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# Plural Constitutionalism and the Pathologies of American Health Care

## I. AMERICA'S TWO HEALTH CARE CONSTITUTIONS

The United States has two health care constitutions,[1] and the old is the enemy of the new. The recently enacted Patient Protection and Affordable Care Act[2] (PPACA) is the latest step in the federal government's incremental efforts over the past half century to construct and entrench a modern constitution of health security similar to those enjoyed by citizens in most other advanced democracies. At present, this constitution of health security is wobbly and uncertain, embodied in a pastiche of several statutes of various vintages,[3] heavily reliant on private employers as the primary insurers for most Americans and only halfheartedly embraced by the American public. Yet for all

1. In a manner similar to Eskridge and Ferejohn, this Essay uses the term "constitution"—intentionally not capitalized—to refer to foundational structural commitments embodied in legal materials outside the canonical "Large 'C'" materials of formal text and Supreme Court doctrine. *See* WILLIAM N. ESKRIDGE, JR. & JOHN FEREJOHN, A REPUBLIC OF STATUTES: THE NEW AMERICAN CONSTITUTION 5 (2010).

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified primarily in scattered sections of 42 U.S.C.).

3. These statutes include the PPACA itself, the Medicare and Medicaid enactments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in scattered sections of 42 U.S.C.), the Emergency Medical Treatment and Active Labor Act (EMTALA), Pub. L. No. 99-272, § 9121(b), 100 Stat. 82, 164-67 (1986) (codified as amended at 42 U.S.C. § 1395dd (2006)), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 18, 26, 29, and 42 U.S.C.). For discussion of the "patchwork" nature of reform in the United States, see Jonathan Oberlander & Theodore Marmor, *The Health Bill Explained at Last*, N.Y. REV. BOOKS, Aug. 19, 2010, at 6.

of this present uncertainty and complexity, the PPACA stands as a potentially transformative policy achievement that may one day come to be regarded, as Social Security and Medicare are now, as a central component of the "constitution of statutes" that is the subject of William Eskridge and John Ferejohn's splendid new book, *A Republic of Statutes: The New American Constitution*.[4]

Such a development is hardly inevitable. Like previous episodes of health reform in the United States, today's emerging constitution of health security is imperiled by the persistence of a much older constitution of authority in American medicine, one that prioritizes individualistic therapeutic choice over other more systemic values. The deep roots and wide public acceptance of this traditional authority structure provide a ready-made rhetorical toolbox for opponents of health reform who mine public misgivings about government or corporate interference with therapeutic choice and thereby foster opposition to new reform ideas. Relatedly, the durable entrenchment of medicine's individualistic authority regime has continually and repeatedly disabled both government and private payors from achieving the cost control and resource prioritization necessary for a sustainable universal health security system. Even as public and private insurers have financed health care for most Americans over the past fifty years, authority over actual medical utilization has remained in the hands of individual physicians and their patients. Federal statutes like the PPACA and Medicare are carefully solicitous of this decentralized authority regime, even while committing to underwrite the rapidly escalating costs of the care provided within it.

The simultaneous operation of these two health care constitutions has produced a health system that contains a central conceptual inconsistency growing more intense with each passing year: it devolves primary authority over medical decisions to individualized physician-patient transactions, while increasingly embodying notions of group solidarity and systemic interconnectedness in its overall design. The enactment of the PPACA only sharpens this tension. Many of the Act's most important measures reflect the principle of group solidarity, yet the Act does little in the near term to alter the individualistic diffusion of therapeutic authority. For instance, insurers will be restricted in their ability to create thinly sliced risk pools by practicing age- and gender-rating and enforcing preexisting-condition exclusions, resulting in greater cross-subsidization among participants in private insurance pools.[5] The

4. ESKRIDGE & FEREJOHN, *supra* note 1.

5. *See* Patient Protection and Affordable Care Act § 1201 (defining exclusive permissible rating criteria for individual and small group markets).

individual mandate to purchase insurance will drive more healthy Americans into the larger private risk pools where the prices they pay will, in many cases, be higher than their own age- and health-adjusted actuarial risk[6]—effectively a redistributive tax on youth and good health. On the public finance side, the Act's substantial expansions of Medicaid coverage are funded primarily by higher taxes on affluent federal taxpayers, reflecting an unprecedented commitment to guarantee coverage for virtually every American below or near the poverty line.[7] For all of these reasons and more, individualized patient and physician choices about utilization will, when aggregated, reverberate through an increasingly integrated system struggling with profound concerns about cost and quality.

The history of Medicare and private employment-based insurance offers a cautionary note about the predictable consequences of such a conceptually incoherent system in operation. For several decades now, the simultaneous embrace of the health security ideal and traditional therapeutic individualism in the Medicare context has been rendered workable only by pouring more and more money into the system. In 1960, just before the creation of Medicare and Medicaid, total health spending in the United States accounted for only 4.7% of GDP.[8] Since then, it has more than tripled as a percentage of GDP, to about 18% in recent estimates.[9] This cost growth is not due solely, or even primarily, to government largesse—growth in private health insurance costs over the past decade has exceeded that of the major public insurance programs. But neither public nor private payors have succeeded in containing cost growth. The Congressional Budget Office forecasts that, if present trends continue, overall health care spending will account for 31% of GDP by 2035, 41% by 2060, and 49% by 2082.[10]

This trend is clearly unsustainable and has catalyzed a growing scholarly consensus that the individuated diffusion of therapeutic authority in American medicine and medical law is problematic from the perspective of both patient outcomes and systemic cost. Medical errors remain commonplace in the United

6. *See id.* §§ 1501, 10106.

