analytical framework that views health care law as a law of relational webs rather than a law of transactions.”<sup>10</sup> Somewhat more pithily, Rob Schwartz suggests that we just “follow the money!” Both observations are intriguing and offer alternative ways of viewing the field’s current status.

Yet despite the ruminative qualities in the *Health Matrix* volume, in many ways medical liability continues to dominate health law. At least in the policy sphere, medical malpractice reform commands so much attention that it effectively eclipses other equally important areas. And the number of health law scholarly articles regarding medical liability continues apace. Just

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when I think there is nothing left to say on the subject, several new articles appear. Medical liability may not be the essence of the health law endeavor to scholars (as the contents of any health law casebook will demonstrate), but I suspect that much of the public at large views malpractice as the core of health law.

In this article, I will take a more pragmatic look at health law in 2005 than in the *Health Matrix* volume, focusing on some areas that have not received as much attention as they deserve. Assuming that the current state and federal tort reform efforts succeed in reducing the current medical liability crisis, attention will shift to other pertinent health law issues.<sup>11</sup> What follows is an agenda for post-tort reform health law. In the sec-

ers and shareholders? Or, should government intervene either to correct market failures or to alleviate the inevitable distributional consequences of a market-driven system? How does the framing of the question affect the development of legal doctrine?<sup>12</sup>

#### *Governance*

Unlike most competitive markets, where the dominant organizational form is a for-profit corporation, the health care industry is comprised of a mix of for-profit and nonprofit organizational forms. Health care administrators often use the phrase “no margin, no mission,” to suggest that meeting the charitable mission is impossible unless the organization generates sufficient

## Who owns the health care enterprise? To what extent should health care be a market-driven industry, accountable primarily to consumers and shareholders? Or, should government intervene either to correct market failures or to alleviate the inevitable distributional consequences of a market-driven system?

ond part, I address what I consider to be the most significant issues that directly affect health law doctrine in the short-term. In the third part, I examine some issues that are largely about the intangible and long-term aspects of the physician-attorney and law-medicine interaction. In the fourth part, I will offer some observations about trends in legal doctrine involving the health care delivery system.

#### DEVELOPING SOUND LEGAL DOCTRINE

Despite the tendency of medical liability to occupy the existing policy and doctrinal spheres, there’s actually a robust, if less visible, debate about the direction of legal doctrine in health care delivery. In this section, I want to focus on two broad areas of interest – competition policy and patient safety. In my view, these represent the most immediate concerns facing health law, particularly in determining the primacy of markets versus deference to medical professionals in shaping health law doctrine and health policy.

#### **Competition Policy**

Competition policy, the role of the government in facilitating a free-market health care system, lies at the heart of how the health care industry is organized and raises a set of interesting and challenging issues at the epicenter of health law. Each of these would warrant a separate presentation to cover adequately, so I’ll just outline them for now. The core questions animating competition policy are: Who owns the health care enterprise? To what extent should health care be a market-driven industry, accountable primarily to consum-

ers and shareholders? Or, should government intervene either to correct market failures or to alleviate the inevitable distributional consequences of a market-driven system? How does the framing of the question affect the development of legal doctrine?<sup>12</sup>

revenue to sustain its operations. Thus, nonprofit health care administrators must balance efforts to maintain adequate margins without compromising the charitable mission. In the managed care era, any given health system might integrate both for-profit and nonprofit forms within its overall structure, and might engage in joint ventures based on a mix of organizational strategies. But these strategies raise complicated legal issues involving antitrust, tax exemption, and regulatory compliance. They also raise questions of governance and fiduciary duties.<sup>13</sup>

Fiduciary duties are rooted in notions of professional norms, but operate within the context of a competitive market. The primary governance fiduciary duties, of care and obligation to the institution, are rooted in the recognition that trustees have an obligation to operate the facility for the community’s benefit, not for their own pecuniary interests. Nonprofit fiduciaries must therefore balance their obligations to the community with the realities of changing markets (i.e., balancing equity and efficiency). At a minimum, fiduciaries must consider intangibles that the market paradigm may not easily value, such as meeting the IRS’s ill-defined community benefit test. Fiduciaries have considerable flexibility to operate within the business judgment rationale, but must be careful to protect the organization’s assets while still meeting the institution’s community benefit obligations.

To say the least, governance is anything but a “sexy” area of the law. In my view, however, it is of fundamental importance in health care because of the competing pressures of mission versus margin. A major problem

is that the law of fiduciary duty is underdeveloped and inadequate to meet the competing needs of executives running a modern health care organization. Health law scholars are just beginning to address these issues. For example, Tim Greaney and Kathleen Boozang argue that fiduciary law is “muddled and too permissive in its oversight” but that the competing doctrine of charitable trust law is “doctrinally inapposite and pragmatically unsuited to govern business conduct in the contemporary health care market.”<sup>14</sup> Instead, they advocate a normative standard called “mission primacy,” which they define as “a doctrinal recognition that the non-profit corporation’s articulated charitable mission is its central objective....Mission primacy...would extend the concept of the duty of obedience to underscore directors’ core responsibilities as stewards of a nonprofit enterprise to advance its public purpose.” As with current fiduciary duty doctrine, their approach would accord considerable deference to trustees, with a more exacting requirement of considering the charitable mission in all decisions.

