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FIVE EASY PIECES: MOTIFS OF HEALTH LAW

Sandra H. Johnson[†]

IN *FIVE EASY PIECES*,¹ the film's title refers to a selection of compositions for the piano that Bobby, the Jack Nicholson character, played in a childhood recital. He selected the pieces only because they were easy to play. Of course, some compositions sound difficult to play but are quite easy, and others sound easy but are quite difficult.² "Five Easy Pieces" in the title of this essay does not refer to compositions for the piano but rather to a selection of familiar motifs, some simple and some difficult, of teaching and practicing health law.

THEY JUST DON'T GET IT

We have all been there, walking away from a talk or a meeting and thinking: "They just don't get it." Sometimes, it is the lawyers shaking their heads about the doctors; and at other times, it is the doctors stunned speechless by the ignorance of the lawyers. For example, tell doctors that they have a "conflict of interest" in relation to a proposed protocol for research with human subjects, and they believe that you have accused them of unethical behavior. In my experience, doctors tend to assume that a conflict of interest exists only when they actually have made a "bad" decision motivated by their financial interest in the sponsor of the research. Lawyers (and, therefore, federal agencies regulating research) view conflicts as objective, structural, and rule-based. You could be a paragon of virtue, and you would be conflicted out of representing a client if a prohibited conflict of interest exists.³ Doctors, in contrast, view conflicts of interest as relating to the individual's character and ability to resist temptation.⁴ We law-

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¹ *FIVE EASY PIECES* (Columbia Pictures 1970).

² Posting of Jed Curtis, jed_curtis@hotmail.com, to IMDB Message Board: *Five Easy Pieces* (Sept. 7, 2003), at <http://www.imdb.com/title/tt0065724/board/nest/2003269>.

³ See, e.g., MODEL RULES OF PROF'L CONDUCT R. 1.7 (2003).

⁴ The focus on resisting temptation is very well explained in Nancy J. Moore, *What Doctors Can Learn From Lawyers About Conflicts of Interest*, 81 B.U.

yers might say that doctors just don't get it when they get angry at us for telling them that they have a conflict of interest. And, perhaps, we just don't get it when we get defensive at their response and fail to understand their starting point.

In regard to a somewhat older issue, many lawyers viewed living wills, in their heyday, as tools that would effectively control future treatment decisions using legal principles of enforceable contract. More than a few doctors told more than a few lawyers that things were not so simple at the end of life. The doctor-patient relationship is not a master-servant relationship and is not one-way, no matter how autonomy- or rights-focused we lawyers are inclined to be by training and temperament.⁵ The human body is more complex than lawyers tend to grasp, and its ways of dying or surviving do not fit easy checklists for decisions. Maybe we lawyers just didn't get it. And, perhaps, doctors simply did not appreciate "outsiders" imposing the "legal" values of autonomy and choice into the physician-patient relationship.

Health law's defining characteristic is that it attempts to bridge such gaps in culture and understanding between law and medicine and the other health care professions. Its purpose, both as an area of study and practice, is not simply to take the dominant legal values of the time—such as privacy, autonomy, efficiency, and adversarial reasoning—and impose them onto medicine. Nor is its purpose simply to subordinate the law's values to the values of health care as they might exist at the time, whether they are paternalism, caring, the technological imperative, heroism, or death denial. From its very beginning, health law, in the form of bioethics or liability or economic regulation, has been viewed variously as the dangerous interloper that would irreparably damage the patient-physician relationship or as the heroic figure jousting with a self-serving profession.⁶ If carried forward to

L. REV. 445 (2001).

⁵ For a brief but somewhat fuller development of this critique see Sandra H. Johnson, *Sequential Domination, Autonomy and Living Wills*, 9 W. NEW ENG. L. REV. 113 (1987) (applying Jay Katz's informed consent model to patient autonomy in the context of living wills).