7. *See* Theda Skocpol & Vanessa Williamson, *Obama and the Transformation of U.S. Public Policy: The Struggle To Reform Health Care*, 42 ARIZ. ST. L.J. 1203, 1232 (2011) (describing the PPACA as a "bill that draws resources from the privileged in order to spread access to affordable health insurance to most of the U.S. citizenry").

8. *See* CONG. BUDGET OFFICE, THE LONG-TERM OUTLOOK FOR HEALTH CARE SPENDING 5 (2007), *available at* http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf.

9. *See* COUNCIL OF ECON. ADVISORS, THE ECONOMIC CASE FOR HEALTH CARE REFORM, at iii (2009).

10. *See id.* at 12-13.

States, and many studies suggest that implementing evidence-driven standards of care and systems-based approaches would reduce error rates and improve outcomes.[11] Moreover, the variations in individual treatment protocols produced by devolution of medical decisionmaking to the bedside have been major drivers of cost increases, particularly when coupled with the moral hazard of third-party insurance, which allows individual patients and their doctors to shift the costs of their particularized decisions to public or private risk pools.[12] Many scholars and policymakers, including Peter Orszag, one of the chief architects of the PPACA, have called for a shift from individualized treatment protocols toward a greater role for evidence-based standards in the practice of medicine. To this end, both the stimulus plan and the PPACA appropriate large sums for cost-effectiveness research in hopes of generating useful aggregate data on best practices, and the PPACA contains some provisions designed to increase the awareness and status of evidence-driven protocols among the nation's practicing physicians.[13] Other proposals for greater incorporation of such data-driven standards in both publicly and privately funded insurance plans have proliferated.[14]

Despite this policy consensus, even tentative efforts at reframing medical authority to channel or constrain individualistic discretion are met with fierce resistance from the public and providers. Two years ago, when the U.S. Preventative Services Task Force promulgated a nonbinding suggestion,

11. *See, e.g.*, THE DARTMOUTH ATLAS OF HEALTH CARE (John E. Wennberg & Megan McAndrew Cooper eds., 1998); Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending* (pt. 2), 138 ANNALS INTERNAL MED. 288, 288 (2003); W. Pete Welch et al., *Geographic Variation in Expenditures for Physicians' Services in the United States*, 328 NEW ENG. J. MED. 621, 625-27 (1993); *see also* INST. OF MED., LEARNING WHAT WORKS BEST: THE NATION'S NEED FOR EVIDENCE ON COMPARATIVE EFFECTIVENESS IN HEALTH CARE 2 (2007) (arguing for increased use of comparative effectiveness research to improve decisionmaking).

12. High-profile examples of this feature of health care delivery abound. Studies have found dramatic variations in Medicare cost per patient in different regions of the country, even after controlling for all relevant health, population, and price-index variables. *See, e.g.*, CONG. BUDGET OFFICE, *supra* note 8; THE DARTMOUTH ATLAS OF HEALTH CARE, *supra* note 11.

13. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6301, 124 Stat. 119, 727 (2010) (codified at 42 U.S.C. § 1320e (Supp. IV 2011)) (establishing new mechanisms for funding and evaluating research on comparative effectiveness). *See generally* Richard S. Saver, *Health Care Reform's Wild Card: The Uncertain Effectiveness of Comparative Effectiveness Research*, 159 U. PA. L. REV. (forthcoming 2011), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1690684 (describing the PPACA's new provision facilitating research on comparative effectiveness).

14. *See* Saver, *supra* note 13 (manuscript at 10-12) (discussing prior private and public efforts to promulgate and apply cost-effectiveness analysis, particularly in the 2009 Recovery Act).

backed by empirical research, that mammograms ought to be prescribed less often for healthy women under the age of fifty, the outrage among the public and physicians was immediate and intense.[15] Within a few days of this recommendation's release, Secretary of Health and Human Services Kathleen Sebelius went to the media expressly to distance herself and the Administration from the expert panel and its epistemic assumption that medicine can and ought to be partially standardized through rational expert decisionmaking and guidelines.[16] Calling the task force an "outside independent panel of doctors" who "do not set federal policy," Sebelius proclaimed that decisions on appropriate breast cancer screening, like other medical decisions, were appropriately devolved to the individualized judgment of physicians and patients. In words that succinctly capture the deep historical roots of the diffuse constitution of medical authority and its keenly individualistic focus, Sebelius told the nation's patients to "[k]eep doing what you have been doing for years—talk to your doctor . . . and make the decision that is right for you."[17]

## II. AMERICA'S HEALTH CARE CONSTITUTIONS AND *A REPUBLIC OF STATUTES*

To what extent can we describe these competing conceptions of medical authority and health security as the product of constitutional contestation? The theory of constitutionalism laid out in Eskridge and Ferejohn's *A Republic of Statutes* is powerful and persuasive and, on my reading, capacious enough to accommodate a discussion of these two variations of noncanonical constitutionalism, neither of which precisely exemplifies their paradigmatic case of a single transformative superstatute. Both of the constitutions of American health care that I discuss here have already met or are capable of meeting the functional tests of entrenchment, durability, contestation, and public acceptance that Eskridge and Ferejohn describe in their work, although neither perfectly fits the authors' "landmark statute" model.[18] The emerging constitution of health security comes closest to the *Republic of Statutes*

15. *See, e.g.*, Joseph Brownstein, *Mammogram Recommendations Draw Widespread Anger*, ABC NEWS (Nov. 18, 2009), http://abcnews.go.com/Health/OnCallPlusBreastCancerNews/mammogram-recommendations-meet-widespread-rejection/story?id=9109591.

