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MEDICINE AND PUBLIC POLICY: LET US LOOK BEFORE WE LEAP AGAIN

STUART H. ROME*

Professor Clark claims health care regulation has failed, primarily because we are too deferential to the medical profession. I am skeptical about the analysis that has led him to this conclusion, and I have reservations about his proposed solutions.

In the 1950's and 1960's, the fear of increasing regulation led many in the medical profession to oppose government sponsored health care programs. The private health insurance industry and a substantial segment of the population shared (and, with the incumbent administration, still shares) the physicians' fears of socialism and the loss of free choice. Congress, notwithstanding this resistance, responded to the enormous public demand for expanded access to valued medical resources by creating Medicaid and Medicare. However, to accommodate the widespread concern about government intervention, Congress left much of these programs to the private sector — socializing more the costs of the services and not so much the providers of the services. Though doctors have reaped profits from this political defeat, it was a defeat nonetheless.

The flood of operating funds from Medicaid and Medicare joined the steady flow of capital funds — from the now-abandoned Hill-Burton program,¹ tax-exempt revenue bond financing and other government supported programs — to encourage the development of health care facilities. Medical research and technology, funded by public and private grants and by profit-motivated investment, found new ways to spend the new health care dollars. Hospital workers, long underpaid, demanded and received more adequate compensation. The impact of all this on our GNP, as Professor Clark observes, has been substantial. It is a largely predictable and — more to the point — largely intended consequence of a widely debated, popularly determined public policy decision. The political decision to spend more on health care is not merely — not even primarily — an expression of deference to professional power.

* Partner, Venable, Baetjer & Howard, Baltimore, Maryland; B.A., 1958, Cornell University; LL.B., 1961, Yale University. Mr. Rome's law practice is substantially devoted to representing hospitals.

1. See *The Hill-Burton Act, 1946-1980: Asynchrony in the Delivery of Health Care to the Poor*, 39 MD. L. REV. 316 (1979).

Whether or not they have produced a significant *measurable* improvement in the *overall* health of our citizenry, our modern health care programs remain popular. Even in the face of a growing public appreciation of the high cost of these programs, there has not been any widespread patient revolt. Ivan Illich² fulminates against the medicalization of our society. Lewis Thomas³ counsels restraint in more avuncular tones. Mill Valley turns to holistic health.⁴ Earnest economists, researchers, bureaucrats and elected representatives warn us of the extravagance of our folly. But increasing numbers of patients visit increasing numbers of doctors, who prescribe increasing numbers of increasingly costly treatments and procedures.

Patients want more health care. And so do the rest of us. That is, even in the absence of direct physician intervention, we are avid consumers of health care goods and services: patent medicines, health spas, health foods, vitamins, self-help books, gadgets and contraptions of all sorts and products of the physical fitness industry. We exercise, not because it is good, but because it is good for us — the means to the end of better health.⁵

Something complex is going on here. But Professor Clark sees it rather simply: There is, in the United States, “a socially excessive consumption of medical services.” Efforts to regulate health care have failed. This failure is due mainly to a legal “system of widespread deference to professional power.” Eliminate or reduce the professional power of physicians and all will be well. Let me express my doubts.

I. ARE THE BENEFITS OF OUR HEALTH CARE SYSTEM INSUFFICIENT?

Professor Clark does not explain what he means in calling our consumption of health care services “socially excessive”. It is a highly charged term that is neither self-explanatory nor explained. Presumably, he intends the term to summarize his argument that our society is utilizing health care services heavily, without deriving benefits commensurate with the high cost.

Professor Clark’s argument that health care benefits are insufficient is based almost exclusively on gross studies of short-term changes

2. I. ILLICH, *MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH* (1976).

3. L. THOMAS, *The Technology of Medicine*, in *THE LIVES OF A CELL* 31 (1974); *id.*, *Your Very Good Health* 81; L. THOMAS, *On Magic in Medicine*, in *THE MEDUSA AND THE SNAIL* 19 (1979); *id.*, *The Health-Care System* 45.

