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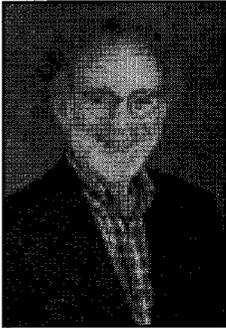
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## Health Law Past and Future: Looking for Stability in All the Wrong Places

*Peter D. Jacobson, J.D., M.P.H.\**



Neither the healthcare delivery system nor the field of health law much resembles the world that the Beazley Institute for Health Law and Policy faced when it started. At that time, managed care was just beginning its ascendance and the fee-for-service system was still dominant. While it would be reductionist to say that health law was relatively stable then, it is fair to suggest that the field was far more stable than it is today. In the interim, the law has struggled to keep up with the transition to managed care, and will continue to struggle now with the waning of managed care and the transition toward a consumer-directed health care (CDHC) system.

Looking back over this period, four themes occur to me as characterizing the relationship between law and healthcare delivery: the increasing complexity of healthcare delivery; elaborate conflicts of interest that provide a general organizing principle; health law's escalating instability; and the increasing importance of law in how health care is delivered. These themes are certainly interdependent, particularly that the system's complexity leads to instability in the law, but each stands on its own as a feature to examine. Moving forward, there is no reason to expect stability any time soon.

### I. THE INCREASING COMPLEXITY OF HEALTHCARE DELIVERY

In 1983, healthcare delivery was hardly the romanticized world of the physician who makes house calls. Yet, on many dimensions, it was far less complex than it is today. For example, while both the technological imperative and the bounty of available pharmaceuticals were well underway in the early 1980s, they are now the dominant drivers of healthcare delivery. Concomitantly, compare the amount of information (which I'm treating as a

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technology) available today to what was available 25 years ago. The information that must potentially be disclosed to meet basic informed consent requirements, let alone to facilitate the expansion of CDHC, is staggering relative to 1983, and is unlikely to decrease any time soon.

Institutionally, much has changed since 1983, though perhaps not as profoundly as the innovations noted in the previous paragraph. We were already talking about vertically integrated health systems, with a multitude of exclusive arrangements between health systems and physicians. Industry consolidation since then has forced physicians to form cartels to bargain with large systems and to invest in competing specialty centers. To be sure, some things have, for the most part, remained unchanged. Access for uninsured populations is probably worse now. The system remains inefficient and costly, and many observers question the quality of care that is delivered.

## II. THE WEB OF CONFLICTS OF INTEREST

Conflicts of interest remain an inevitable aspect of medical care, as they are in any entrepreneurial activity. At its most basic level, as Marc Rodwin has observed, medical care raises potential conflicts between a physician's professional obligations to the patient and financial incentives.<sup>1</sup> Yet the conflicts of interest in the current healthcare delivery system are so pervasive, and potentially disruptive, that they virtually form a general organizing principle for teaching health law. In the managed care era, the conflicts between an insurer's economic interests, the interests of plan beneficiaries, and those of individual patients erupted. Those conflicts remain unresolved.

Consider a few other examples. The complex web between pharmaceutical manufacturers and physicians, especially physicians conducting clinical trials for new pharmaceuticals, is so entrenched that it is the subject of numerous Inspector General opinions on illegal kickbacks and questions regarding university oversight. An equally intractable issue now is about physician ownership of specialty hospitals. Not only do specialty hospitals compete with general hospitals for the most profitable medical services, but physicians must choose between their economic investment and what is best for the patient. And finally, a contentious series of conflicts over conscience clauses (i.e., the right of a healthcare provider to refuse certain services based on his or her moral beliefs) remains unresolved.

A consistent pattern in these and similar conflicts is that legal doctrine has not sufficiently evolved to mediate the conflicts or provide guidance for

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1. Mark A. Hall and Carl E. Schneider, *Where is the "There" in Health Law? Can It Become a Coherent Field?*, 14 HEALTH MATRIX 101, 103 (2006).

non-litigious resolution. More to the point, if, as Carl Schneider and Mall Hall have argued, an intricate web of personal relationships defines healthcare law, the inevitability of conflicts of interest should not be surprising.<sup>2</sup> I had hoped that fiduciary duty doctrine would emerge to fill the gap, but courts have not effectively used fiduciary duty concepts beyond the ERISA preemption context.

### III. HEALTH LAW'S INCREASING INSTABILITY

In 2005, I wrote the following:

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. 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.<sup>3</sup>

Nothing occurring in the interim leads me to change my mind, and nothing suggests greater stability going forward.

Regardless of what model of healthcare delivery emerges over the next few years, courts will struggle to develop stable legal doctrine. All of the factors discussed above militate against stability and predictability. Nonetheless, there are some constants. First, it is likely that courts will continue to defer to market arrangements. Second, if CDHC gains momentum, courts will need to confront directly the tort-contract conundrum, i.e., whether contract or tort principles will prevail in determining medical liability for choices that patients make and for the disclosure of information. Courts will also need to consider whether to impose cost-effectiveness criteria or allow costs to be a defense in medical liability litigation. Perhaps more problematic will be to observe how medical professional norms evolve when physicians recommend treatments that patients cannot afford or are not covered by insurance. Third, cost versus access was a central theme in managed care litigation and will be no less salient in CDHC litigation.

### IV. THE INCREASING IMPORTANCE OF LAW TO HEALTHCARE DELIVERY

By 1983, there was little doubt that understanding the legal implications

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2. See Peter D. Jacobson and Michael T. Cahill, *Redefining Fiduciary Responsibilities in the Managed Care Context*, 26 AM. J. OF LAW & MED. 155-174 (2000).