16. *See* News Release, U.S. Dep't of Health & Human Servs., Secretary Sebelius Statement on New Breast Cancer Recommendations (Nov. 18, 2009), *available at* http://www.hhs.gov/news/press/2009pres/11/20091118a.html.

17. *Id.*

18. *See* ESKRIDGE & FEREJOHN, *supra* note 1, at 26-28 (describing the manner in which "superstatutes" resemble rules found in the Constitution).

paradigm case, though the commitments it embodies are spread across numerous statutes enacted in different eras, and today it is too new and too tenuously supported to be considered firmly entrenched in the manner of the more archetypal "constitutional" enactments that Eskridge and Ferejohn discuss.

The older constitution of individuated medical authority exemplifies another variety of noncanonical constitutionalism that Eskridge and Ferejohn acknowledge but do not explore at length in their book, namely a constitutional regime created and entrenched over time by legal forms more diverse and multimodal than federal statutes and by institutions more diffuse and eclectic than the national legislature and federal bureaucracy (though those actors are one part of the story here). This entrenchment has come from the bottom up, embodied in over a century of multimodal health law development. Such a decentralized method of construction may in this case have produced a more durable constitutional edifice: in many respects the long accretion and multiple institutional authors of the individualized constitution of medical authority have contributed to its present deep entrenchment in popular attitudes and professional practice—making it difficult to root out through even vigorous programs of national legislative reform. Recent episodes of failed reform suggest that something more concerted than periodic federal statutory revision is required to unsettle the old constitution of medical authority and render it compatible with modern health security imperatives. At the end of this Essay, I offer some brief thoughts on that point.

First, however, I will give slightly more detail on the construction, operation, and interaction of the two constitutions of American health law. I explain the diffuse and formally multifaceted construction of medicine's traditional authority structure and then explore the subsequent interaction of this regime with the newer statutory health security model that the PPACA, Medicare, and Medicaid advance.

## III. THE LONG CONSTRUCTION OF THE CONSTITUTION OF THERAPEUTIC INDIVIDUALISM

American medicine's fundamental authority structure is a creature of multimodal legal development taking place over two centuries, as common law forms, professional state licensure regimes, private institutional ordering, and devolutionary constitutional understandings all coalesced to entrench and fortify a highly individualistic conception of medical decisionmaking in American law and public attitudes. Despite the myriad legal forms and legal institutions involved in framing this regime, the common impulse was relentlessly centrifugal: therapeutic authority was devolved to and resided in

the most granular level of medical interaction. This long story is summarized succinctly here; I explore these developments in much greater detail in a longer historical article.[19]

Central to the individualistic diffusion of medical authority in the United States were three basic devolutions of power generated by a coalescence of constitutional federalism, weak state licensure regimes, and professional eclecticism and resistance to standardization. The first decentralization was a product of constitutional federalism, as regulatory power over medicine was understood to rest with the states, where it largely remains today. To the extent that states regulated medicine at all (and in the nineteenth century, most repealed their licensure laws under popular pressure), they in turn delegated authority to the profession itself in the form of licensure boards. Finally, the medical boards effected a third devolution to individual practitioners through their inability or unwillingness to actively monitor or standardize the actual practice of medicine. This regime was then locked in place by a set of canonical common law doctrines that state courts constructed and applied at the nineteenth century's end, serving to extend and entrench this diffuse authority structure throughout the nineteenth century.

Much has been said about the first devolution of American health law, driven by early understandings of constitutional federalism. Importantly for the later underdevelopment of a federal statutory constitution of health security, the primacy of the states in health care matters proved after the New Deal transformation to be a more durable structural commitment than the now outdated doctrinal limitations on the Federal Commerce Clause authority that produced it in the first place. In statutory formation through the past half century, the diminished federal role in health care matters has persisted even in the absence of formal doctrinal impediments to more robust congressional activity. The significant role left for the states in modern statutes like Medicaid and the PPACA is a manifestation of this ongoing structural understanding, and its implications are ably explored in the paper that Abbe Gluck presented at the conference for which this Essay was written.[20]

This congressional reluctance to exercise the full scope of the federal commerce power when legislating on health care matters has even deeper historical roots and as such reflects a durable brand of legislative constitutional ordering that has differed from the constitutional views of both the judiciary

19. Theodore W. Ruger, The Centrifugal Constitution of American Health Care (Mar. 2, 2011) (unpublished manuscript) (on file with author).