4. See Leonard, *The Holistic Health Revolution*, New West, May 10, 1976, at 40-49.

5. Other self-prescribed cures for our suffering are more mischievous and no less popular: tobacco, marijuana, cocaine, narcotics and alcohol, to name but a few.

in mortality and morbidity. The morbidity and mortality studies to which Professor Clark refers are useful. However, they tell us much less⁶ about our health care system than he thinks.

Our system of health care produces much more than reductions in mortality and morbidity. Moreover, there appears to be a fairly high degree of satisfaction with these other outputs, many of which cannot be accurately quantified. To identify the most obvious benefits,⁷ apparent to any hospital visitor:

- the alleviation of pain, suffering and anxiety
- food and shelter
- nursing care
- rehabilitation
- the employment of large numbers of skilled, semi-skilled and unskilled workers in useful labor that produces goods and services intended to promote positive human and social values
- a market for goods and services produced by others
- education, research and innovation
- philanthropy, volunteerism and other activities that foster social cohesion and stability and community security and strength
- an outlet for our Western need to resist fate
- peripheral economic and social activity that is less harmful than many alternatives.

Professor Clark ignores these benefits. He ignores, also, the gains from extending health care services to the poor, the aged and the disabled and the gains from the increased employment and improved compensation of hospital workers — gains in health status, in social justice and in political stability. Finally, he ignores the economic gains from returning to the workforce patients whose mortality may be unaffected by medical intervention but whose illnesses, in former times, would have disabled them longer, perhaps even permanently.

Undoubtedly, these benefits could be purchased more cheaply. It does not follow from this, however, that the benefits are not worth purchasing at all.

II. HAS HEALTH CARE REGULATION FAILED?

Professor Clark's assertion that health care regulation has failed

6. And, as Professor Teret and Dr. Miller make clear in their response to Professor Clark, much more.

7. Also obvious is the costly practice of defensive medicine. Whether or not it is beneficial is debatable. Beyond debate is the proposition that defensive medicine is not the product of "widespread deference to professional power."

would seem to warrant careful documentation, beginning with a definition of the objectives of the regulation and extending to a cogent, detailed presentation of the results. This he has not done. The evidence of regulatory failure cited by Professor Clark seems quite sketchy. The troika of regulatory programs the effectiveness of which he disparages — utilization review, health planning (certificate of need) and rate regulation — have been in operation for a rather brief period. None had objectives quite so grandiose as those that Professor Clark's readers might infer.⁸ Although some of the studies cited by Professor Clark may support his conclusion that the results of these regulatory constraints have been disappointing, we simply do not know, and cannot know, how much more expansive and costly health care would have been without these regulatory constraints.

Others, who have more vested interests in the utilization review, health planning and rate regulation programs, surely can plead their cases better than I. However, let me say from the perspective of a lawyer representing Maryland hospitals, that each of these programs *has* had a clearly perceptible restraining effect. This is especially true of health planning and rate regulation. The planners and rate reviewers, in *direct* actions, have disapproved capital projects, new programs and rate increases. Their *indirect* impact, perhaps, is even greater. The mere existence of these regulatory programs has increased the numbers of those hospital trustees, managers and consultants who counsel restraint and has increased their credibility. Quite often, rather than face battle with the bureaucrats, hospitals have abandoned proposed capital projects, new programs and rate increases or trimmed them down, without any direct bureaucratic participation or awareness.

III. IS LEGAL DEFERENCE TO THE MEDICAL PROFESSION THE MAJOR FACTOR UNDERMINING HEALTH CARE REGULATION?

While I share some of Professor Clark's feeling that we sometimes defer to the medical profession when we should not, it seems to me that he substantially overstates his case. Deference to the medical profession is not, to my mind, the big monkey wrench in the regulatory machinery he claims it to be.

