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OVER UNDER OR THROUGH: PHYSICIANS, LAW, AND HEALTH CARE REFORM

WILLIAM M. SAGE*

INTRODUCTION

Physicians are law-abiding citizens. Sometimes, however, the medical profession accuses the law itself of wrongdoing. Two years ago, for example, the editor-in-chief of the *New England Journal of Medicine*, Dr. Jeffrey M. Drazen, published an editorial called "Government in Medicine."[1] In it, he expressed unhappiness that the Supreme Court had upheld Congress's partial birth abortion ban, and he criticized Congress's earlier attempt to intervene in Terri Schiavo's medical care. I agree with him on both of these specific issues. But then he went farther, asserting that "the judicial branch has regrettably joined the legislative branch in practicing medicine without a license," and arguing sweepingly that "[g]overnment regulation has no place in [medicine]."[2]

The superficial irony, of course, is that none other than government requires, defines, and supplies medical licenses. For a physician to want regulation out of medical licensing is as absurd as the oft-quoted saw about a senior citizen telling his congressman to "keep the government out of my Medicare."[3] Legal restriction and coercion are pervasive in American health

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1. Jeffrey M. Drazen, *Government in Medicine*, 356 NEW ENG. J. MED. 2195 (2007).

2. *Id.* at 2195.

3. For an even blunter statement of this point, consider economist Uwe Reinhardt's response to a physician writing in support of libertarian law professor Richard Epstein (himself no great friend of medical licensing) during Epstein's exchange with Reinhardt over the desirability of government-mandated health insurance for the poor in the *Journal of the American Medical Association* (*JAMA*):

> [Dr. James F.] Lally writes of "a fierce sense of rugged individualism, independence, and self-reliance that have been and still are the hallmarks of the American ethos." Where are these rugged individualists? . . . Would I find them in the medical profession, whose members rely so heavily on public subsidies for their education and the science they apply, who now seek a federal tax preference for medical savings accounts, who plead with government to punish managed care organizations that are late in paying bills, to impose on managed care organizations any-willing-provider laws, and to regulate

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care, often determining what is offered to patients, who provides it, and who pays for it. Political control of health care regulation varies considerably, as does the level of specificity at which that regulation operates. Still, the physician-editor's comment reveals a basic truth. Even—or perhaps especially—in today's complex and expensive health care system, the American medical profession continues to regard law with unease and mistrust.[4]

The sources of discomfiture are multiple and varied, with deep historical roots. Substantial amounts of Paul Starr's classic work, *The Social Transformation of American Medicine*, chronicle physicians' many (usually successful) attempts over the past 250 years to use legal authority to suppress professional rivals and fend off corporate influences while simultaneously keeping legal authority from exerting unwanted control over them.[5] In earlier work, I ascribed the current "lawyerization" of the medical profession principally to four relatively recent encounters between medicine and law: medical malpractice, bioethics, federal health entitlement programs, and the managed care onslaught and backlash.[6]

Unsurprisingly, a love-hate relationship of this duration and intensity defies easy explanation. The history of medicine's attitudes toward law is not unidirectional, and neither is the "law" involved in American health care monolithic. Federal law and state law, for example, have different sources of authority, scopes of influence, and styles of application. As the *New England Journal of Medicine* editor observed, physicians are subject to both statutory law and judge-made law,[7] to which one might add executive-branch administrative law as also capable of "practicing medicine." Regulatory oversight, moreover, is quite unlike civil litigation as an enforcement regime. The admixture of regulation and litigation is a striking aspect of health system governance in the United States, which in other work I have discussed as reflecting incomplete conceptual commitments to consumer sovereignty,

> managed care organizations with countless other strictures, and who have never balked at using archaic licensure laws to protect their own economic turf? . . . As all of these self-styled, rugged individualists enlist their government's coercive power to protect their own fiscal health, they might more gracefully countenance the use of that power and also protect the physical health of poor children and, indeed, of all poor people.

Uwe E. Reinhardt, Letter to the Editor, *Articulating a Social Ethic for Health Care*, 279 JAMA 745, 746 (1998).

4. *See* Drazen, *supra* note 1.

5. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982).

6. William M. Sage, *The Lawyerization of Medicine*, 26 J. HEALTH POL. POL'Y & L. 1179 (2001).

7. Drazen, *supra* note 1, at 2195.

industrial efficiency, and social solidarity where health care is concerned.[8] Finally, much of what passes for law in health care is quasi-legal at best, consisting of delegated authority, structured self-regulation, and professional norms.

In her Childress Lecture, Professor Sandra Johnson explores physicians' accusations against legal governance.[9] She focuses on allegations regarding "bad law," which she defines as law that harms patients.[10] To her credit, she examines these controversies with an open mind, looking for principled objections and not merely contextual resistance to legal measures that threaten physicians' collective economic self-interest. The moment seems right for such an approach. Scholarship on the professions has followed an intellectual pendulum from an altruistic extreme in the Talcott Parsons era to a protectionist extreme in the Eliot Freidson era.[11] It now seems to be swinging back again, offering hope that "professionalism" can be understood as more than an empty vessel. Still, the *New England Journal of Medicine* editor's over-generalization suggests that physicians might well choose "no law" over "good law" as a solution to imperfect law.