20. Abbe R. Gluck, *State Implementation as Federal Statutory Interpretation: A Federalism Agenda for the Age of Statutes (and Health Reform)*, 121 YALE L.J. (forthcoming 2011) (on file with author).

and the executive branch on the same issue. Presidents from John Adams forward repeatedly endorsed the national constitutional authority to legislate on matters of quarantine and vaccination.[21] After Congress refused to act in this area through much of the nineteenth century, often on the grounds of a dearth of constitutional authority, the Supreme Court in 1886 offered a remarkable bit of dicta exhorting Congress to legislate in the field and preclearing the legitimacy of such hypothetical federal legislation.[22] Still, members of Congress in the nineteenth and early twentieth centuries continued to hold a limited conception of their own authority over health matters, both expressly in floor debates and implicitly in their failure to act.[23] In repeatedly adopting a more constrained view of federal power over health issues than its coordinate branches, Congress has for the past two centuries engaged in the kind of unique legislative constitutionalism that Eskridge and Ferejohn describe in the context of other lawmaking episodes. But in this area the institutional understanding of federal authority was inverted: Congress clung to a narrower understanding of federal power than did the Supreme Court or the President. The result for health care has been a statutory "constitution" of negation, devolution, and underenforced authority at the federal level.

Federal inaction meant that regulatory authority remained vested in state governments, and the states either failed to enact any legislation or further devolved regulatory authority to the medical profession itself. The earliest model was one of absolute nonregulation of medical practice, as popular opposition blocked states from enacting even weak licensure regimes. By the middle of the nineteenth century, nearly every American state had failed to

21. *See, e.g.*, President John Adams, Second Annual Message to Congress (Dec. 8, 1798), *available at* http://www.presidency.ucsb.edu/ws/index.php?pid=29440 (positing that the national government could legislate on disease control since "contagious sickness may be communicated through the channels of commerce"); *see also* President Thomas Jefferson, Fifth Annual Message to Congress (Dec. 3, 1805), *available at* http://www.presidency.ucsb.edu/ws/index.php?pid=29447 (opining that the national government possessed the authority to enact quarantine laws under its "general commerce" authority).

22. *See* Morgan's S.S. Co. v. La. Bd. of Health, 118 U.S. 455, 464 (1886) (lamenting that Congress had not seen fit to act in the area of quarantines and declaring that "whenever Congress shall undertake to provide for the commercial cities of the United States a general system of quarantine . . . all State laws on the subject will be abrogated, at least so far as the two are inconsistent").

23. *See generally* Michael Les Benedict, *Contagion and the Constitution: Quarantine Agitation from 1859 to 1866*, 25 J. HIST. MED. 177, 177-93 (1970) (noting the minimal federal intervention on quarantine and related issues until the nineteenth century's end); Carleton B. Chapman & John M. Talmadge, *Historical and Political Background of Federal Health Care Legislation*, LAW & CONTEMP. PROBS., Spring 1970, at 334, 334-47 (same).

enact medical licensure laws or repealed them under popular constitutional pressure.[24]

The public arguments against medical licensure laws were framed in explicitly "Large 'C'" Constitutional terms and faintly mirror the defenses of individual therapeutic choice that recur in today's political debates. For instance, a Boston editorialist in 1824 claimed:

> Any man in the United States has not only a natural right, but a constitutional right to employ at pleasure, any person to administer medicine to himself or family; and any man has a natural and constitutional right to administer, when requested, such medicine as he judges best to cure the sick . . . .[25]

A physician observed contemporaneously that "'[t]he people regard it among their vested interests' . . . 'to buy and swallow such physick as they in their sovereign will and pleasure shall determine.'"[26]

Such arguments were embraced by state legislatures and executives in their repeal of (or refusal to enact) licensure regimes. For example, Pennsylvania never enacted regular licensure legislation because in 1824 the governor vetoed the plan, writing in his veto message that "'the provisions of this bill seem to interfere with the undoubted right of our citizens, secured by the constitution and laws, to' . . . 'employ[] the person, who, in [their] opinion, may be best qualified to afford relief to [their] sufferings.'"[27]

These early nineteenth-century sentiments are instructive for present understanding of the therapeutic-individualism constitution in two ways. First, they illustrate the manner in which the character of longstanding constitutional structures can toggle between canonical "Large 'C'" constitutionalism and

24. *See* JOSEPH F. KETT, THE FORMATION OF THE AMERICAN MEDICAL PROFESSION: THE ROLE OF INSTITUTIONS, 1780-1860, at 13 (1968) (listing specific state repeals and noting that "[w]ithin the space of little more than a decade [after 1830], however, nearly every state had repealed its penalties on unlicensed practitioners").

25. *An Attempt To Infringe upon the Constitution of the United States Defeated: Or Real Republicanism*, MEDICAL NEWS-PAPER; OR THE DOCTOR AND THE PHYSICIAN (Boston), Feb. 15, 1824, at 1.

26. JAMES HARVEY YOUNG, THE TOADSTOOL MILLIONAIRES: A SOCIAL HISTORY OF PATENT MEDICINES IN AMERICA BEFORE FEDERAL REGULATION 52 (1961) (quoting an unnamed New York doctor).