8. Utilization review was intended, not to make wholesale changes in the norms of medical practice, but to curtail unnecessary, costly deviations from these norms. Maryland's model rate review legislation speaks of assuring hospital solvency, the reasonableness of costs in relation to services offered, the reasonableness of charges in relation to costs and the elimination of undue discrimination among purchasers. It contains not a word about *reducing* costs, nor about *curtailing* services. See MD. ANN. CODE art. 43, §§ 568H-568Y (1980).

Other, more obvious factors contribute more significantly to what Professor Clark loosely terms "the current situation". First among these is our tremendous appetite for health care; second, the political commitment to extend the perceived benefits of health care to the poor, the aged and the disabled; and, third, the reciprocal lack of broad public support for Professor Clark's prescribed health care diet. Health care services are popular; the denial of medical services is not. The limited success of health care regulation is largely due to limited public support.

While Professor Clark sees these public attitudes as but symptoms of public deference to physicians, I rather think that deference is itself but a symptom of a very complex combination of forces at work in modern society and, perhaps, imbedded in human nature. Indeed, Professor Clark gives partial recognition to this possibility when he says that "the proper stance of the law toward professionals — any and all professionals — is a very deep and difficult problem," that it "is a profound and basic fact of our society, and [in addition to economic analysis] it must also be examined in psychological, social, and political terms." We should contemplate the full significance of this insight. Our attitudes toward health care and physicians are complicated, varied and irrational, rooted in obscure impulses not easily altered by reasoned discourse.

Increases in health care costs, of course, are encouraged by the combination of economic factors identified by Professor Clark — most significantly, a lavish system of insurance, the prevalence of fee-for-service reimbursement and the relative lack of incentives for restraint. However, to see these arrangements as Professor Clark does — as little more than a manifestation of unchecked professional power — is historically, politically, economically, sociologically, psychologically and metaphysically inadequate. Hospitals, for example, favor increased health care benefits, support fee-for-service medicine, seek to expand and resist regulation for reasons having almost nothing whatever to do with the influence of physicians. What business does not want to increase production and sales, please its customers, reduce costs, construct impressive buildings and resist government control? The behavior of hospitals in these matters is similar to that of virtually all corporations, most especially those in the profit seeking sector far from the health care system and the influence of physicians.

The somewhat disappointing results of utilization review, health planning and rate control are due, also, to ignorance. We know little of

the mechanisms of illness and even less about those of healing.⁹ There is little consensus on the *precise* definition of the problems to which the new regulatory laws are addressed and even less regarding *precise* solutions. We lack the expertise that the enabling legislation seems to have contemplated. Although utilization review is run by doctors, health planning and rate review are not; the occasional participation of physicians in these latter activities is usually ornamental and almost always ineffectual.¹⁰ Of the fourteen specific review criteria mandated by the federal health planning laws, only four raise, even peripherally, medical issues on which the particular expertise and authority of physicians can be brought to bear with any significant force.¹¹ In rate review, the regulators are bent on defining health care issues, not in medical terms, but in economic terms that physicians can neither comprehend readily nor respond to effectively. Health planning and rate review are striking examples of delegations of vast power to non-physicians — putative experts whose competence was not first conclusively demonstrated to be adequate to the tasks assigned to them.

Health planning is in the grip of demographers, other statisticians, public health officers and the like. Their analytical tools are limited and in an early stage of development. Their predictive methods and standards are frequently faulty and, because they are largely mandated by law or regulation, often inflexible. Thus, health planners find it difficult to earn respect. The complex resource allocation issues they address are resolved politically more often than through deference to their limited expertise, even though the law indulges them with the presumption that this expertise is genuine.

Rate review, at least in Maryland, is in the hands of economists, accountants and the like. Their data collection and econometrics leave much to be desired. They simply cannot identify and quantify all of the factors affecting cost and quality. Their success, it appears, is due mainly to their considerable powers of intimidation, to regulatory lag and to the hospitals' general support of their efforts to contain costs and

9. The well known efficacy of placebos in some cases and the demand for laetrile and other false cures should be much more humbling than it is to those who believe that the health care enterprise can be governed by reason alone.