⁶ For a variety of views on the impact of law on medical ethics and practice see DAVID J. ROTHMAN, *STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISION MAKING* (1991) (discussing how physician discretion has been curtailed by legislators, regulators, judges, institutions, bioethicists, and consumer-oriented patients); GEORGE ANNAS, *JUDGING MEDICINE* (1988) (arguing that applying legal principles to medical dilemmas will give patients more control over medical decisions); GEORGE ANNAS, *STANDARD OF CARE: THE LAW OF AMERICAN BIOETHICS* (1993) (exploring the values that should determine the legal standards of health care); Alexander Morgan Capron, *Why the Law and Life Sciences?*, HASTINGS CENTER REP., Jan.-Feb. 1994, at 42, 43 (explaining the natural involvement of law in the bioethics field and its positive and negative effects); Alex-

the point of caricature, neither of these characterizations is accurate. Health law draws its identity as a field from the commitment to work from a deep insight into the culture and context in which the law will operate.

I DON'T KNOW

Sometimes "I don't know" is the only correct answer. Health law teachers need to teach that answer, and health lawyers need to practice it.

Civil Procedure was not my favorite class in the first year of law school. I never really got it, at least at that point, but I learned an important lesson from that course. One day in class, I heard my name called and became alert enough to hear the professor asking me whether the federal jurisdiction rule at issue meant "residence" or "domicile." I had not focused on the discussion the class had been having, so I was at a distinct disadvantage in coming up with an answer. I looked at the rule in front of me and decided that I couldn't even fake it. So I answered, "I don't know." What followed was the life lesson.

The instructor nearly jumped up and down with joy and shouted, "Of course, you don't know! You can't know! It's just not there." That day I learned that "I don't know" can be just the right answer. This lesson has come in very handy in health law and in bioethics. In fact, I sometimes have had the entire class say "I don't know" out loud together just to get over the embarrassment of using the phrase.

Think of how often in the health care context the accurate answer to a question about the law is "I don't know." In some cases, "I don't know" is the right answer because we have not yet done the homework that would reveal the correct answer. Obviously, it is not safe to "fake" answers in such a circumstance. It is equally unsafe to provide a firm answer when, due to the nature of the law, the lawyer is exercising educated and professional judgment in drawing any conclusion at all. For example, in many states, like Missouri, there are only one, or perhaps two, court decisions concerning end-of-life treatment deci-

ander Morgan Capron, *What Contributions Have Social Science and the Law Made to the Development of Policy on Bioethics?*, DAEDALUS, Fall 1999, at 295 (discussing how the law's influence on bioethics favors abstract principles rather than empirical evidence); Susan M. Wolf, *Shifting Paradigms in Bioethics and Health Law: The Rise of a New Pragmatism*, 20 AM. J.L. & MED. 395 (1994) (discussing the paradigm shift from general abstract principles to a patient-by-patient consideration); Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463 (2002) (emphasizing the role of trust in the physician-patient relationship).

sions⁷ and nothing more comprehensive than an advanced directive for health care statute.⁸ In this and similar circumstances, it is absolutely critical to be aware and honest about whether there is law that determines the course that has to be followed, or whether we are simply guessing, from an educated perspective, but guessing nonetheless.

Too often, I hear about lawyers who tell their health care clients “you can’t” or “you must” do something when there simply is no law that requires anything. An exercise I use in my Bioethics class to bring that point home is to provide the students with a simple set of facts involving a very young child in the end stages of a terminal illness whose parents want ventilator support withdrawn, even though the child cannot breathe on his own. The question is also “simple”: Is it legal to withdraw ventilator support in this situation in the state of Missouri? That question is divided into 10 or 12 sub-questions, for example: Is it homicide? Is it child abuse or neglect? Is it legal under the federal “Baby Doe” regulations? Is it legal under the Missouri hospital licensing statute and regulations? There is no case or statute on point in Missouri to resolve this question, yet students invariably report that it is illegal to withdraw ventilator support, and may amount to homicide or abuse, for example, because there is no law that expressly permits withdrawal.