My purpose in this commentary is twofold. First, I want to offer a few thoughts on why the American medical profession sometimes has a hard time accepting law on its own terms. Second, I want to suggest that even "good law" from the perspective of the medical profession—should it overcome its habits of resistance—may still be bad health policy for the United States.

Under President Barack Obama, Washington, D.C. is asserting a progressive interest in health care reform for the first time in over fifteen years. Accordingly, I choose as metaphor for my comments a famous anecdote from the life of another young, progressive (though Republican) President. Teddy Roosevelt and his children used to go on character-building outings, which they called "scrambles," in Washington's Rock Creek Park. Whenever they encountered an obstacle, the rule was that they could go over it, they could go under it, or they could go through it. But they could never go around it; they could never take the easy way.

8. *See* William M. Sage, *Unfinished Business: How Litigation Relates to Health Care Regulation*, 28 J. HEALTH POL. POL'Y & L. 387 (2003).

9. Sandra H. Johnson, Professor Emerita of Law & Health Care Ethics at Saint Louis University School of Law, Keynote Address at Saint Louis University Law Journal Richard J. Childress Memorial Lecture: Still Crazy After All These Years: Is Regulating Physician Practice an Exercise in Futility? (Oct. 17, 2008), *in* Sandra H. Johnson, *Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, 53 ST. LOUIS U. L.J. 973 (2009).

10. Johnson, *supra* note 9, at 974–76.

11. *Compare* TALCOTT PARSONS, THE SOCIAL SYSTEM (1951), *with* ELIOT FREIDSON, PROFESSIONAL POWERS: A STUDY OF THE INSTITUTIONALIZATION OF FORMAL KNOWLEDGE (1986).

Analogously, physicians do not always deal with law in the easiest way, which is to comply with it. Instead, one can divide physicians' contentious interactions with law into three categories. Sometimes, physicians leap over the law, regarding it as superfluous. Other times, physicians squeeze under the law, regarding it as oppressive. Finally, there are times when physicians plow through the law, regarding it merely as a manifestation of political power.

This essay begins with some generalizations about why physicians seem ill at ease with law and lawyers. It then offers a few examples of "over under or through" phenomena. Finally, it returns to Dr. Drazen's complaint, and suggests that the most important source of tension between law and physicians is not that law improperly devalues physicians' expertise, but that law accedes too readily to physicians' declared (and ethically defensible) allegiance to each individual patient, and does not demand greater service to society as a whole.

I hope that the points I will make about the medical profession seem accurate, and that they prove relevant to the current health reform debate. However, as I am sure Professor Johnson would agree, they are certainly not "eternal truths." Professions are composed of people, and as the people change the professions change as well. The medical profession is growing relatively slowly, so that it takes many years for newer physicians to replace established ones. And law has acted more as a brake on professional change than as an accelerator. Nonetheless, it would be misleading to suggest that modal behaviors of doctors (or lawyers) at any moment in time constitute immutable characteristics of their profession. Therefore, one should expect the medical profession to alter its collective mindset—including its orientation to law—as both its constituent membership and its surrounding environment evolve.

I. PHYSICIANS AND THE LAW

Why might doctors be uncomfortable with law? I studied both medicine and law, and have practiced each profession. As several commentators have observed, there are indeed different professional traditions involved.[12] Lawyers are accustomed to adversarial posturing, with final recourse to an impartial but inexpert decision-maker. Doctors prefer consensus, and are only deferential to professional seniority and clinical experience. Lawyers are at ease with applying rules; doctors are more used to assuming roles. When a medical student dons a white coat or swears the Hippocratic Oath, he or she acquires a mental image of what a physician is and does. Lawyers do not form their professional identities at such an early point in their collective education,

12. *See, e.g.*, Daniel M. Fox, *Physicians Versus Lawyers: A Conflict of Cultures*, *in* AIDS AND THE LAW 210 (Harlon L. Dalton et al. eds., 1987); Peter D. Jacobson & M. Gregg Bloche, *Improving Relations Between Attorneys and Physicians*, 294 JAMA 2083 (2005); Sage, *supra* note 6.

and they see themselves performing a much wider range of tasks subject to an equally wide range of constraints.

One result of physicians' unshakeable self-image and gestalt sense of their work is that they guess in situations where lawyers would "look it up." Physicians guess with the best of intentions and from the greatest wealth of experience that they can bring to bear, but they guess nonetheless. New information technologies such as personal data assistants and decision support software are narrowing the gap, but the core difference in approach remains.