At first reading, I fully agreed with the central tenet espoused, but found mission primacy to be too vague for useful doctrinal development. On reflection, though, I think there’s considerable merit to this approach because it offers an overarching theory that can then be more precisely defined through subsequent common law development. I would nonetheless amend their standard to place the charitable mission in a paramount position, requiring compelling evidence to permit any deviation or departure from the mission.<sup>15</sup>

A good example of how the mission primacy standard might work (even though it would not have changed the result) is the case of *In the Matter of Manhattan Eye, Ear & Throat Hospital v. Spitzer*,<sup>16</sup> or *MEETH* for short. In *MEETH*, the board of trustees of a nonprofit acute care hospital specializing in ophthalmology, otolaryngology, and plastic surgery decided that the facility could no longer be competitive and needed to sell its assets. To make a long story short, the board hired a consulting firm, which concluded that the business had no value and that the underlying real estate was the only valuable asset. Ultimately, the board voted to monetize the value of the real estate and made no effort to preserve *MEETH*’s charitable health care mission. The New York State Attorney General challenged the board’s decision essentially to close the hospital and sell it for the value of the real estate. Based on its analysis of the fiduciary standard of duty of obedience, the court ruled that the sale violated New York law, stating that:

...While it may be appropriate, in certain cases, to solve financial difficulties by eliminating the organization’s mission by selling its assets and then un-

dertaking a new mission,...the duty of obedience... mandates that a board, in the first instance, seek to preserve its original mission. Embarkation upon a course of conduct which turns it away from the charity’s central and well-understood mission should be a carefully chosen option of last resort. Otherwise, a board facing difficult financial straits might find sale of its assets, and “reprioritization” of its mission, to be an attractive option, rather than taking all reasonable efforts to preserve the mission which has been the object of its stewardship.

Clearly, in my view, the court reached the right result. The question is whether the mission primacy standard would provide a stronger doctrinal rationale than the court’s reliance on the fiduciary duty of obedience. I believe that the answer is yes. The two doctrines have different starting points and the mission primacy standard places the burden on the trustees to demonstrate why mission primacy should not prevail. The duty of obedience test effectively places margin and mission on an equivalent plane. Trustees have greater flexibility to argue that business judgment requires the sale or conversion of the assets to non-charitable purposes. In contrast, the mission primacy standard arguably forces the parties to start with the charitable mission as the preferred option and should only be rejected if the trustees present compelling evidence that continuing the mission is impossible.

But to demonstrate how subjective and potentially difficult the “mission primacy” standard might be doctrinally, consider that my analysis of the application of the standard to the *MEETH* case differs from Professors Greaney and Boozang. They note that “[i]n this regard, mission primacy would likely have required a less categorical evaluation of purpose in *MEETH*,” whereas I view the result as being more categorical (or at least no less so). Nevertheless, mission primacy is a promising start for rethinking legal doctrine with regard to governing the nonprofit health care enterprise.

Professor Jill Horwitz has also been examining governance issues and proposes that all hospitals should be governed by a duty of integrity, defined as a moral constraint on organizational behavior. The duty of integrity would operate as follows:

A for-profit hospital can decide which services to provide based on the profitability of the service, as long as that decision does not violate the ethical responsibilities of the hospital as a healthcare provider. This means that if the hospital invests in a service because it is profitable it must invest in related, unprofitable services....Not-for-profit hospitals cannot decide to offer services solely to gener-

ate profits, but could do so to subsidize other services that they could not otherwise offer. Under this theory, a not-for-profit hospital could market special services to particularly high-paying clientele to subsidize unprofitable services.<sup>17</sup>

While the content of the duty would differ across organizational forms, the duty would impose contractual obligations for health care and health care justice. Allowing for differences in moral obligations according to form (that for-profits can pursue profits *per se*, unlike nonprofits), the duty of integrity would require all facilities to benefit the public. Whether this is a workable framework remains to be determined (though I have no doubt that the board in *MEETH* would not have satisfied the duty of integrity), but it is certainly a useful complement to the Greaney and Boozang approach.

### *Tax Policy*

A set of issues closely related to governance considerations is the increasingly scrutinized tax exempt organizational form. To the extent that the tax exempt form continues to be integral to the organization of health care delivery, the debate over governance remains salient. But the question we might ask is whether the tax exempt form is obsolete in an increasingly competitive industry? If so, the governance debate will shift dramatically toward defining and ensuring a level of community benefit that for-profits should provide.

The battle over the tax exempt form is two-fold: whether markets or a social justice paradigm should prevail; and whether nonprofits actually justify their tax exempt status. Supporters of the competitive market paradigm argue that for-profits provide relatively equal amounts of free care, contribute tax revenue to the community, and provide more efficient health care delivery.<sup>18</sup> More cynically, market proponents might add that the social justice model of publicly funded charity hospitals has failed because the public refuses to invest resources into facility modernization. Accordingly, only the private sector can “save” charity hospitals by converting them to for-profit status.<sup>19</sup>

Market proponents argue that since it is more efficient to encourage institutional integration for providing health care, the resulting efficiencies will generate additional tax revenue to provide adequate amounts of uncompensated care. Proponents of social justice and equity in the distribution of health care are likely to counter that the value of community benefits nonprofits provide, especially when those services would be otherwise unavailable, should outweigh efficiency gains. For efficiency to outweigh equity, market proponents should have the burden of demonstrating that a

more efficient delivery system will accommodate those unable to pay.