3. Peter D. Jacobson, *Health Law 2005: An Agenda*, 33 J. OF LAW, MED., AND ETHICS 725, 736 (2005).

was an important aspect of healthcare administration, far beyond the medical liability issues that dominated health law in the 1960s and early 1970s. At this point, law is so pervasive that healthcare administrators can make very few strategic decisions without considering the legal ramifications. For example, joint ventures between non-profit health systems and for-profit physician groups are essential for generating revenue in a tight economic environment. But sophisticated joint ventures raise contractual, antitrust, fraud and abuse, and tax questions that require legal involvement from the outset.

Equally important, the regulatory environment is increasingly stifling and oppressive. In particular, the current fraud and abuse regime impedes legitimate market arrangements and transactions that would benefit patients. Estimates of the regulatory burden on health administration vary, but are non-trivial in any event. As a proponent of regulation, I have no problem with imposing regulatory costs on healthcare delivery. But those costs should bear some relationship to measurable benefits. At this point, it appears that the costs far outweigh the undeniable benefits. Regulatory reform should be high on the congressional agenda.

Thus, one constant of the past twenty-five years is the omnipresence of law as a major factor in health care. That is not going away, and indeed will continue apace. Whatever healthcare reform legislation emerges from Congress will only exacerbate this trend. As just one example, physicians will continue to invest in specialty surgical centers to the disadvantage of competing health systems. In response, health systems will continue to retaliate against physicians. Eventually we will reach equilibrium, and legal doctrine will be an important contributor, if nothing else, by setting the parameters of the debate.

But as important as law is to the healthcare enterprise (and to public health delivery as well), it is important to recognize the limits of what legal regimes can achieve in a complex and rapidly changing industry such as health care. One need not be a confirmed libertarian to suggest that academics should assess the limits of law along with its force. For example, many commentators (especially Tim Greaney) have observed that antitrust enforcement has failed to curtail the increasing consolidation of healthcare markets;<sup>4</sup> that is no doubt true. At the same time, is it realistic to expect that even robust antitrust activity could have prevented the consolidation? At best, antitrust enforcement might have slowed the consolidation. But given the economic and other factors driving health

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4. See Thomas L. Greaney, *Competition Policy and Organizational Fragmentation in Health Care* (unpublished research paper) (on file with Saint Louis University No. 2009-04), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1395792](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1395792) (last visited Jan. 22, 2009).

markets toward consolidation, it is difficult to see how antitrust alone could have prevented it from occurring.

#### V. GOING FORWARD

Recognizing that a coherent theory of health law is unlikely, is there a clear direction for health law doctrine to take? Over the next few years, we will have the opportunity to observe whether CDHC dominates health insurance and delivery, and how the health insurance reform legislation affects the healthcare delivery model. Law will play a significant role in how these facets evolve. As with the transition to managed care, law can facilitate the underlying market arrangements or it can impede them. The contribution academics can make is to articulate where regulatory policy can facilitate these transitions and how the courts should think about CDHC litigation.

Less than a theory of health law, which is what animates legal academics, we need a pragmatics of health law, a sense of the role of law in shaping and, yes, constraining, the powerful tendencies in the healthcare marketplace to subordinate patient welfare to economic gain. The pragmatics of health law need not be a-theoretical. Quite the contrary, it should be based on sound conceptual and theoretical foundations. Where it differs from a normative theory of health law is that it understands the role of law in the everyday strategic decisions health administrators make. Standing alone, even if one could be imagined, a theory of health law is somewhat orthogonal to the health care enterprise.

The pragmatics of health law approach is uncomfortably close to Judge Richard Posner's pragmatic jurisprudence. As Posner defines it, "pragmatism refers to basing a judicial decision on the effects the decision is likely to have, rather than on the language of a statute or a case, or more generally on a preexisting rule."<sup>5</sup> Although it is not what I mean to convey, I do not have a better term for it at this point. What I have in mind is to extend the Schneider-Hall insight about relationships to a concept of health law that could balance the conflicting tensions inherent in a relationship approach. At the heart of medical care is the physician-patient relationship. But in many judicial opinions, the patient seems to get lost amidst the various actors. How can courts, regulators, and legislators return patient concerns to the center of the legal response? At one point, I thought that fiduciary duty might be an effective organizing principle. However, while fiduciary duty is a necessary component of health pragmatics, it is not a sufficient approach.

Another possibility is some convergence of population health concepts

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5. THE HONORABLE RICHARD A. POSNER, HOW JUDGES THINK 40 (2008).

with health care legal doctrine. For the most part, health law and public health law have been treated as separate and distinct realms. For a variety of reasons, that separation is likely to change, and future health law doctrinal developments will be infused with public health law concepts, and *vice versa*. Take obesity as an example. Without question, obese individuals require considerable medical treatment, so that medical necessity decisions generate considerable litigation. At the same time, obesity is a public health epidemic, requiring traditional public health intervention strategies. The intersection between the two doctrinal approaches presents health law scholars with an opportunity to integrate public health into health law doctrine. Doing so will be challenging, but doctrinal convergence can benefit both health care and public health delivery.

#### VI. CONCLUSION

For healthcare administrators and physicians, the law is a nuisance—an intrusive and costly impediment to the healthcare mission. For health law scholars, these are exciting times. The proposed health insurance reform legislation raises fascinating constitutional and regulatory questions. Separate and apart from congressional action, the healthcare delivery system is likely to undergo significant change over the next decade. Its current form is no more stable than the law that responds to the inevitable changes. If one is looking for stability in the relationship between law and an industry, health care is the last place to find it. That is fine with me. Doctrinal instability is much more fun!