Professor Johnson also notes that physicians lack affection for procedure, which is an essential characteristic of a functioning legal system.[13] She is correct that doctors generally want to get quickly to the right result, while lawyers are more interested in following the process set out to reach that result. Habit-driven self-interest may reinforce both positions: doctors' lucrative piecework consists of tests and procedures, while lawyers' consists of hours billed during protracted litigation. More deeply, however, lawyers understand that fairness depends on procedural integrity, while doctors see themselves as individually providing fairness as well as expertise. The medical profession assumes it knows what patients want—better health at any price—and seldom recognizes that services provided to one patient influence services available to others. By contrast, the legal profession often needs guidance from clients as to the desired goals (lawyers get off track ethically, for example, when they come to believe that all clients want is more money), and it is inevitable that wins for some clients often imply losses for others. Consequently, lawyers see fair process as furthering their work rather than impeding it, and they are more tolerant of it.

Some of physicians' apparent resistance to law stems less from law itself than from a perceived change in the source of law. Health law teachers often introduce law students to the field by identifying "paradigms" that help explain the law's trends and tensions.[14] Among these is the "professional paradigm," meaning legal deference to the judgment of the medical profession, as contrasted with furtherance of contractual freedom, social welfare, or personal autonomy.[15] In fact, much of what one thinks of as health law has really been the medical profession's self-regulatory apparatus. Physicians have controlled, directly or indirectly, virtually everything required to practice medicine, including medical education, specialty certification, professional licensing, hospital privileges, and liability insurance. Even the legal determination of medical malpractice is based on a deviation from professional norms as

13. Johnson, *supra* note 9, at 992.

14. *See, e.g.*, James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459 (1994); Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155 (2004).

15. Blumstein, *supra* note 14, at 1463–67.

evidenced by the testimony of physician experts. In addition to the deference accorded physicians to decide how medicine should be governed, physicians are often empowered to make judgments that are partly social, such as eligibility for disability compensation or other social services. Attempts by non-physicians to withdraw these privileges, or to flex legal muscle themselves, are naturally resented.

A paradox of medical care in the United States is that its enormous social expense—over $2 trillion annually[16]—has not resulted in the organization of physicians and other service providers into industrially efficient delivery systems. A large number of physicians still practice individually or in very small groups.[17] Fragmentation of medical practice is not only a source of inefficiency in the U.S. health care system, but it is also a partial explanation for why the relationship between physicians and the law is contentious. Combine fragmented medical practice with financial prosperity, local prominence, and high self-esteem—a reasonable description of American medicine for the past fifty years—and interactions between physicians and law becomes personal as well as professional. The U.S. health care system, which one can think of as the world's most expensive cottage industry, has bred a lot of big fish in a lot of small ponds.

For example, physicians often see legal entanglements as affronts to personal privacy or professional reputation, and respond accordingly—especially when they believe they are acting in the public interest rather than their own. Professor Johnson mentions physicians' dislike of Big Brother-ish triplicate reporting systems for controlled substances.[18] I would add almost anything having to do with medical malpractice.[19] For example, I have long supported abolishing the malpractice component of the National Practitioner Data Bank (NPDB) because it discourages physicians from disclosing adverse events to patients and settling claims.[20]

16. Micah Hartman et al., *National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998*, 28 HEALTH AFF. 246, 246 (2009).

17. *See* Lawrence P. Casalino et al., *Benefits of and Barriers to Large Medical Group Practice in the United States*, 163 ARCHIVES OF INTERNAL MED. 1958 (2003).

18. Johnson, *supra* note 9, at 1027–29, 1027 n.267.

19. *See generally* William M. Sage, *Reputation, Malpractice Liability, and Medical Error*, *in* ACCOUNTABILITY: PATIENT SAFETY AND POLICY REFORM 159 (Virginia A. Sharpe ed., 2004) ("[A] malpractice suit is a genuinely felt professional insult—an assault on both physicians' self-esteem and their esteem by others.").

20. *See, e.g.*, William M. Sage et al., *Bridging the Relational-Regulatory Gap: A Pragmatic Information Policy for Patient Safety and Medical Malpractice*, 59 VAND. L. REV. 1263, 1300 (2006) (explaining the rationale for repeal of the NPDB malpractice reporting requirement); *see also* Martin J. Hatlie & Susan E. Sheridan, *The Medical Liability Crisis of 2003: Must We Squander the Chance to Put Patients First?*, 22 HEALTH AFF. 37, 39 (2003) (urging, among other things, repeal of the NPDB as part of comprehensive medical liability reform).

Cash flow is another aspect of atomistic medical practice that influences how physicians relate to law. As U.S. Representative Jim Cooper observes, physicians' practices are America's most undercapitalized businesses.[21] Doctors use expensive collective resources, such as hospitals, without making capital investments in them; collect as revenue only a small fraction of what they cause to be spent on overall patient care; and expect that almost all of that revenue (net of current operating expenses) will be taken as personal compensation. They respond readily to even minor cash incentives[22]—as do many small businesspeople—and tend to defer many non–urgent practice expenditures. As a result, they often engage law reactively, rather than viewing legal services and regulatory compliance as an ongoing aspect of doing business.