Regardless of how that conceptual debate proceeds, the IRS and local municipalities are increasingly scrutinizing tax exempt facilities regarding their compliance with community benefit expectations. Given that there are few, if any, operational differences between for-profit and nonprofit health care facilities (known as convergence – the differences are in how the revenues are distributed), what is the justification for continuing the tax exempt form? One of the policy goals supporting tax exempt facilities is to provide health care for those unable to pay. Historically, the presumption has been that for-profits will shirk their community responsibilities. Yet several scholars dispute that characterization. Since many public hospitals face severe financial stress, they may no longer be able to provide levels of free care as in the past. And as cash-strapped state and local governments seek new revenue sources, they will be tempted to scrutinize closely tax exempt health care facilities to ensure that they are providing commensurate community benefits in return for the tax exemption.<sup>20</sup>

In a competitive environment, nonprofits are forced to cut back on the unprofitable services they provide.<sup>21</sup> This has led to a series of unsuccessful lawsuits claiming that nonprofits have overcharged uninsured patients. Further, competition has compelled nonprofits to seek revenue generating sources, often through joint ventures with for-profit entities. Without going into the legal intricacies of these deals (i.e., Revenue Ruling 98-15), the competition policy question is whether these arrangements erode the charitable mission, in part because insiders may benefit in violation of the IRS’s private benefit/private inurement rules (prohibiting nonprofit insiders from more than incidental benefits from a transaction).

Professor John Colombo is highly critical of the IRS’s analysis of private inurement/private benefit because it compromises legitimate revenue-generating ventures with an overly broad interpretation of private benefit. Colombo argues that the IRS has expanded the definition of private benefit such that the exemption could be revoked in any given transaction if the private benefit outweighs the public benefit (regardless of the financial enhancement to the exempt purpose).<sup>22</sup> In arguing against the IRS’s private benefit/private inurement analysis, Colombo states colorfully: “What, exactly, does it mean to say that a joint venture impermissibly serves the ‘private interests’ of a for-profit investor? For cryin’ out loud, a joint venture between a nonprofit organization and for-profit investors is *supposed* to serve the investors’ ‘private interests’ (e.g., make them money) – otherwise, they wouldn’t be part of the deal. And so what if it does?”<sup>23</sup>

### Antitrust

Any analysis of competition policy should really start with developments in antitrust doctrine.<sup>24</sup> Antitrust enforcement lies at the heart of determining the extent to which health care will be dominated by professionalism or by market competition. But for all the *sturm und drang* over antitrust, it appears as though antitrust enforcement has not generated the changes its proponents had anticipated.<sup>25</sup> For example, the FTC has lost most of its challenges to mergers, and physicians have notably failed in using antitrust litigation to challenge staff privileges decisions. Nevertheless, the application of antitrust law has unmistakably altered the competitive environment in at least two ways: by not protecting other competitors from managed care, and by supporting managed care's cost containment initiatives at the expense of physician dominance.

In some ways, the most important doctrinal developments will be in how courts integrate quality of care into antitrust analysis. For health care antitrust cases, developing adequate doctrine to incorporate quality of care considerations is essential. For instance, a range of cases, including joint ventures and mergers, will be resolved very differently depending on how potential quality of care gains will be weighed against the anticompetitive aspects of the arrangement. As Peter Hammer and Bill Sage have noted, courts have generally not consistently applied or defined non-price considerations (i.e., quality of care) in health care antitrust analyses.<sup>26</sup> Take, for instance, the following quote from *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*:<sup>27</sup>

...when dealing with a heterogeneous product or service, such as the full range of medical care, a reasonable finder of fact cannot infer monopoly power just from higher prices – the difference may reflect a higher quality more costly to provide – and it is always treacherous to try to infer monopoly power from a high rate of return....One HMO may charge higher prices than other HMOs (and Security does charge higher prices) not because it has a monopoly but because it is offering better service than the other HMOs in its market. Compare itself stresses the quality of the Marshfield Clinic's doctors, as part of its argument that it cannot succeed unless the Clinic is forced to join it. Generally you must pay more for higher quality.

Even if conceptually accurate, the opinion does not define what quality of care means or how it should be weighed against price considerations.

To be fair, it is not surprising that judges might be reluctant to define quality of care, since health services researchers disagree about how to define and measure quality. And while antitrust law must reconcile trade-offs between price and quality, physicians have historically opposed intrusions into their clinical domain. Because it is increasingly likely that quality of care will be used to justify arrangements that would otherwise be suspect as anticompetitive, this is fertile territory for health law scholars.

In particular, an interesting doctrinal issue in cases involving quality of care is whether antitrust doctrine will reject professional norms in favor of market mechanisms. To Professor Havighurst's dismay, the Supreme

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Court held in *California Dental Association v. Federal Trade Commission*,<sup>28</sup> that the California Dental Association's restrictions on advertising did not constitute a naked restraint on trade. The Court rejected the FTC's quick-look analysis under the rule of reason and held that the agency needed a more detailed review to determine whether the restrictions might have procompetitive effects. Professor Havighurst criticized the opinion as substantially expanding potential defenses based on professional concerns. "Indeed the CDA opinion is the most explicit one to date that embraces the notion that professional self-regulation may directly restrain competition yet still be open to justification by demonstrating the existence of a theoretical market failure that the restraint in question may help to overcome."<sup>29</sup> If the *California Dental* reasoning were to be extended to quality of care defenses, professional norms could well emerge as a strong defense to antitrust challenges.