27. Governor John Andrew Shulze, Veto Message (Dec. 8, 1824), *reprinted in* PENNSYLVANIA ARCHIVES, PAPERS OF THE GOVERNORS 1817-1832, at 543 (4th ser. 1900). As was typical of the nonjudicial constitutional discourse of the era, Shulze's veto statement did not cite a specific constitutional clause or even necessarily distinguish between state and federal documents in making the constitutional objections.

noncanonical constitutionalism. For a brief period in the early nineteenth century, debates over government control of therapeutic authority played out in explicitly constitutional terms, especially among the predominant constitutional institutions of the time: state legislatures and state governors. Today the vernacular of therapeutic individualism has become untethered from the judicialized forms of canonical constitutionalism; people still claim a vague "right" to therapeutic choice of doctor or treatment and act on understandings of that right in both the public and private spheres, but such claims are rarely linked to formal doctrinal or textual constitutional arguments in the way they once were.

Second, these early bruising licensure battles help explain the weak nature of the medical licensure regimes that arose at the end of the nineteenth century and persisted through the twentieth. Constitutional federalism gave states original regulatory authority, and in turn states delegated power to license individual physicians to the profession itself. But professional leaders were reluctant to attempt to standardize practice and provoke another round of popular resistance, and so the medical boards that arose after 1870 effectively worked a third devolution of therapeutic authority down to the level of the individual physician. Though state boards set criteria for admission to practice and policed the unlicensed practice of medicine by outsiders, they did extremely little to regulate practice among those doctors who possessed the requisite credentials.[28] The profession was "self-regulated" only at the ex ante juncture of the right to exclude—medical boards had neither the conceptual mandate nor the institutional resources or competency to smooth out practice variations among already-licensed practitioners. Unlike strong-form guild regulation with authority over day-to-day standards and practices, medical boards operated as merely a boundary mechanism to police the broad outer limits of medical legitimacy.

Together, these three devolutions coalesced to produce an authority regime at the nineteenth century's end that was highly diffuse and individuated. As one contemporary physician said in objecting to a proposed American Medical Association ethical requirement that would have precluded consultation with irregularly trained physicians, "There can be in medicine no heresy, because there is no orthodoxy."[29] Once in place, this thrice-devolved authority regime

28. *See* Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285, 286-87 (2010) (discussing criticism of state medical boards for "failing to discipline dangerous physicians, and generally being lax in their oversight duties at the expense of a vulnerable public" (footnote omitted)).

29. John Harley Warner, *Ideals of Science and Their Discontents in Late Nineteenth-Century American Medicine*, 82 ISIS 454, 466 (1991).

was entrenched through most of the twentieth century by a myriad of health law doctrines that courts began to employ and frame over one hundred years ago.

The common law doctrines that state courts applied from the late nineteenth century onward reflect courts' eclectic borrowing and modification from fields of tort, contract, fiduciary duty, and others, creating what one scholar has called a "chaotic, dysfunctional patchwork."[30] Nonetheless, it is conceptually possible to lump broad swaths of health law's traditional canon into two general functional clusters. In the first basket are first-order specificity rules, which articulated and enforced legal doctrines that encouraged and protected therapeutic individuation. For instance, the customary standard of care in medical malpractice was in fact an amalgam of multiple standards of care, with courts permitting meaningful therapeutic variation along variables such as type of medical training, mode of practice, geographic location, and other factors.[31] Thinly-sliced liability rules (such as the "locality rule," an invention of American common law never adopted in English law) permitted doctors to practice medicine differently from physicians in other towns in the same state.[32] Even to the present day, medical liability rules have worked reasonably well to shift costs and compensate patients in cases of clear mistakes but have done little or nothing to promote optimal methods of care as between various therapeutic alternatives.[33]

A second set of legal doctrines operated primarily to preserve therapeutic individualization indirectly, though no less significantly, by blocking or trumping forms of private ordering that might otherwise have exerted a standardizing influence on medical authority. Courts framed and employed

30. M. Gregg Bloche, *The Invention of Health Law*, 91 CALIF. L. REV. 247, 321 (2003).

31. *See, e.g.*, Jones v. Chidester, 610 A.2d 964, 965 (Pa. 1992) ("A medical practitioner has an absolute defense to a claim of negligence when . . . the prescribed treatment or procedure has been approved by one group of medical experts even though an alternate school of thought recommends another approach.").

32. *See* Jon R. Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408, 410 (1969) (describing the locality rule's origins and noting that "the English courts never developed such a principle"). For early cases developing the rule, see, for example, Smothers v. Hanks, 34 Iowa 286 (1872); Tefft v. Wilcox, 6 Kan. 46 (1870); and Hathorn v. Richmond, 48 Vt. 557 (1876).

33. Several recent medical malpractice reform proposals seek to alter this dynamic, for instance by expressly incorporating evidence-based standards as safe harbors against malpractice liability, as was done in the Maine Medical Liability Demonstration Project. *See* Timothy K. Mackey & Bryan A. Liang, *The Role of Practice Guidelines in Medical Malpractice Litigation*, 13 VIRTUAL MENTOR 36, 38-39 (2011), *available at* http://virtualmentor.ama-assn.org/2011/01/pdf/hlaw1-1101.pdf.

doctrines such as the prohibition on "corporate practice of medicine" to preserve the traditional diffuse structures of medical authority against incursion from new organizational forms of private control, particularly the rise of the corporation in the late nineteenth-century United States and the nonprofit hospital in the twentieth. Such trumping rules were actively sought by doctors and willingly extended by common law courts, with the result that the practice of medicine developed and expanded without meaningful public or private control for much of the twentieth century.