A role-driven common professional identity coupled with individual under-investment in the practice environment promotes herd behavior when it comes to legal governance. It is relatively easy, for example, to engage physicians collectively in efforts to reform the law, and even to co-opt physicians in order to benefit other political interests. Professor Johnson alludes to this in her article. During the most recent medical malpractice crisis, for example, business groups seeking to curtail personal injury litigation generally used physicians as poster children for tort reform.[23] Organized medicine never realized that its chance of obtaining customized relief from malpractice insurance costs was undercut by this more sweeping political strategy. Grassroots physicians saw only a familiar enemy—in this case, trial lawyers, though it could as easily have been insurance companies or "big government"—and mobilized without hesitation.

II. "OVER": LAW AS IRRELEVANCE

Physicians routinely disregard certain laws that strike them as incompatible with their professional identity and traditions. Consider federal antitrust law, which asserts that sellers should act independently of one another, and that buyers not sellers should set the terms of trade. This seems unnatural to

21. *See* Jim Cooper, Commentary, *Fresh Thinking Response*, FRESH-THINKING, Nov. 25, 2007, at 10, http://www.fresh-thinking.org/docs/workshop_071129/Commentary_Cooper_on_Jost.pdf (responding to Timothy Stoltzfus Jost, *Legal and Regulatory Issues Presented by Health Care Reform*, FRESH-THINKING, Nov. 29–30, 2007, http://www.fresh-thinking.org/docs/workshop_071129/Paper_T_ Jost.pdf).

22. *See generally* Thomas L. Greaney, *Economic Regulation of Physicians: A Behavioral Economics Perspective*, 53 ST. LOUIS U. L.J. 1189 (2009) (discussing how and why physician decisionmaking does, or does not, conform to traditional behavioral economic theories).

23. *See* CTR. FOR LEGAL POLICY, MANHATTAN INST., TRIAL LAWYERS, INC.: A REPORT ON THE LAWSUIT INDUSTRY IN AMERICA 2003, at 12 (2003), http://www.manhattan-institute.org/pdf/triallawyersinc.pdf; *see also* Postings of Bill Sage & James R. Copland, to PointofLaw.com, http://www.pointoflaw.com/feature/condition_critical1205.php (Nov.–Dec. 2005).

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physicians, who prefer to decide jointly as professional colleagues who is (and who is not) worthy of treating patients, to plan the range of services that will be available in their community, and to set the conditions under which those services will be delivered.

Sometimes the law explicitly permits these behaviors, but sometimes it does not. Yet some physicians continue to believe that their small businesses are entitled to act anti-competitively. They band together to fix fees billed to private health insurers, reasoning that the insurers are big and they are small.[24] They question medical staff privileges for newcomers, reasoning that their communities have enough physician specialists already.[25] If they come to believe that medical practice should change, they change it by group assent, not commercial innovation. They file many antitrust claims themselves, usually against hospitals that are dealing more favorably with other physicians, but are often unclear on the theory of the law and succeed only rarely.[26] In one topsy-turvy case, a surgeon sued his local hospital for keeping competing surgeons out, on the theory that the hospital was making him work harder (and earn more money) than he wanted to.[27] Other lawsuits—disappointingly many—reflect personal animosity rather than cognizable legal injury.[28]

Another illustration of jumping over the law comes from medical education.[29] Working hours for medical interns and residents have been

24. *See, e.g.*, Mesa County Physicians Indep. Practice Ass'n, 127 F.T.C. 564 (1999), 1999 FTC LEXIS 67 (prohibiting a contracting organization from negotiating collectively on behalf of 85% of independent physicians in a single geographic area).

25. *See, e.g.*, Patrick v. Burget, 486 U.S. 94 (1988) (upholding treble damage judgment against physicians in an Oregon town who revoked hospital privileges of a recently arrived surgeon after he decided to establish his own practice instead of being employed by the existing surgeon group).

26. In one detailed study, physicians in solo or small-group practice constituted 53% of private health care antitrust plaintiffs; suits by physicians against hospitals represented 45% of the overall sample. Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102 COLUM. L. REV. 545, 566, 575 (2002).

27. Patton v. E. Idaho Reg'l Med. Ctr., No. 92-36805, 1994 U.S. App. LEXIS 3192, at *3–4 (9th Cir. Feb. 18, 1994).

28. *See, e.g.*, Wright v. S. Mono Hosp. Dist., 631 F. Supp. 1294, 1298 (E.D. Cal. 1986) (describing verbal threats against a physician, his spouse, and his unborn child, followed by a fistfight in a radiology suite).