### Fraud and Abuse Regulations

A fundamental aspect of competition policy is the role of regulatory oversight. At this point, whether the current regulatory environment is burdensome or beneficial (or creates situations where compliance with one regime is inconsistent with another) has not been adequately explored. Among the various regulatory programs, the fraud and abuse regime is perhaps the most significant one to consider because of the high compliance costs and the potential impediments to beneficial and efficient arrangements between physicians and

health systems. A good example is the concept of gain-sharing, where physicians share in costs saved by MCOs. One branch of the government, Congress, encourages such innovations, while another, the Office of the Inspector General (OIG – DHHS), initially condemned the concept as violating the fraud and abuse statutes. Recently, OIG has backed off a bit to allow these arrangements under certain circumstances, but has yet to characterize gainsharing plans it would find acceptable.<sup>30</sup>

Surprisingly, health law scholars have paid only limited attention to this area. Some scholars, including Jim Blumstein and David Hyman, have taken a market approach to argue that managed care would alleviate the need for governmental oversight of fraud and abuse.<sup>31</sup> In contrast, Joan Krause has argued that fraud and abuse may be viewed as one aspect of the government's quality of care oversight mechanism.<sup>32</sup> Yet developing an alternative regulatory framework that would prevent egregious examples of fraud and abuse without the onerous structure now in place has not been developed. While I recognize that health law scholars might not find this an attractive area because of its lack of theoretical content, it is vitally important to health care practitioners and health care delivery.

### *Summary*

The various aspects of competition policy covered above offer considerable potential for empirical and conceptual health law scholarship. What they may lack in theoretical excitement is more than offset by the impact health law scholars can have in shaping competition policy doctrine and influencing the structure and delivery of health care.

### **Patient Safety**

Patient safety concerns have become a dominant feature of the health policy/regulation debate. A key point of intersection between the patient safety movement and medical liability is whether to report adverse medical events and, if so, whether the confidentiality of information can be protected. Firms and physicians are not likely to support reporting requirements that would expose them to liability. Thus, the question is whether retaining the current liability system, which focuses on an individual patient's care, is superior to cooperative alternatives more broadly concerned with systems improvements to protect patient populations.<sup>33</sup>

Most of the patient safety discussion has appropriately focused on systems improvements<sup>34</sup> without adequately considering the management/governance failures that contribute to systemic deficiencies in quality of care. As a result, some of the previous discussion of governance would be applicable to patient safety. In

addition, changes in legal doctrine could enhance and encourage the adoption of patient safety systems. For example, accrediting bodies have developed sentinel event reports to encourage facilities to report errors and devise strategies for system-wide patient safety improvements. These are voluntary reports that accreditors will keep confidential (though the reports can probably be obtained during litigation).<sup>35</sup>

Professor Bryan Liang has been a proponent of error disclosure without recrimination, and I agree with his analyses about the need to focus on preventing future errors rather than placing blame on an individual physician or facility.<sup>36</sup> This is not to suggest that liability litigation for substandard care should be abandoned. To the contrary, permitting blame-free error disclosure puts the emphasis on deterrence without undermining other desirable tort system goals, such as compensation. Plaintiffs' attorneys will simply need to gather evidence of substandard care from alternative sources rather than being handed what amounts to an admission of error. By analogy, we protect peer review information even though it may be damaging to a physician whose staff privileges may be denied. Likewise, we mandate child abuse reports and provide physicians with immunity even if the allegations prove to be false.

This general approach has now been codified in the recently enacted Patient Safety and Quality Improvement Act of 2005.<sup>37</sup> Through the establishment of patient safety organizations (PSOs), the Act creates a system for confidential reporting of adverse medical events. Health law scholarship can contribute to the ways in which the Act is implemented by developing regulatory strategies to ensure that PSOs achieve the Act's goal of balancing patient safety with accountability for medical error.

The area of patient safety has received appropriate attention from health law scholars. Since patient safety is likely to be on the policy agenda for the near future, further scholarly contributions and attention are certainly warranted.

### ADDRESSING BROADER ISSUES IN LAW AND MEDICINE

Beyond the purely doctrinal world discussed above, there are some important intangible issues shaping the law-medicine interaction that health law scholarship could productively illuminate. I use the word intangible because the doctrinal implications are not obvious for two of the three areas I will consider, and because these issues are as much contextual as they are subject to doctrinal development. Understanding them in context helps make sense of where the field is at present and identifies some aspects that require additional thinking.

## Reducing Health Care Inequalities – The Absence of Judicial Leadership

If health care delivery and law were driven by a social justice model (as discussed below) as opposed to a market approach, reducing health care inequalities might be of lesser import for health law scholarship. As it stands, market competition drives health care delivery. Despite claims that the market will correct inequalities, there is little evidence showing that market arrangements have effectively addressed inherent inequalities, so it seems appropriate to consider possible judicial interventions.

Since courts are unlikely to impose a right to health care, the primary opportunity to address inequalities is through statutory interpretation. When interpreting legislation, courts are often presented with opportunities to develop doctrine that would reduce health inequalities. Among the many possible examples, four particular instances show the judiciary's opportunities

of 1973. The beneficiaries argued that the limitation disproportionately affected persons with disabilities who would require more inpatient care. In rejecting the challenge, the Supreme Court suggested that Congress did not intend to require the state to provide specific levels of care and that the state retained considerable discretion in how to structure its program. Significantly, the Court signaled its unwillingness to address any resulting inequalities by stating that:

...to require that the sort of broad-based redistributive decision...always be made in the way most favorable, or least disadvantageous, to the handicapped...would be to impose a virtually unworkable requirement on state Medicaid administrators.

