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Thirty-Five Years of Health Law in Illinois

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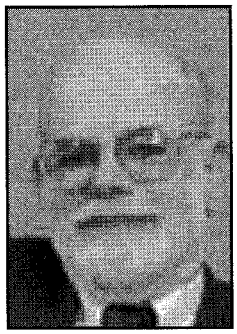
I. HEALTH LAW BACKGROUND



In 1975, I was assigned as minority counsel to the Illinois State Senate Committee on Insurance and Licensed Activities. In that role I reviewed, analyzed, and drafted legislation and amendments thereto which affected various areas, not the least of which were the requirements for health insurance policies and the licensing of health care professionals. Thus began my now thirty-four year journey as an attorney practicing in the area of health law.

Among other things, I worked on legislation addressing medical malpractice in the first year of what would become an almost annual exercise seeming to go to the Illinois Supreme Court once every decade. In one way or another, I have participated in all of those battles principally as counsel to the Illinois State Medical Society and its related entities.

I was privileged to serve for over twenty-five years first as Legislative Counsel and then General Counsel to both the Illinois State Medical Society and ISMIE Mutual Insurance Company, the largest provider of professional liability coverage to physicians in Illinois and an entity with a close relationship to the Medical Society. I have served as both a member of and chairman of the American Medical Association Litigation Center which provided legal assistance to cases all over the country in which cutting edge issues related to medicine and the practice thereof were litigated in state and federal courts. For some of those years I was in-house counsel while for most of those years I was engaged in the private practice of law. In that capacity, I was privileged to be counsel to and the principal drafter of licensing legislation for the Illinois Occupational Therapy Association. I have represented nursing homes, hospitals, individual physicians and medical practices.

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Upon resuming the private practice in my current capacity, I have served as a hearing officer in hospital licensure and disciplinary hearings and participated in litigation related thereto.

For many years I have been adjunct faculty in the Medical Humanities Department of the Southern Illinois University School of Medicine lecturing and conducting short term seminars in issues related to medical ethics, medical malpractice, patient relationships, and physician employment issues.

I have been privileged also to serve as adjunct faculty in the Legal Studies Department of the University of Illinois Springfield for which I teach a graduate level course in confidentiality and privacy addressing issues as diverse as liability, public health quarantine and vaccination, disclosure of confidential records, and the impact in an emergency situation such as a terrorism attack or a natural disaster like Hurricane Katrina in New Orleans on issues related to confidentiality and privacy in health care.

For 15 of those years I served as a member of the Board of Directors and Treasurer of the Illinois Comprehensive Health Insurance Plan. That Plan, created as a result of legislation in 1987, operates as an insurance company for individuals who, because of a chronic health condition, are unable to secure health insurance in the private market. Part of my responsibilities for the ICHIP Plan were to chair the grievance committee which acted as the final arbiter in the appellate process when a procedure, service, or medication was declined for coverage by the administrator of the plan. In that role I dealt with coverage and insurability issues as the Director and Officer of a health insurance company would.

I have also been a patient within our health care system as have members of my immediate family.

II. THE DEVELOPMENT OF HEALTH LAW IN ILLINOIS

When I began this journey, the practice of health law was a rather arcane specialty with fairly few lawyers able to truly concentrate and become expert in the field. Outside of the larger cities the ranking expert in the field of health law was most likely the attorney for the hospital. Conflict of interest issues having been different in that day and age, that attorney frequently also represented the local physicians. That is much less likely to be the case today. While there were some attorneys in places like Washington, DC who might have had a growing practice dealing with some of the arcane issues related to Medicare, the bulk of the representation was done by general practitioners and tended to be either corporation lawyers representing the hospital who would handle health care regulatory aspects of the hospital's needs more as an after thought. Physicians and other providers may have had some cases in which they were being excluded

from inclusion in Medicare and Medicaid programs based on quality of care issues or were the subject of federal actions seeking criminal charges or reimbursement for alleged overpayments. Those cases tended to be handled by criminal defense lawyers.

Virtually no one represented individual patients with health care issues outside of the Plaintiff's bar which was representing patients who believed they were victims of negligent care.

While we had common law principles and some statutory insight on issues like confidentiality, privacy, the physician/patient relationship, they tended to flow from very traditional common law precepts.

When I began this journey Medicare was a government program which was at most ten years old. To an extent it was still feeling its way and insurers were reimbursing based on a cost plus model with relatively little oversight as to the charges which were sought.

As I said earlier, in the mid-70's the issue of the availability and cost of professional liability insurance for physicians exploded on the scene and began what is now an almost thirty-five year debate. While there have been some modifications since that time, agreements have been relatively few and far between with issues hotly contested in state legislatures around the country and at times on the federal level.

Shortly thereafter the United States Supreme Court's decision in the case we all know of as *Roe v. Wade* brought constitutional principles on the implications of some health care procedures in direct conflict with the moral precepts of significant numbers of our citizenry.