29. The two examples are connected. Antitrust litigation commenced a few years ago against the National Residency Matching Program (NRMP) alleging that, by prohibiting individual negotiation between applicants and teaching hospitals, the NRMP facilitated collusion among residency training programs on salaries paid to residents. *See* Frances H. Miller & Thomas L. Greaney, *The National Resident Matching Program and Antitrust Law*, 289 JAMA 913, 913 (2003). Under political pressure from academic medical centers, Congress granted the NRMP (which does provide an efficient means of hiring residents and assuring continuity of patient care) an antitrust exemption, effectively ending the litigation. *See* Pension Funding Equity Act of 2004, Pub. L. No. 108-218, § 207, 118 Stat. 596, 611 (codified as amended at 15

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regulated for almost twenty years, but these laws have been ignored by both trainers and trainees.[30] The rhythm, content, and duration of medical training is a product of two professionally controlled processes: a centralized set of accreditation standards and review activities conducted by educational leaders, and a decentralized set of workplace decisions made by department chairs, attending physicians, and residents themselves. The former group seemed immune from government compulsion but proved susceptible to financial pressure—to be specific, threatened suspension of Medicare graduate medical education (GME) payments if standards were not adopted and enforced. The latter decision-makers do whatever they consider "appropriate," which is usually determined by personal experience, expectations, and paths of least resistance.

Nonetheless, regulation has improved residents' working conditions, with potential long-term benefits for patient safety, physician welfare, and organizational efficiency.[31] It has done so, however, by a serpentine path that emphasizes the expressive rather than the coercive power of law. In the 1980s, a patient's unexpected death at a prestigious hospital because of an error by overworked, under-supervised trainees typically triggered a predictable course of events. First, an academic discussion of the clinical aspects of the case would be held at a department-run "M&M" (morbidity and mortality) conference.[32] Second, the department chair would dress down the residents at fault, making sure their classmates heard about it, but would not screen the training environment for safety hazards.[33] Third, in the unlikely event the patient's family somehow learned of the error, the hospital would quietly agree to a tort settlement with an iron-clad confidentiality clause.[34]

Because her father was a prominent journalist and attorney, 18 year-old Libby Zion's death in 1984 at New York Hospital after residents ignored obvious symptoms of a severe drug interaction followed a strikingly different

U.S.C. § 37(b) (2006)). During its pendency, however, the residency programs tried to solve the problem of overworked, underpaid residents by agreeing collectively to limit residents' hours. *See* Bridget Kuehn, *IOM: Shorten Residents' Work Shifts to Reduce Fatigue, Improve Patients' Safety*, 301 JAMA 259, 259 (2009). A clearer indication that competition remained an alien concept in academic medicine would be hard to find.

30. Kuehn, *supra* note 29, at 259.

31. *See* INST. OF MED., RESIDENT DUTY HOURS: ENHANCING SLEEP, SUPERVISION, AND SAFETY (Cheryl Ulmer et al. eds., 2008) [hereinafter IOM, RESIDENT DUTY HOURS], *available at* http://www.nap.edu/catalog.php?record_id=12508#toc.

32. *See* ATUL GAWANDE, COMPLICATIONS: A SURGEON'S NOTES ON AN IMPERFECT SCIENCE 58–62 (2002) (describing an M&M conference at Harvard).

33. *See generally* CHARLES L. BOSK, FORGIVE AND REMEMBER: MANAGING MEDICAL FAILURE (1979) (observing and analyzing responses to error in surgical training programs).

34. *See* Hatlie & Sheridan, *supra* note 20, at 38–39 (explaining how confidentiality clauses prevent both injured patients and safety researchers from realizing that others have suffered similar injuries).

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course.[35] First, the Manhattan District Attorney convened a criminal grand jury, which figuratively indicted the existing system of resident training rather than literally indicting the individuals involved.[36] Second, the Commissioner of New York's Department of Health appointed a blue ribbon commission, chaired by a prominent physician, which issued a report agreeing with the grand jury's assessment of residency training.[37] Third, the state legislature enacted a statute limiting residents' hours and requiring closer supervision.[38]

The effect of the statute? Negligible. Residents, particularly in surgical programs, continued to work far longer than the law allowed. Why? Likely because of a combination of hospital budgets, union contracts, scheduling snafus, and professional norms. The New York experience did, however, trigger a national debate, set in motion self-regulatory decisions (conducted in the shadow of federal regulatory authority to curtail funding), and inspire support for scientific research on patient safety to validate restrictions in professional terms.[39] In December 2008—twenty-four years after Libby Zion's death—the Institute of Medicine released a comprehensive report on residents' hours recommending further restrictions.[40] Medical training ultimately was altered by a process of professional evolution—including the abuses and errors recalled by today's professional leaders and the more structured employment expectations of today's graduates—but far more slowly and variably than would be the case if physicians simply allowed law to be adopted and then complied with it.

An additional irony is that many physicians seem not to recognize what has actually happened to change residency training. One of the funniest moments of my teaching career occurred shortly after the Accreditation Council on Graduate Medical Education adopted self-regulatory restrictions on residents' hours in 2003. A group of surgical residents at New York-Presbyterian Medical Center showed up at my office, knowing only that I was Columbia Law School's health law expert. They told me they did not like having their hours limited, and asked me point blank "who they could sue." After a few minutes, it became clear not only that they had mistaken professional self-regulation for externally imposed law, but also that their gripe was with their own hospital's administration, which chose to make its trainees

35. *See* David A. Asch & Ruth M. Parker, *The Libby Zion Case: One Step Forward or Two Steps Backward?*, 318 NEW ENG. J. MED. 771 (1988).