*Alexander v. Choate* characterizes the prevailing judicial attitude toward addressing deficiencies in state and federal programs. It is hard to imagine a more explicit

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to confront health inequalities. Even though the results have not been promising for those looking to the courts for leadership, it is important for health law scholars to continue pressing for doctrinal changes that would reduce these disparities.<sup>38</sup>

### *Medicare and Medicaid*

By their very nature, the Medicare and Medicaid programs are characterized by economic inequalities. Medicare beneficiaries, for example, must purchase supplemental insurance for certain services. Medicaid benefits vary across states and are much less generous than Medicare, offering opportunities for judicial intervention. As Colleen Grogan and Eric Patashnik note, the Medicaid program is rife with equity concerns, particularly with regard to differential benefits for poor families and the elderly, blind, and disabled.<sup>39</sup> Indeed, they argue that Medicaid has served to exacerbate existing health inequalities. Repeatedly, however, the courts have refused to redress inequalities in government health care programs.

In a landmark case, *Alexander v. Choate*,<sup>40</sup> Medicaid beneficiaries challenged the Tennessee Medicaid program's fourteen-day limitation on annual inpatient days as a violation of Section 504 of the Rehabilitation Act

statement opposing an expansive role in redressing social inequalities. Since this case, the courts have rarely taken affirmative steps to address inequalities in governmental health care programs, despite increasing evidence of widening racial and socioeconomic disparities in Medicare and Medicaid. For instance, in a case challenging Tennessee's planned procedures for reducing enrollment in TennCare, the Sixth Circuit Court of Appeals ruled that the state's plan does not violate either Medicaid laws or regulations or constitutional due process requirements.<sup>41</sup> Instead of addressing the potential inequalities resulting from the state's plan, the court ruled that the changes were administrative in nature and therefore did not generate due process requirements.

### *EMTALA*

Congress enacted the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) in response to concerns about "patient dumping."<sup>42</sup> This occurs when patients who are unable to pay are refused emergency medical treatment or are transferred from one hospital to another before their condition has been diagnosed and stabilized. Underlying the EMTALA statute is the assumption that people have a right to at

least basic emergency medical attention regardless of insurance status or ability to pay. EMTALA requires that a patient be diagnosed and stabilized before being transferred to another facility. Most states have more stringent requirements for emergency departments to provide care of last resort.

The original legislative intent of EMTALA was to reduce discriminatory practices in emergency rooms and prohibit socioeconomic inequalities in access to emergency medical treatment. From its inception, the legislative goals of EMTALA were not well defined, allowing considerable room for judicial interpretation. The Supreme Court first addressed EMTALA in *Roberts v. Galen of Virginia*,<sup>43</sup> holding that a plaintiff does not need to prove that the failure to provide emergency treatment resulted from an improper motive. But the Court noted that EMTALA's requirements are limited in scope to stabilizing and screening a patient. EMTALA does not establish a federal standard of emergency medical care and the courts have refused to broaden EMTALA to address inequalities in access to basic medical services. As a general proposition, courts have deferred to Congress for any such expansion. Under current law, where no emergency situation (or other exception) exists, physicians retain the authority to refuse treatment to any individual without facing legal liability.<sup>44</sup>

To be sure, some opinions have expanded EMTALA's scope. For example, courts have held that EMTALA applies to all patients in the hospital who have an emergency condition, not just those who arrive for treatment in the emergency room. Courts have also applied EMTALA to all parts of a hospital or health care system. Nonetheless, most judicial interpretations of EMTALA have been restrictive, holding that the courts should not address the efficacy or appropriateness of medical procedures performed under the statute. Most courts have ruled that EMTALA ensures only that the hospital's protocol is uniformly followed regardless of a patient's ability to pay.<sup>45</sup>

#### *Hill-Burton*

The 1947 Hill-Burton Act was passed in response to a perceived national shortage of hospitals, and provided federal monies for the unprecedented expansion of the U.S. hospital sector. The primary intent of the Hill-Burton Act was to provide federal financial assistance to states to "provide for adequate hospitals and other facilities" and "to furnish needed services for persons unable to pay." To this end, the Act required that the facilities receiving assistance must: 1) make the facility available to all persons residing in the territorial area, and 2) provide a "reasonable volume of services" to persons unable to pay. Unfortunately, these two stipula-

tions – the "community service obligation" and the "reasonable volume" (or "uncompensated care") assurances – were not well defined and initially not widely enforced.

The Hill-Burton obligations were at best a vague and limited legislative attempt to address economic and social inequalities in the provision of health care services. From 1946 to 1976, the Hill-Burton program supported the construction of forty percent of hospital beds in the United States.<sup>46</sup> But hospitals receiving Hill-Burton funds largely ignored the community service and reasonable volume requirements. These requirements were not enforced until the late 1970s, when federally funded legal service lawyers persuaded the federal courts to enforce the Hill-Burton statute.<sup>47</sup> During this time, advocacy groups for indigent patients unsuccessfully sought to use Hill-Burton to establish a right to health care for the indigent.

In 1979, primarily in response to Hill-Burton litigation, the Department of Health and Human Services (DHHS) issued regulations interpreting the community service and uncompensated care requirements. These regulations placed severe time limits on the uncompensated care provision, but did not place any time limits on the community service requirement. For most Hill-Burton hospitals, the uncompensated care requirement expired more than ten years ago, having had only a limited effect on the quantity of uncompensated services provided to indigent patients. The courts have consistently rejected the opportunity to expand Hill-Burton's community service requirement, which remains in place, beyond the DHHS regulatory provisions.