10. In this observer's experience, most conscientious regulators involved in health care planning and rate review are not conspicuously deferential toward the medical profession. Nor do they often blame the medical profession and its influence for inhibiting their effectiveness. Typically, they blame the lawmakers, the law, lawyers and — as Dr. Cohen's comments in this issue illustrate — our legal system of due process.

11. See 42 U.S.C. § 300n-1(c) (Supp. III 1979).

to promote rate equity¹² among payors.

IV. IS THE LAW EXCESSIVELY DEFERENTIAL TO THE MEDICAL PROFESSION?

I am in broad agreement with Professor Clark's assertion that our society often is inappropriately deferential toward the medical profession.¹³ However, this is not to say that I agree with the particulars of his argument. As the foregoing discussion indicates, I find some of it factually inaccurate and much of it stridently polemical, infused with a medical nihilism that is not likely to gain the favor of the American public in the foreseeable future. It is curious that Professor Clark does not seem to recognize that deference to physicians is eroding, that respect for physicians is diminishing and that intrusions into the physician-patient relationship are increasing.¹⁴

Professor Clark's discussions of malpractice, consent to treatment, education and licensure warrant further comment.

The most striking aspect of recent developments in malpractice law is *not* deference to physicians, as Professor Clark insists, but the opposite: the erosion of local norms as standards of acceptable physician conduct, the breach of the conspiracy of silence and the steady rise in the standard of due care required of physicians. The law of malpractice, like much of negligence law, is ruled by norms of behavior. It is hardly surprising that those who are most expert in what constitutes the exercise of due care by a physician are those who by training and experience are themselves physicians. The failure of the judiciary to mandate studies of the efficacy and cost-effectiveness of medical procedures is characteristic of the relatively passive function of the judiciary in our

12. Generally, "rate equity" means increasing payments from Blue Cross, Medicaid and Medicare to cover a fair share of the costs of bad debts and charity care.

13. I agree, also, that our society often is inappropriately *non*-deferential toward the medical profession. Consider for example, the Surgeon General's losing battle against the tobacco industry.

14. It should be useful to analyze the causes and extent of the erosion of professional autonomy and the effects of that erosion; to make value judgments about the desirability of the various forces at work; and to make recommendations for the improvement of their interaction. The newer regulatory programs and policies — utilization review, health planning, rate review, institutional review, informed consent and so on — clearly must be included among the causes of the decline in professional autonomy. I think Professor Clark might even agree with this judgment. His point seems to be only that these programs and policies are too rooted in the old-fashioned notion of doctor-knows-best and simply do not go far enough. Other causal factors would seem to include the shift from community practice to hospital practice, from individual practice to group practice and from general practice to specialty practice; the growing socio-economic gulf between physicians and patients; and the high use of technology and physician extenders.

Anglo-American system of adversarial jurisprudence and cannot fairly be ascribed to judicial deference to physicians. Malpractice litigation has had an enormous inhibiting impact on the behavior of physicians. It has promoted the practice of defensive medicine, at enormous cost and with questionable benefits.

The doctrine of informed consent bases "a physician's duty to disclose . . . on the patient's need to know rather than on customary practice" and, therefore, as Professor Clark acknowledges, is not an example of deference to physicians. It is a significant incursion on professional autonomy — within the area of professional expertise — and has gained significant acceptance in the nine years since its first judicial elaboration in *Canterbury v. Spence*.¹⁵ Contrary to Professor Clark's assertion, the doctrine *does* involve judicial evaluation of efficacy, in two respects. First, it requires physicians to explain accurately and fully to their patients the probable results of treatment alternatives, including the alternative of no treatment at all. Second, if a patient claims that, had he been fully informed, he would not have consented to the treatment performed on him, the validity of this subjective assertion will be measured by an objective standard: what a fully informed reasonable person would have done in like circumstances. While it is true that malpractice cases do not often raise the issue of informed consent,¹⁶ the more significant fact of the matter is that the doctrine of informed consent has had a significant impact on the practice of medicine. It is promoted by the Joint Commission on Accreditation of Hospitals, the American Hospital Association and others. It is the law of Maryland and seems to be widely adhered to, although it perplexes many physicians and may cause their patients unnecessary anguish.