36. *Id.*

37. *Id.* at 773.

38. N.Y. COMP. CODES R. & REGS., tit. 10 § 405.4 (2008).

39. *See* Robert Steinbrook, *The Debate over Residents' Work Hours*, 347 NEW ENG. J. MED. 1296 (2002) (describing events and the debate leading up to the adoption of accreditation standards); Harry H. Yoon, *Adapting to Duty-Hour Limits Four Years On*, 356 NEW ENG. J. MED. 2668 (2007) (explaining how residency programs have accommodated self-regulation).

40. *See* IOM, RESIDENT DUTY HOURS, *supra* note 31.

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punch a clock in what seemed both a degrading and an ineffective manner. Explaining gently that the enemy was them, I sent the residents back to their program director to discuss a better approach to compliance.

III. "UNDER": LAW AS OPPRESSION

In addition to leaping over laws as if untouched by them, physicians expend considerable effort squeezing under laws, and feeling the weight crush and oppress them. In this situation, they fight law hard, and may injure themselves further by doing so. Two examples of perceived laws of oppression are medical malpractice liability and federal prohibitions on fraud and abuse.

Medical malpractice has a history and meaning to physicians too complex to explain in a short commentary.[41] Still, a few aspects bear mention. Physicians significantly overestimate the likelihood of a malpractice judgment against them, and emotionally conflate a civil claim for compensation with an accusation of moral turpitude.[42] Why? Stories and rumors of cases against colleagues spread quickly through communities—often as professional sympathy, occasionally as malicious gossip. Plaintiffs are current and former patients who seem to be betraying their doctors by accusing those doctors of mistreating them. Lawyers' contingency fees strike physicians as converting tragic misfortune into financial gain, and lawyers' aggressive advocacy as devoid of judgment or restraint. Cases seem to go on forever, constantly hanging over physicians' heads like the Sword of Damocles. And, every year, large amounts of cash are extracted from physicians' small businesses to pay for malpractice insurance, with sudden, seemingly random increases in cost or decreases in availability.

As a result, hatred of malpractice law and support for "tort reform" is a sustaining issue for all sorts of physician groups, whether social gatherings and medical staff meetings or county, state, and national medical societies. However, gains in this endless fight have been incomplete or transitory, as the effects of hard-won legislative battles are undone by courts, eroded by subsequent lawmaking, strangled by tight insurance markets, or undercut by the emotional impact of an actual claim. At the same time, comprehensive efforts to remedy the root causes of a malfunctioning malpractice system—most involving better injury prevention, fair compensation for injury, and

41. *See generally* MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM (William M. Sage & Rogan Kersh eds., 2006).

42. For a discussion of the difference between malpractice perception and malpractice reality, see TOM BAKER, THE MEDICAL MALPRACTICE MYTH 68–92 (2005), and FRANK A. SLOAN & LINDSEY M. CHEPKE, MEDICAL MALPRACTICE 51–83 (2008).

improved liability insurance—attract little support from the medical profession.[43]

Fraud and abuse liability has acquired a similar mystique, but with a different narrative of oppression. Instead of personal betrayal and rapacious lawyering, most fraud claims (qui tam suits aside) are seen as an assault on entrepreneurial liberty and hard work by an authoritarian state. The edifice of federal anti-fraud enforcement has been built out haphazardly over time to cope with the fiscal disaster of a Medicare program that, for political expediency, was designed with perverse incentives and few financial safeguards.[44] Physicians regard federal fraud enforcers as akin to the Internal Revenue Service: imposing arcane bureaucracy, randomly singling out putative wrongdoers, and mercilessly driving the accused into financial ruin.[45]

Again, physicians tend to view fraud control from a small business perspective—unlike the massive supplier enterprises (e.g., pharmaceuticals or for-profit hospitals) that attract the majority of attention from government fraud auditors—and excuse their own failures of documentation and their overly optimistic billing practices as necessary and forgivable adaptations to excessive administrative burdens. It does not help that, as with tax shelters and tax compliance for the well-to-do, there are legions of advisors and consultants offering physicians easy money deals and fancy billing methods, which simultaneously enhance the risk of fraud and increase resentment of fraud enforcement.

The government has brought a few large dollar cases against solo physicians, which may have been intended as a warning but served mainly to heighten paranoia. In the best known example, *United States v. Krizek*, the government spent six years (!) pursuing an aging psychiatrist for billing longer patient visits than actually had occurred,[46] and sought civil penalties of roughly

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43. *See* William M. Sage, *Why Are Demonstrations of Comprehensive Malpractice Reform So (at All) Controversial?*, 37 U. MEM. L. REV. 513 (2007).