The community service obligation of the Hill-Burton Act is one of the clearest opportunities for courts to interpret legislation to reduce inequalities in access to health care services. Even though the regulation permits denial of care based on ability to pay, there is wide latitude in the regulation for interpretations that could dramatically increase the availability of health care services to indigents. But the judiciary has declined this opportunity. Courts have not taken advantage of the community service provisions to require Hill-Burton facilities to address inequalities. There are few (if any) reported cases that have used the community service requirement to reduce disparities in health care services.<sup>48</sup> Tellingly, in a 2000 volume devoted entirely to health inequality in the U.S., Hill-Burton is not even mentioned as a potential legal remedy.<sup>49</sup>

#### *ERISA*

The Employee Retirement Income Security Act (ERISA) offers an interesting study in the doctrine of unintended consequences. Originally enacted to pre-

vent recurring pension plan abuses, Congress included employee health benefits within its coverage. The Act is widely regarded as having contributed to the growth of managed care by limiting the ability of state law to regulate ERISA-covered benefit plans. In doing so, ERISA unwittingly created a managed care regulatory vacuum since the Act preempts (that is, precludes) state regulatory oversight of managed care delivery or state tort litigation against MCOs for an ERISA-covered patient. There is no countervailing federal regulation of employee health benefits.

After a series of judicial decisions that expanded preemption beyond congressional intent, the Supreme Court began to backtrack in 1996, allowing some liti-

### In strongly deferring to Congress, the Supreme Court has sent an unmistakable signal that it does not view its mandate as alleviating market deficiencies or inequalities.

gation against MCOs to go forward in state courts and some states laws to be implemented. In general, courts have rejected challenges to the inequalities brought about by the operation of managed care's financial incentives, ruling that public policy has encouraged the use of financial incentives to reduce health care costs. The courts have stated that Congress, not the courts, should make any changes to managed care policy.<sup>50</sup>

In strongly deferring to Congress, the Supreme Court has sent an unmistakable signal that it does not view its mandate as alleviating market deficiencies or inequalities. For those concerned with inequalities in health care, the *Pegram v. Herdrich*<sup>51</sup> case is a striking example of market deference. In this case, the patient challenged the operation of managed care's financial incentives in delaying needed health care. The Supreme Court ruled that Congress, not the judiciary, should evaluate whether financial incentives are appropriate. What is particularly troublesome about the *Pegram* opinion is that the Court went further than necessary to resolve this case. The Court easily could (and should) have retained an institutional oversight role to ensure that incentives operate fairly. That the Court voluntarily abjured its traditional oversight role means that it is unlikely to use its existing powers to alleviate health inequalities. Any attempt to redress inequalities in health care through litigation in federal court must therefore overcome the courts' institutional constraints and concerns. It will be difficult, if not insurmountable, to convince the judiciary that its over-reliance on institutional reasons to ignore policy issues leaves patients vulnerable and inequalities festering.<sup>52</sup>

### The Culture of Technology

Another item on my post-tort reform agenda is to address the effects of the technological imperative on health care delivery/policy and legal doctrine. My working hypothesis is that technology drives medical liability and health policy.<sup>53</sup> Although data are not available to determine whether a few technologies account for a significant portion of medical liability risk, or to quantify technology's overall contribution to claim frequency and award severity, it seems clear that technology is the major driver of medical liability trends. But more significantly, the nation's culture of technology underlies the relationship between law and medicine. No other factor plays such a powerful explanatory role in litigation trends or overall health policy.

Observers of the U.S. health care system frequently remark on the nation's culture of technology. Americans expect, indeed demand, both continued innovation and widespread (though not universal) availability. For reforms of both the health care delivery system and the medical liability system to be effective, we must contend with the culture of technology.

Historian Kenneth De Ville has been a leading proponent of the relationship between technology and medical liability. His explanatory framework for recurrent medical malpractice crises invokes both long-term cultural factors and short-term topical influences, and is a useful starting point for understanding litigation trends and for adopting appropriate policy responses.<sup>54</sup>

Under long-term cultural trends, De Ville notes several factors: 1) an upward-sloping baseline proclivity to sue; 2) breakdown of community solidarity that discouraged litigation; 3) a rising secular belief that humans can improve their lives; 4) a growing preoccupation with physical well-being; and 5) increased demand that there be a remedy for every wrong. Topical influences include: 1) attitudes toward the medical profession; 2) more sophisticated plaintiffs' attorneys; 3) increasing media coverage; 4) changes in legal doctrine; and 5) the absence of national health insurance. The inadequacy of health insurance deserves special attention as an incentive for litigation. When technology-laden medical care is needed following iatrogenic injury, the expense an uninsured patient can be devastating.

Three aspects of the cultural dimension particularly influence the law-medicine interaction. One is the oft-noted phenomenon of unrealistic expectations – that all medical interventions, particularly those relying on innovative technology, will be successful. A second aspect is the pressure that cultural expectations put on manufacturers and physicians to use the latest technology without adequately assessing its value. The ex-

amples of electronic fetal monitors (EFMs) and high-dose chemotherapy with autologous bone marrow transplant (HDC-ABMT) for metastatic breast cancer patients show the dangers of premature technology diffusion. The third aspect is overconfidence in the scientific basis of technological innovation, which reinforces the lack of assessment by not putting pressure on the system to justify new technologies.