Around that same time the cost of health care began to be a very significant problem for those who were paying for health insurance, principally employers. The recession from which the country emerged in the early to mid-1980's made costs of increasing importance. The traditional insurance mechanism of merely taking a bill and paying it gave way to entities like health maintenance organizations, preferred provider organizations and the like. For the first time payors would not accept services provided by any physician or other health care provider but rather started to limit their panels of participating providers as a way to both improve quality and lower cost.

At the same time the explosion in the development of medical technology and pharmaceutical compounds and products altered the ways in which care was provided and the cost structure of that care.

We went from a country in which much critical care was rendered to inpatients in hospitals to one in which efforts to reduce hospital stays to the minimum possible became the rule of the day. When giving birth, women who would previously stay in the hospital for up to five days are now being discharged within twenty-four hours, much to the shock of our elected officials. People with significant spinal cord injuries who often were

hospitalized for a period of rehabilitation for up to sixteen weeks are now being discharged within three weeks.

Care started to be rendered on an increasing basis to out patients who generally came to health care facilities for the training and rehabilitation which they previously received within the hospital context. While this was seen to lower costs to some extent it also made more difficult the issue of quality control.

Physicians who traditionally had practiced as sole practitioners or in very small groups of two and three physicians (frequently with their spouse as office assistant and business manager) started to come together into larger multi-specialty or single specialty groups. The economies of scale were perceived as both a vast improvement and a necessary evil to deal with the increasing complexity of our regulatory and payment systems.

For the chronically ill and permanently disabled a significant move began, which is not yet complete, in which individuals were being institutionalized and moved into community settings both to afford them a better quality of life and to reduce the costs to government agencies of providing care.

In the field of mental health the State of Illinois revamped the Mental Health and Developmental Disabilities code in the late 1970's, which acted as a further impetuous to this movement of deinstitutionalization.

Beginning in the late 70's and gaining attention in the mid to late 80's, people began to address what level of care they felt was appropriate.

In cases coming from several states, including Illinois, our courts were called upon to address difficult and personal issues such as when an individual or their representative can decline care and choose to allow their life to end. Names which today are not known by many such as Karen Ann Quinlan were on the lips of everyone as courts grappled with the issue of allowing the parents of a young woman to order care to be ended. Moral and ethical issues were raised and debated in these cases and others. Within the past several years the same or similar issues arose in the case of Terry Ann Schiavo in Florida.

The Illinois Supreme Court and legislature determined when an individual can decline further care. This lead to the Living Will Act, then the Durable Power of Attorney for Health Care law, which permits surrogates to make determinations for individuals unable or unwilling to make them on their own.

III. FUTURE CHALLENGES

Within recent memory the tracking of the human gene has lead to the promise of great strides in curing many conditions but has raised significant ethical and legal questions with respect to the extent to which information

contained within an individual's DNA can or should be disclosed or held in confidence. Some of these issues relate back to basic constitutional principles of unreasonable search and seizure or the perceived constitutional right to privacy. Others relate to concerns as to whether the insurance industry or employers might use this most personal information to make decisions with respect to the employment or insurability of individuals. Decisions were perceived to potentially be based upon the mere suggestion of the possibility of a future occurrence.

As this is being written, the United States Congress may be close to wrapping up work on what is perceived to be the most significant revamp in the methods by which individuals receive and pay for health care since the passage of the law creating Medicare in the mid 1960's. While one can argue as to whether this is truly health reform or health insurance reform, whether this is historic or merely the rearranging of the proverbial deck chairs on a sinking ship, what is absolutely clear is that we are likely to be embarking upon a process which may never be complete but which will take 10 or more years of analysis, education, modification, and experience before we can determine its true impact.

The use and potential misuse of electronic health records raise daunting issues for the law and health care practitioners. The provision of services to patients on a remote basis using what has come to be called telemedicine will significantly alter the landscape and potentially have health care delivered by people who may be thousands of miles away and with whom we will never be able to shake hands.

The development of biologic agents to treat various conditions has implications for the field not just of health law but of intellectual property, patents, the rights of individuals whose biological tissue may have been utilized in developing processes or products merely to name a few.

The growth of the economic impact of health care in and of itself even without the changes of which I have spoken would indicate that the practice of health law will have a hugely significant role in the future of our country and of our profession. I would submit, however, that when one combines that with the technological and scientific changes we anticipate, one can see that some of the most daunting and significant issues for our society will be found and analyzed within the sphere of health law.

I would leave it at that but wish to point out that among the other issues that are capturing the world's attention and crying out to be addressed we see things like global warming and environmental concerns. All of this impacts the health of our society. Similarly, the food products which can be raised and grown also will impact our health and law. This is but one issue not previously delved into by health lawyers to a great extent which will challenge us for the next several decades. The challenge and stimulation is unlikely to leave this field of endeavor.

What all of this says is that the relative turmoil in our perceptions of health care, our legal basis for providing and paying for health care, and our views as to the impact of health care have undergone in the last thirty-five years what can only be termed revolutionary change.

I think it highly unlikely that the next twenty-five years will be any less challenging, changing, or stimulating.