44. For history and interpretation of the Medicare fraud control regime, see, for example, James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J.L. & MED. 205 (1996); David A. Hyman, *Health Care Fraud and Abuse: Market Change, Social Norms, and the Trust "Reposed in the Workmen*,*"* 30 J. LEGAL STUD. 531 (2001); Timothy Stoltzfus Jost & Sharon L. Davies, *The Empire Strikes Back: A Critique of the Backlash Against Fraud and Abuse Enforcement*, 51 ALA. L. REV. 239 (1999); William M. Sage, *Fraud and Abuse Law*, 281 JAMA 1179 (1999).

45. *See generally* RONALD T. LIBBY, THE CRIMINALIZATION OF MEDICINE (2008) (discussing the impact of health care fraud laws on the physicians who are the target of the resulting investigations); David A. Hyman, *Collateral Damage*, 27 HEALTH AFF. 1476, 1476 (2008) (book review) (describing the Libby book as "one-sided but deeply troubling," and noting that "a study of physicians who had been convicted of Medicaid fraud found that not one of them believed they had done anything wrong").

46. United States v. Krizek, 192 F. 3d 1024 (D.C. Cir. 1999).

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$81 million (!!).[47] *Krizek* is paradigmatic of physicians' reaction to fraud enforcement in part because the physician and his wife, who also did his billing (while his lawyer daughter represented them), were refugees from both Nazi Germany and Soviet Russia, and during the very protracted course of the litigation came to regard the American government as but another totalitarian regime.[48]

IV. "THROUGH": LAW AS POLITICS

The last category of physician maladaptation to law consists of situations in which doctors come to regard law as overtly political, and therefore devoid of meaning apart from the politics by which it is determined. Their response is to plow through the law, engaging the political process with brute force but little normative or factual argument. Medical malpractice, while fiercely contested in the political arena, does not match this description because of its well-established empirics. Better examples are Medicare payment negotiations, at the federal level, and scope of practice restrictions, at the state level.

The political compromise with the American Medical Association that created Medicare in 1965 simultaneously renounced government control over medical practice and pledged reimbursement based on customary and prevailing physician charges.[49] The inflationary perils of this structure were apparent by the early 1970s, and subsequent decades have been marked by a series of efforts to rein in spending by altering provider payment amounts rather than take on the more politically contentious issues of eligibility, benefits, delivery models, and means testing. The first comprehensive reform of physician reimbursement, the Resource Based Relative Value Scale of the early 1990s, began as a consensus effort among professional leaders to redress a perceived imbalance between lavishly paid procedural subspecialties and under-rewarded "cognitive medicine" such as primary care.[50] However, it

47. United States v. Krizek, 859 F. Supp. 5, 7 (D.D.C. 1994) ("[I]n its claim for relief, the government asks for triple the alleged actual damages of $245,392 and civil penalties of $10,000 for each of the 8,002 allegedly false reimbursement claims . . . ."), *aff'd* 111 F.3d 934 (D.C. Cir. 1997).

48. *See* Thomas L. Greaney & Joan H. Krause, United States v. Krizek*: Rough Justice Under the Civil False Claims Act*, *in* HEALTH LAW AND BIOETHICS: CASES IN CONTEXT 187 (Sandra Johnson et al. eds., 2009).

49. *See* DAVID A. HYMAN, MEDICARE MEETS MEPHISTOPHELES 27–39 (2006) (describing how Medicare begets avarice).

50. For a summary of the physician payment reform debate, see Alice G. Gosfield, *Value Purchasing in Medicare Law: Precursor to Health Reform*, 20 AM. J.L. & MED. 169, 169, 173–74 (1994).

soon deteriorated into internecine warfare, with various physician groups asserting rights to special formulas and supplemental payments.[51]

Because of the aggregate fiscal implications of federal entitlement programs, these professional political contests eventually spilled onto the giant battlefield that constitutes budgetary politics in Washington, D.C.; first under the "paygo" (pay-as-you-go) rules for balancing revenues and expenditures, and then through establishment of a "sustainable growth rate" for physician payment.[52] This latter process seems to have virtually no true legal content, instead resembling the medical budget-setting negotiations between government and organized medicine familiar in Canada and parts of Europe—with the added contortion of Congress loudly legislating deep cuts in budgetary out-years to show its political courage and then quietly undoing them shortly before they would actually take effect.

State health professional licensing laws and associated limitations on the scope of permissible practice display a similar realpolitik that renders actual law nearly invisible. Unlike Medicare entitlement negotiations—which join physicians in pitched battles against other potential claimants of federal funds—scope of practice restrictions are determined not only by direct lobbying of state legislatures but also by procedural maneuvering among rival professional disciplinary boards (e.g., medicine, nursing, pharmacy, chiropractic, podiatry). Physicians as a group engage both processes vigorously, with the result that surprisingly little liberalization of practice rights has occurred in the United States despite the creation of a large pool of "mid-level" providers whose competence has been repeatedly demonstrated in research studies.[53]

In 1993, for example, a federal proposal to expand practice rights (and associated Medicare and Medicaid reimbursement) for advanced practice

51. *See generally* Timothy S. Jost, *The Most Important Health Care Legislation of the Millennium (So Far): The Medicare Modernization Act*, 5 YALE J. HEALTH POL'Y L. & ETHICS 437, 439–40 (2005) (explaining congressional action to consistently increase payments under this formula in response to physician arguments).