Any enduring solution to the recurrent medical malpractice crises and to the costs of health care must include sustained engagement with the underlying culture of technology. I suggest that we need a much more forthright debate about the cultural aspects of technology, with physicians and attorneys, along with academics, taking the lead. It may well be that we have simply become too devoted as a society to the technological imperative to have a meaningful dialogue about it right now. In fact, there are powerful arguments in its favor. There is no question that technology permits physicians to attack conditions that would otherwise cause suffering and even death. Technology has clearly contributed to higher quality of life and perhaps longevity as well.<sup>55</sup>

Yet without some way to limit public expectations, physicians will never escape the quandary technology imposes. Too much pressure exists throughout the medical system to adopt innovative technologies without adequate time to determine their appropriateness and effectiveness. The current fragmentation in the health care system, with profitable specialty facilities advertising the latest in technological advances, forces competitors to match the technology. So a technology spiral is evident: patients want the latest technology (especially when they do not absorb the full costs), physicians are forced to provide it or else lose patients, and manufacturers are quite content to oblige with new products.

At best, cultural change will not occur quickly and will be difficult to achieve. To begin the process of altering the culture of technology, it seems to me that physicians can play a significant role by communicating the limits of technological solutions to medical problems. This needs to occur at both the individual patient encounter and at the professional society level. During the physician-patient encounter, patients need to understand that technology is not a magical solution. But patients whose only hope lies with the latest technology, even if unproven, have little incentive to listen to the caveats. At the professional society level, medical leaders should begin a dialogue with the public based on more realistic expectations about medical care's limits. The dialogue should focus on reducing the public's reliance on technology and properly depicting technology as only one aspect of medical care.

As a caveat to this discussion, there are serious issues of ethics and values that must be examined when placing limits on technology. When dealing with "last hope" interventions, it is understandable that individuals will want not just aggressive therapy, but the latest technology available (even if it has not been shown to be effective in clinical trials). In the dialogue about limits to technology, we must at least keep individual patient needs and legitimate demands in mind. Perhaps the best we can do is to manage conflicting values and develop institutions to mediate the competing interests.<sup>56</sup>

In sum, the technological imperative is an issue that should be part of the broader health policy and health law debate. In particular, health law scholars can contribute to a critical analysis of the conflicting values and how the law can best balance the competing interests.

### **Mutual Distrust Between Attorneys and Physicians**

A third area that health law scholars should address is the toxic relations between attorneys and physicians.<sup>57</sup> For reasons that are both historical and related to competing policy objectives regarding medical malpractice litigation, relations between the two professions have deteriorated substantially over the past two decades. If the effects on patient care and health care delivery were not so serious, we could laugh this off as more reminiscent of the periodic (if enduring) feuding between the Hatfields and McCoys than a serious long-term breach between two esteemed professions. Come to think of it, the periodic malpractice crises are beginning to resemble the Hatfields and McCoys!

Yet the animosity is serious and threatens to spin out of control. With some physicians now threatening to refuse care to attorneys and their families, the possibility of a permanent breach is no longer theoretical. But state level tort reforms may permit a dialogue over how to return to a more productive relationship. If so, health law scholars (especially those with ties to the medical community) can play a crucial role in the reconciliation process. In my view, the patient safety movement will not reach its full potential without some concordance between physicians and attorneys that allow for collaborative policy efforts centered on patient care, not on protecting professional interests.

### **HEALTH LAW 2005 – TRENDS AND PROSPECTS: OR, WHY I'M ALWAYS WRONG!**

#### **Competing Paradigms**

In co-authoring a law school casebook with Larry Gostin, I argued that:

Four conceptual paradigms can be applied to transform the health care system: economic (the stan-

dard competitive model); professional (professional self-regulatory norms); rights-based (social justice); and institutional (comparative institutional analysis). The organizing principle of this chapter is that these analytical frameworks compete for dominance in shaping how the health care enterprise is organized, financed, and delivered. Each approach will emphasize different sets of norms and ideals, alternative policy goals, diverse organizational structures to achieve those goals, and divergent legal rules and levels of regulatory oversight. The competing paradigms framework is designed to encourage thinking about alternative ways of interpreting a case or agency decision, and asking whether a different paradigm would yield more socially desirable results. How and why would the effects on health care delivery differ across the competing paradigms?

Through the competing paradigms framework, this chapter will address three legal and policy issues central to the modern health care enterprise: how health care delivery should be organized – the section on competition policy; how it should be financed – the section on insurance coverage; and how errors should be sanctioned – the section on liability. Within each section, we will use the competing paradigms framework to address several key questions: which paradigm would best allocate scarce resources; what is the appropriate legal rule for resolving disputes (i.e., tort vs. contract); what are the cost-quality-access tradeoffs at issue; and what are the tradeoffs between efficiency and equity. Each section will also examine how the answers to these questions affect patient care and the physician-patient relationship.<sup>58</sup>

My thinking about the competing paradigms was largely rooted in an ongoing struggle between market proponents (a consumer-driven health care system), proponents of a social justice model (largely governmentally determined), and medical professionals. In this framing, tort versus contract is a convenient proxy for the translation of the competing paradigms into legal rules.

Realistically, the social justice model is on hold – that’s a euphemism for being dead in the water. Instead, the real struggle for doctrinal supremacy in health law is between the market and professional models. The oft-studied role of tort versus contract in setting legal doctrine in health care delivery is simply one aspect of that larger battle. By both temperament and philosophy, I remain rooted in the social justice model, skeptical that markets will protect access to health care.