If one concedes that physicians are expert in the diagnosis and treatment of disease, it would be altogether reasonable to defer to their expertise in matters of physician education and licensure and to entrust to them the supervision of less qualified non-physician medical personnel. Professor Clark disagrees. In the thrall of a Jacksonian impulse to reject this expertise, he urges us to give serious consideration to proposals "to reform and liberalize, if not abolish, health licensing laws." This seemingly egalitarian notion, upon more careful consideration, is in

15. 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). See Annot., 88 A.L.R.3d 1008 (1978).

16. The reasons are familiar to any malpractice lawyer and have nothing whatever to do with any supposed deference to physicians. If physician negligence can be established, whether or not consent was obtained is immaterial. Most hospitals routinely obtain signed consent forms. To prevail in a consent case, the plaintiff must assume the heavy burden of proving objectively that a fully informed reasonable patient in the plaintiff's same circumstances would have refused to consent. And so on.

fact rather elitist. The well-to-do and better educated are better equipped than the poor and poorly educated to find competent care.

Professor Clark's analysis would gain considerable persuasive force if he more assiduously pursued a distinction of which he undoubtedly is aware but which he seems to regard as largely insignificant. I refer to the distinction between deferring to a professional acting within his area of expertise, which to me seems appropriate, and deferring to a professional in matters beyond his expertise, which to me seems inappropriate. It is all too common for hospital administrators, trustees, health planners, rate regulators and others to fail to make this distinction. Of course, doctors fail to make it, too. This functional deference warrants careful study. It may account for more that is undesirable in our health care system than the formal deference described by Professor Clark's legal analysis. Defining the boundaries of appropriate professional prerogatives is a useful undertaking. It has contributed largely to the development of the doctrine of informed consent, by requiring the physician to present all of the material facts within his expertise and reserving to the patient the ultimate decision of whether or not to submit himself to the physician's proposed intervention. It also has led to the involvement of ethicists and other non-physicians in keeping a close guard on the use by physicians of human subjects in experimental medical programs.¹⁷

V. ARE PROFESSOR CLARK'S PROPOSALS FOR CURTAILING PROFESSIONAL POWER HELPFUL?

Professor Clark correctly recognizes the great social value of "the adoption by service providers of a fiduciary attitude." But he substantially ignores the full significance of this attitude. It produces a measure of self-restraint, voluntary peer review (formal and informal), continuing education, uncompensated care, preventive medicine and other

17. Starting with the Nuremberg war crime trials, concern about the misuse of medical experimentation has grown steadily, both in the United States and abroad. This concern was expressed in the Declaration of Helsinki adopted by the World Medical Assembly in 1964, revised and adopted by the 29th World Medical Assembly in Tokyo in 1975. In the United States, the American Medical Association established ethical guidelines stressing the need for fully informed and uncoerced patient/subject consent. The reports of two specially commissioned groups, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 43 Fed. Reg. 56,174 (1978), and the Belmont Report, 44 Fed. Reg. 23,192 (1979), expressed deep concern over the need to temper the physician's quest for knowledge with the protection afforded potential human subjects by the review by non-physicians of proposals for experimentation. The current federal regulations, 46 Fed. Reg. 8942 (1981) (to be codified in scattered sections of 21 C.F.R.) and 46 Fed. Reg. 8366 (1981) (to be codified in 45 C.F.R. § 46), require the presence of ethicists and other non-physicians on an institutional review board.

practices against narrow self-interest that, however flawed the system, may well be more than the law could successfully coerce. Clearly, what helps to sustain this fiduciary attitude are many of the instances of deference with which Professor Clark finds fault, particularly those regarding education and licensure. For this reason, some measure of deference should be preserved, even if total autonomy is not.