Throughout the century, observers noted the pernicious policy effects of these displacing rules. A *Yale Law Journal* commenter presciently declared in 1938 that the prohibition on institutional control of physicians stifled "extensive experimentation with methods of medical organization" that was undertaken in an "[e]ffort[] to obtain adequate medical care at reasonable costs."[34] Mark Hall wrote much more recently that the rule against corporate employment of physicians was a "puzzling doctrine . . . clouded with confused reasoning and . . . founded on an astounding series of logical fallacies," and he comprehensively cataloged the doctrine's "long history of suppressing needed innovation" throughout the twentieth century.[35] The core doctrines of American health law did not create the original diffusion of authority in nineteenth-century medicine, but they were instrumental in calcifying and extending that individuated authority regime throughout the twentieth century. Although most of these doctrines have been modified or abandoned by state courts in recent decades, they did more than enough work earlier in the century to lock in the basic regime of medical authority that persists today.

Finally, the mid-twentieth century's most important doctrinal innovation relative to physician authority did nothing to alter the general diffusion of health care decisions, even as it worked a sea change in the relative power balance between physicians and patients. Legal scholars, ethicists, and common law judges coalesced after 1960 to articulate a new emphasis on informed patient consent and the cognate principle that medical decisionmaking ought to be shared between doctor and patient rather than dictated by the former.[36]

34. *See* Note, *Right of Corporation To Practice Medicine*, 48 YALE L.J. 346, 346-47 (1938).

35. Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 510-11 (1988) (noting specific episodes of hospital and insurance industry innovation at different periods in the twentieth century that were thwarted by judicial invocation of the doctrine and lamenting that "courts were entirely unresponsive in tempering" its dampening effect on innovation).

36. *See* RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT (1986) (describing historical legal rules and medical practice and twentieth-century changes); *see also* Kristin Madison, *Patients as "Regulators"? Patients' Evolving Influence over*

This produced a crucial shift in health law doctrine and worked a dramatic legal and normative change in the relationships between physicians and patients. Yet the real legal changes fostered by the informed consent ideal did nothing to reduce the diffuse character of medical decisionmaking in the United States. Medical decisions were now binary rather than unitary but remained devolved to the most particularized level of the delivery system.

## IV. CONSTITUTIONAL COEXISTENCE AND CONFLICT: THE UNEASY AND INCOMPLETE RISE OF THE HEALTH SECURITY CONSTITUTION

The longitudinal developments described above firmly entrenched the constitution of therapeutic individualism in American law, public attitudes, and professional practice by the time the federal government entered the health care field. Twentieth-century efforts to frame a meaningful constitution of health security by incrementally expanding Americans' access to private or public health insurance necessarily confronted this existing authority regime, and the older model has remained dominant even as the two constitutional visions increasingly coexist uneasily in federal law and health system organization. It is possible to sketch a rough typology of three modalities of interaction between these two conceptions of health constitutionalism.

In the first mode of interaction, the entrenched regime of medical individualism exerts an absolute trumping or blocking effect on proposed extensions of health insurance security. This manifested earliest in the private sector, as common law rules derived from the imperative of therapeutic individualism, like the bar on institutional "practice of medicine" in the early 1900s, blocked innovative arrangements that would have extended access to medical care to more Americans in that era.[37] In the public sphere, on several notable occasions throughout the past hundred years, public initiatives to meaningfully expand health coverage failed in the national legislature (if they were proposed at all) based in large part on resistance from patients and physicians to any perceived threat to, or reordering of, the diffuse structures of medical authority.[38] The entrenched public backing of medical individualism

*Health Care Delivery*, 31 J. LEGAL MED. 9 (2010) (describing midcentury changes in doctrine and therapeutic practice). *But cf.* Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 933-37 (1994) (questioning whether informed consent as practiced matches the "law in the books").

37. *See* Note, *supra* note 34, at 346-47.

38. *See, e.g.*, Jonathan Oberlander, Perspective, *Learning from Failure in Health Care Reform*, 357 NEW. ENG. J. MED. 1677 (2007).

has provided a rich and reliable vein of normative support that opponents can invoke to block the momentum of reform efforts.

This dynamic was on full display in the 1990s, when a broad majority of Americans initially favored the sweeping reforms of the health care system proposed by President Clinton. The Clinton initiative provoked huge levels of countervailing political advertising that heavily stressed the specter of bureaucratic intrusion into the physician-patient relationship.[39] Polling data suggests that these invocations of medicine's traditional authority regime had significant traction. Within a twelve-month period, support for the President's plan fell from 71% to 43%.[40] Mining similar themes, in last year's political battle over health reform, Republican pollster Frank Luntz built on opinion surveys to recommend that opponents of the PPACA make as their central message the threat to traditional medical autonomy that the new statute would pose and to stand by the mantra that "[g]overnment should not stand between the patient and the physician."[41]

Beyond the trumping effect that the regime of therapeutic individualism has exerted over health security proposals on many occasions in the past century, a second dynamic relevant to current policy formation implicates constitutional coexistence and pluralism. Even where statutes and private ordering have succeeded in implementing a partial health security constitution, the form and operation of those statutes have been built around the older constitution of medical authority. Major federal statutory interventions like the Food, Drug, and Cosmetic Act[42] in 1938 and the enactment of Medicare and Medicaid in 1965[43] expressly disclaimed federal authority over the actual practice of medicine even while expanding federal authority in crucial ways over the safety and security of the medical system.