Just as importantly, my view is that physicians remain central to the health care enterprise and are responsible, legally and ethically, for patient well-being. The reality is that clinical care starts and ends with physicians rather than with institutions. As a normative matter, the physician-patient relationship should be central to the health care enterprise. Unlike market-oriented scholars, therefore, I prefer a legal regime that is patient-centered – based on professional norms as opposed to market forces.<sup>59</sup>

But preferences and realistic assessments of the direction of legal doctrine are not the same. Surprisingly, the professional paradigm seems more alive and well than others (including Professor Havighurst) would like (if less so than I would prefer). Take the battle between tort and contract for dominance in medical liability doctrine as an example. Without question, contract is an increasingly important force. Contractual arrangements requiring arbitration have generally withstood legal challenges. Yet for the most part, deference to professional norms remains the standard in determining medical liability. Even if one accepts Professor Philip Peters’ analysis that a trend among state courts is to move away from deference to the professional custom standard toward a “reasonable and prudent physician” standard, it is not clear how the emerging reasonable physician standard differs conceptually from professional custom and whether case outcomes are actually different in jurisdictions switching to the new approach.<sup>60</sup>

Likewise, antitrust doctrine, at least with regard to quality of care considerations, has not fully adopted a market model. As noted above, recent cases have opened the possibility that antitrust courts will rely on professionals to define quality of care. Whether doing so would limit the effectiveness of antitrust enforcement remains to be seen.

Governance may be a third area where professional norms will play a more pronounced role. Health care administrators’ fiduciary duties are so suffused with medical professional norms that courts may well defer to them as opposed to business norms. True, executives will be accorded great latitude in exercising their best business judgment. Even so, it seems difficult to extricate business judgment from medical professional judgment, especially in a nonprofit institution. If the Greaney/Boozang mission primacy standard takes hold, it seems inextricable from medical professional norms as a way of defining what constitutes mission primacy.

### Future Prospects

One critique of the foregoing analysis is that it selectively highlights a few instances of professional norms

being upheld and implicitly extrapolates that into a sustainable doctrinal trend. That's probably an accurate assessment. Indeed, it would be foolish to suggest that courts are likely to protect physicians at the expense of surging market forces. Most likely, the inexorable trend is toward legal doctrine in health care that supports markets. In fact, I think a reasonably compelling case can be made that legal doctrine has already developed to support the market arrangements through which managed care has become dominant. With the Supreme Court's recent decision in the *Davila* case,<sup>61</sup> returning to the Court's original broad ERISA preemption doctrine, I see little likelihood that legal challenges to managed care's preeminence will be successful any time soon. At least in health care, the courts seem to be willing to let the market determine the winners and losers.<sup>62</sup>

Nevertheless, even the examples of professional norms cited above suggest that courts may be reluctant to abandon physicians altogether to market arrangements.<sup>63</sup> Why that is so I'm not entirely sure. One possibility is that judges have the same reflexive preference for physician-centered care (as opposed to institutional-centered care) as I do. Another is that the academic dominance of law and economics, which would almost surely result in limiting professional dominance, has not yet taken hold in judicial decisions. Professor Gregg Bloche expands on the role of professional ethics and norms, arguing that they pervade health law. He observes that while antitrust law may be the most visible conflict between professional norms and market arrangements, this tension is manifest in many issues. "Conflicts over the lawfulness of financial rewards to physicians for frugal practice, the authority of treating physicians versus health plan managers to determine medical need, and the supervisory powers of plan managers over clinical practitioners pit professional norms against immediate market pressures."<sup>64</sup> This analysis suggests that it may be difficult for courts to ignore the role of professional norms, even if judicial doctrine favors market arrangements.

To be effective, professional norms need to adapt to changing marketplace realities without sacrificing the core value of patient advocacy. As Professor Gail Agrawal argues, professional norms are essential for legitimizing cost control programs through cost-conscious clinical decisions. "Professional norms are also part of a social contract between the medical profession and the public,"<sup>65</sup> and can comfortably exist within a framework dominated by the economic model.

## CONCLUSION

Health care is a field driven by fads. Just a few years ago, managed competition was the solution to the system's deficiencies. Then it was health insurance purchasing

cooperatives, followed by business health purchasing coalitions. Along the way, managed care emerged as the ultimate solution. Each of those was exposed as flawed.<sup>66</sup> Now the mantra is consumer-driven health care. That, too, will be exposed as flawed and another fad will emerge. All of this makes it difficult to establish sustainable legal doctrine in health care. Health law scholarship might profitably focus on some of the areas outlined above that will be critical for the relationship between law and medicine regardless of what model of health care delivery emerges over the next few years.

Even if health law does not lend itself to the development of legal theory that drives the legal academy, the more prosaic aspects of developing sound legal doctrine in health care are critically important for practitioners. As an applied field, health law scholars have much to offer judges, policymakers, and, most importantly, health care practitioners.

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  20. See *Bethesda Healthcare Inc. v. Wilkins*, 806 N.E.2d 142 (Ohio 2004) (holding that a fitness center that the plaintiff nonprofit hospital owned was not entitled to a tax exemption because few non-dues-paying members used the center); *IHC Health Plans, Inc. v. Commissioner of Internal Revenue*, 325 F.3d 1188 (10th Cir. 2003) (upholding the county's refusal to grant tax exempt status because the system failed to meet the community benefit standard).
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