52. *See* 42 U.S.C. 1395W-4(f) (2006) (sustainable growth rate for Medicare); Jost, *supra* note 51, at, 439–40 (explaining the sustainable growth rate); Tim Westmoreland, *Standard Errors: How Budget Rules Distort Lawmaking*, 95 GEO. L.J. 1555 (2007) (discussing the relationship between federal fiscal policy such as paygo rules and substantive law, including health entitlements).

53. A review of eleven trials and twenty-three observational studies in primary care settings concluded that "[q]uality of care was in some ways better for nurse practitioner consultations." Sue Horrocks et al., *Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors*, 324 BRIT. MED. J. 819, 819 (2002); *see also* Linda H. Aiken, *Achieving an Interdisciplinary Workforce in Health Care*, 348 NEW ENG. J. MED. 164, 165–66 (2003) (describing the quality of non-physician professionals); Mary O. Mundinger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial*, 283 JAMA 59, 59 (2000) (demonstrating equivalent outcomes).

nurses in connection with national health reform was countered immediately by an aggressive public relations campaign from the American Medical Association to mobilize physicians and frighten patients.[54] The image used in the campaign—ducks wearing stethoscopes saying "quack, quack"—suggests that organized medicine had an antiquated understanding of the issues and was not truly prepared to debate public policy or law. Only physicians who have been personally hauled before state disciplinary bodies seem to understand how important law is to professional licensing and practice restrictions, particularly in its commitment to due process.[55]

CONCLUSION: THE FUTURE OF HEALTH LAW

Sometimes "the law is a ass,"[56] and fighting or flouting it can be heroic. In the United States, moreover, criticism of law extends both to outright government coercion and to fear of private litigation, which seems to replace personal discretion, expert judgment, and compassion with timidity, pedantry, and bureaucracy.[57] The concerns physicians have with the law, as eloquently described by Professor Johnson,[58] are real phenomena.

My assessment of physicians' protests diverges from Professor Johnson's in its prescriptive dimension. According to the medical journal editorial decrying government regulation with which this commentary began: "[P]hysicians want . . . oversight and open discussion . . . to occur among informed and knowledgeable people who are acting in the best interests of a specific patient."[59] Most physician complaints about law have to do with the first assertion, that government is inexpert in clinical matters. I am more interested in the second assertion, that for medical law to be legitimate it must serve the interests of individual patients. I believe that health law has been overly "medical," meaning excessively concerned with protecting and

54. *See generally* THETIS M. GROUP & JOAN I. ROBERTS, NURSING, PHYSICIAN CONTROL AND THE MEDICAL MONOPOLY 417–18 (2001) (noting the opposing efforts of the American Nursing Association and the American Medical Association to respectively expand and contain the practice rights of advanced practice nurses); Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 YALE J. ON REG. 417, *passim* (1992) (providing context to the general resistance among physicians to expanding practice rights of advanced practice nurses).

55. *See, e.g.*, Hoover v. Agency for Health Care Admin., 676 So. 2d 1380 (Fla. Dist. Ct. App. 1996) (reversing as arbitrary a professional board's decision to overrule its own hearing officer).

56. CHARLES DICKENS, OLIVER TWIST 489 (Kathleen Tillotson ed., Oxford University Press 1966) (1838).

57. *See, e.g.*, PHILIP K. HOWARD, THE DEATH OF COMMON SENSE *passim* (Warner Books 1996) (1994).

58. Johnson, *supra* note 9, at 974–76.

59. Drazen, *supra* note 1, at 2195.

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promoting physician-patient dynamics.[60] For the next generation of health law, I believe the role of government should be to articulate society's collective interest in a properly functioning health care system.

American health care has serious systematic flaws. We spend too much and receive too little. People who could stay well get sick. Many people who get sick have nowhere to go for care. These are not just individual interests; they are collective ones. If health reform depends on the specific interests of individual patients—which are inevitably defined by political anecdote as people who already suffer from life-threatening illness—I suspect we will never accomplish anything. We will be asked, in slick advertisements by well-funded special interests, whether we would want our sick parents, children, or spouses to be forced to navigate a hypothetical reformed system, as opposed to staying with "their doctor." Almost any proposed change to the existing system will seem too risky. In my view, "good law" is not about informed and knowledgeable people acting in the interests of a specific patient. It is about informed and knowledgeable people acting in the collective interest—in building a health care system that is compassionate, that is just, that is economically productive, and that doesn't waste money that might be better spent elsewhere. I hope that the physicians of the future will come to feel similarly.

60. *See* William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497 (2008).