For instance, Congress disclaimed any intent to regulate medical practice despite becoming a major funder of new hospitals in the Hill-Burton Act in the 1940s, which provided that "nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any

39. *See, e.g.*, *Harry and Louise* (Health Ins. Ass'n of Am. television advertisement 1993), *available at* http://www.youtube.com/watch?v=Dt31nhleeCg.

40. *See* Robert J. Blendon, Mollyann Brodie & John Benson, *What Happened to Americans' Support for the Clinton Health Plan?*, HEALTH AFF., Summer 1995, at 7, 8-9.

41. FRANK I. LUNTZ, THE LANGUAGE OF HEALTHCARE 20 (2009) (using the language of Senator John Kyl).

42. Federal Food, Drug, and Cosmetic Act, Pub. L. No. 75-717, 52 Stat. 1040 (1938) (codified as amended at 21 U.S.C. §§ 301-399b (2006)).

43. Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended primarily in scattered sections of 42 U.S.C.).

supervision or control over the administration, personnel, maintenance, or operation of any hospital with respect to which any funds have been or may be expended under this title."[44] Likewise, the Medicare statute commits the federal government as the guarantor of medical access for older Americans and others but nonetheless states that "[n]othing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided."[45]

Unsurprisingly, federal administrative behavior has historically embraced this conceptual duality and unease about unsettling the traditional medical authority regime. While a succession of federal agencies gave health security to tens of millions of retirees in the administration of Medicare, they refused to define the basic benefit standard of "medical necessity" or otherwise exert systematic control over the delivery of health care by doctors and hospitals. To this day, the agencies in charge of Medicare reimbursement have not issued regulations about which procedures will be considered reimbursable, largely delegating such determinations to treating physicians. Medicare has operated as a national health security statute wrapped around an individuated authority regime, casting the federal government as a payor for services while diffusing actual therapeutic choice to individual physicians. In this sense, the oft-mocked chant of "Keep your government hands off my Medicare!"[46] heard at Tea Party rallies is, in fact, a fair description of Medicare's bifurcated architecture, even if it is a disastrous policy prescription going forward. Medicare, and to a great extent the new PPACA, consciously and perilously seek to juggle the two opposing conceptions of health care constitutionalism with the predictable consequence of systemic incoherence papered over only by throwing ever more money at the problem.

A similar systemic incongruity applies to the private-sector health insurance regime as it has developed since the World War II era. This private, employment-based insurance system forms a core part of the overall constitution of health security in the United States; employers have been the primary insurers for most Americans over the past half century and remain so today even as that model is under severe strain from escalating medical costs.[47]

44. Hospital Survey and Construction Act, Pub. L. No. 79-725, § 635, 60 Stat. 1040, 1049 (1946).

45. Pub. L. No. 89-97, § 102(a), 79 Stat. 290, 291 (1965) (codified at 42 U.S.C. § 1395 (2006)).

46. *See, e.g.*, Timothy Noah, *The Medicare-Isn't-Government Meme*, SLATE (Aug. 5, 2009, 2:04 PM), http://www.slate.com/id/2224350.

47. Federal legislation and administrative regulation were crucial causal drivers behind the growth of this private-sector regime at midcentury. Most notable was the favorable federal

This private-sector developmental story makes clear that there is no easy market-based solution to the conceptual clash between health security and therapeutic individualism. To the contrary, the popular constitution of therapeutic individualism is at least as entrenched against private reordering as it is against federal statutory revision, with analogous cost consequences.

Although insurance contracts have typically been drafted to give insurers the right to refuse to fund treatments that are not "medically necessary," until recently insurers rarely second-guessed the decisions of treating physicians.[48] The most important private insurance plans were for decades "wedded to a vision of themselves as mere financing intermediaries bound to give effect to any doctor's prescription."[49] And in rare instances where insurers did initially deny coverage for unnecessary procedures, they were frequently rebuffed in that endeavor by courts receptive to patient and physician claims of authority. Courts steadfastly embraced therapeutic individualism in such rulings, explaining for instance that "[o]nly the treating physician can determine what the appropriate treatment should be" and that "[a]ny other standard would involve intolerable second-guessing" by third-party payors.[50]

The deep entrenchment of the individualistic authority regime against even concerted efforts at private reordering was laid bare in the resounding collapse of the managed care movement of the past decade. For a period following the demise of the Clinton plan in 1994, many health policy scholars and industry analysts put great faith in the growth of managed care delivery systems, which sought to centralize care management through prospective utilization review, payment reform, and in some cases direct employment of physicians. Many insurance companies made huge investment-backed strategic decisions to position themselves for the new era of managed care, and for a time private payors succeeded in flattening the health care cost curve by controlling physician and hospital treatment patterns.[51] Yet, despite neither regulation nor

tax treatment for employer-provided health benefits, a massive tax expenditure that remains crucial today. Also spurring the rise of employer-provided insurance were World War II-era price controls that froze wages but not benefits, leading manufacturing employers to compete for scarce workers with lucrative benefit packages. *See* David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 NEW ENG. J. MED. 82, 83 (2006).