All of us, including physicians, should welcome Professor Clark's suggestion that we study the efficacy of the medical school curriculum and licensing requirements and seek to improve them. Similarly, we should welcome continuing, expanded research into the efficacy of current medical practices and alternatives.¹⁸ Professor Clark's proposed federal commission on medical technologies undoubtedly could develop information that should be useful in articulating government health care reimbursement programs. These programs, in turn, could be expected to exert an influence on the norms of professional practice. So far, so good. But Professor Clark would go further. He would empower his federal bureaucracy of wholly independent technocrats, "doing the best they could on the basis of available evidence" — an astonishingly lenient standard that ignores any consideration of the probity of that evidence — to make binding determinations of both clinical effectiveness and cost effectiveness and, based on these determinations, to make binding reimbursement determinations. His commission thereby could effectively impose a medical orthodoxy having life and death consequences, by refusing to fund certain medical practices altogether and by restricting the funding of certain other medical practices to certain defined classes of patients and circumstances. Professor Clark's argument that the influence on health care policy of professionals practicing medicine has been excessive and should be reduced does not to my mind support his suggestion that we should place the power to make binding decisions on the complex resource allocation and ethical questions of health care in the hands of a small cadre of remote bureaucrats practicing cost-benefit analysis.¹⁹

18. Professor Clark seems to assume that his proposed commission on medical technologies would reduce health care costs. This is by no means certain. It might produce a call for more extensive health care programs at greater direct cost, to assure greater long term social and economic benefit. For example, massive preventive health programs, which may have significant impact on morbidity, are quite costly. They seek to influence the behavior of large, inattentive, intractable populations — the potentially ill — without altogether eliminating the cost of care of those who, notwithstanding the preventive effort, actually fall victim to the disease under attack. Hypertension would appear to be just such a case.

19. If Professor Clark is correct in his judgment that health regulation has failed, he should recognize that this failure is in part a failure in the use of a kind of countervailing professional power quite similar to that of his proposed commission on medical technologies. See text accompanying notes 9 to 12 *supra*.

Cost-benefit analysis in the area of health care policy is truly voodoo economics. The variables are too numerous and too complex; too many of the operative values are non-economic and cannot be accurately assigned dollar values. It is a morally repugnant false science. There is no reason to believe that the cost-benefit analysts are any better than the rest of us at fixing the value of compassion, hope, avoiding pain or prolonging life. These are not economic issues, and we should resist the impulse to so professionalize them by ceding to economists the conclusive determinative power to price them — or to ignore them. We should not trade what Professor Clark regards as excessive deference to physicians for what I believe would be excessive deference to Professor Clark's array of biochemists, biostatisticians, epidemiologists, economists and public policy analysts. If, as now seems inevitable, the federal government is going to ration health care, let us endorse an open political process for making these decisions, rather than enshrine the unproven — and, I submit, altogether spurious — expertise of people who call themselves cost-benefit analysts. As the furor over abortion seems to suggest, the dramatic issues of health care cannot be effectively removed from the normal political processes of a democratic society.

The practice of medicine, though we tend to forget it, is an art that reflects many of the enduring and transient values and beliefs of the society in which it is conducted. One of the hallmarks of our medical profession has been its impulse to improve itself. As the inappropriateness of procedures is demonstrated and accepted, doctors tend to abandon them. This harbings well for Professor Clark's suggestion that we devote more resources to studying the effectiveness of our currently accepted medical and surgical treatments and procedures. Our experience with health care regulation to date suggests, however, that, before norms of health care are legally *imposed* by a non-physician bureaucracy, an extended trial period of voluntary compliance would be appropriate. In any event, we should wait until we have a firm solution to the "key problem" which Professor Clark helpfully has identified: "how — or whether — inexpert lay persons can control expert professionals without making things even worse."