48. *See* Hall, *supra* note 35, at 469 (describing the "historical reluctance" of insurers to base reimbursement denials on lack of medical necessity).

49. Clark C. Havighurst & Nancy M.P. King, *Liver Transplantation in Massachusetts: Public Policymaking as Morality Play*, 19 IND. L. REV. 955, 965-66 (1986).

50. Mount Sinai Hosp. v. Zorek, 271 N.Y.S.2d 1012, 1016 (Civ. Ct. 1966).

51. *See* James C. Robinson, *From Managed Care to Consumer Health Insurance: The Fall and Rise of Aetna*, 23 HEALTH AFF. 43, 44 (2004).

restriction from the federal government and only weak and incomplete legal responses from the states, strong-form managed care practiced by large insurers in the 1990s collapsed resoundingly, largely due to intense patient and physician opposition.[52]

The demise of managed care at the end of the twentieth century underscores the ongoing trumping effect of the constitution of therapeutic individualism over innovative private ordering, as well as public statutory reform. This in turn illustrates one feature of the operation of entrenched noncanonical constitutionalism: it is more elastic than the constitution contained in formal doctrine, and it operates without categorical distinctions like the "state action" limitation of canonical constitutional law. Public resistance was deployed against managed care insurers in the 1990s just as it had been against President Clinton's health plan a few years before.

## V. THE PPACA AND THE HEALTH SECURITY CONSTITUTION

The PPACA enters the field of play at a time when the tension between therapeutic individualism and universal health security is becoming increasingly pointed due to cost growth and demographic factors. The extension of the health security constitution envisaged by the PPACA can occur only with greater elements of systemic solidarity and institutional control than have heretofore been possible in light of the deeply held individuation norm. The controversial "individual mandate" is part of this solidarity principle; even more important are latent devices encouraged by the bill to change payment and delivery structures to reduce systemic costs by standardizing and institutionalizing the delivery of health care. But all of these measures conflict with the older health constitution of absolute individual choice, and where that conceptual clash surfaces as express political debate, public opinion has consistently favored the traditional allocation of authority.

If there is a way out of this constitutional impasse, what is needed is a third mode of interaction between the new constitution of health security and the older structures of therapeutic individualism. Overly blunt efforts at systemic reorganization, like the major changes proposed by the Clinton reform initiative or the aggressive managed care initiatives from private insurers in the 1990s, will founder under the still-powerful trumping effect exerted by popular embrace of therapeutic individualism. The second model of statutory accommodation and subservience illustrated by the Medicare program's public underwriting of diffuse medical decisionmaking similarly fails to provide a

52. *See id.* at 44-45.

solution to this impasse. The old constitution of individualized authority must yield somewhat to the new imperatives of health security and systemic solidarity, but new methods are required to avoid a conflict between the two regimes.

On this point, the most encouraging new ideas put forth in sections of the PPACA involve innovative payment structures that seek to indirectly shape the behavior of individual providers by creating incentives that align with optimal utilization patterns.[53] Given the deep entrenchment of the individuated therapeutic control model, the most promising approaches in the immediate term seek to reform physician payment to indirectly reduce costs and increase standardization. Many of these payment reforms seek to shift from pure "fee for service" reimbursement, where every single test or procedure generates physician income, to more holistic or bundled payments ranging from payment "per episode of care" all the way to the payment of an annual capitated fee for each patient a physician cares for.[54] The hope is that such payment models will directly achieve cost savings and indirectly produce more standardized care by incentivizing physicians to seek the most efficient and high-quality methods of care.

Most importantly from the perspective of avoiding conflict with entrenched authority structures in medicine, payment reform seeks to change behavior without reordering the superficial structures of medical authority. By enlisting (or conscripting) individual treating physicians in the cost-control enterprise, payment reform does not unsettle the longstanding form of the treatment interaction in the way that direct managed care utilization review did, even as it shifts key incentives behind the scenes. Shifting underlying payment incentives while asking physicians to continue making case-based therapeutic decisions conscripts doctors as agents for systemic change, providing them responsibility not only for patient outcomes and autonomy but also for broader quality and cost concerns. It is unclear whether physicians will willingly take up such a function, though evidence suggests that even physicians are belatedly realizing the importance of moving away from the older, highly individuated authority model.

In sum, a deep clash between the solidaristic vision central to the emerging health security constitution and the individuated regime of medical authority

53. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3401-3403, 124 Stat. 119, 480-507 (2010) (codified at 42 U.S.C. §§ 1395b-6 to 1395yy (Supp. IV 2011)) (addressing Medicare cost control through payment restrictions).

54. *See, e.g.*, Harold D. Miller, *From Volume to Value: Better Ways To Pay for Health Care*, 28 HEALTH AFF. 1418 (2009); Meredith B. Rosenthal, *Beyond Pay for Performance—Emerging Models of Provider-Payment Reform*, 359 NEW ENG. J. MED. 1197 (2008).

that has been entrenched over two centuries has been revealed, and it will intensify in the future. For the health security constitution to be fully realized and made sustainable, it must prevail over the prerogatives of the traditional medical authority structure that is firmly entrenched in American law and public opinion. Both constitutions will continue to coexist for the foreseeable future, but through innovation in payment structures, it may be possible to convert the wide diffusion of medical authority into an engine for reform rather than permitting it to serve as an impediment to change.

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