This is certainly a teaching moment. Are treatment decisions that will result in death illegal unless a specific statute or case authorizes the decision? Where do the commonly shared values and legally recognizable standards in health care develop—only in the courts or legislatures? The appropriate answer to the question asked in the exercise is not a bold “Yes” or “No” but rather, “I don’t know.” That answer should be stated and explained quite clearly and carefully. The lawyer should proceed, of course, to discuss his or her best judgment on what the legal risks of the action are and how those risks can be minimized, taking into account the institution’s particular identity and mission. In this case, for example, the lawyer might refer to policies and guidelines from relevant health care organizations; recommend

⁷ Compare *In re Warren*, 858 S.W. 2d 263, 265 (Mo. App. 1993) (allowing a guardian to make medical decisions for an incompetent person without the court’s authorization), with *Cruzan v. Harmon*, 760 S.W.2d 408, 427 (Mo. 1988), *aff’d sub nom. Cruzan v. Dir. Mo. Dep’t Health*, 497 U.S. 261, (1990) (holding that an incompetent person retains the right to life and guardians are not permitted to make end of life decisions). See also *In re Busalacchi*, No. 59582, 1991 WL 26851 (Mo. Ct. App. 1991) (presenting essentially the same situation as that of Nancy Cruzan but finding her case inapplicable).

⁸ See, e.g., Uniform Rights of the Terminally Ill Act of 1985, MO. REV. STAT. § 459.010–.055 (1992) (Missouri’s living will statute). See also Durable Power of Attorney for Health Care Act, MO. REV. STAT. § 404.800 –.865 (2001).

that prognosis be verified through a consultation; make sure that the hospital's ethics committee looks at the case; advise the hospital about the option of a court order in particularly extreme circumstances; advise consulting others in the area to see what they do; and so on. The lawyer who begins with "I don't know" where the state of the law is uncertain can provide the health care client with the most valuable professional advice.

Lawyers who pronounce "shall nots" to health care clients in situations in which there are no commandments are dangerous, and health care clients who defer too much to their lawyers run the risk of breaching their values and acting contrary to their own best interests. As a defense against lawyers who don't know how to say "I don't know," or its first cousin but not twin, "it depends," I advise health care clients to avoid asking their lawyers whether they can do something and, rather, to ask their lawyer what the legal risks of their proposed course of action are and how best to eliminate or manage those risks.

THE MUSIC GOES ROUND AND ROUND

Having worked in health law for more than twenty-five years, I am no longer surprised when an issue thought to be resolved explodes onto the scene once again several years after it was tied up with a ribbon and put on the back shelf marked "things done." Health law seems to have a robust replay function.

For example, not too many years ago, it seemed that the widespread legal and medical acceptance of brain death had produced the ultimate compromise of the issues raised by the determination of death, and had provided a satisfactory response to the relationship between brain death and the requirements of organ harvesting. Of course, the controversy over the status of anencephalic infants was hot for a moment a few years ago;⁹ and there is the persistent debate between whole brainers and higher brainers.¹⁰ Not until the practice of harvesting organs from non-heart beating donors (NHBDs)¹¹ became

⁹ E.g., *In re T.A.C.P.*, 609 So. 2d 588 (Fla. 1992) (holding that anencephalic infants are considered alive so long as their cardiopulmonary system is functioning).

¹⁰ Compare James L. Bernat et al., *Defining Death in Theory and Practice*, HASTINGS CENTER REP., Feb. 1982, at 5-9 (arguing against the higher brain function formulation to define death), with Robert M. Veatch, *Correspondence: What it Means to be Dead*, HASTINGS CENTER REP., Dec. 1982, at 45 (criticizing the conclusion reached in the Bernat article, and arguing in favor of higher brain function requirement). See also THE DEFINITION OF DEATH: CONTEMPORARY CONTROVERSIES (Stuart J. Youngner et al., eds. 1999) (presenting the controversies surrounding the many definitions of death).

¹¹ For one of the earlier scholarly discussions of organ harvesting from

relatively widespread; however, was there a substantial, not-solely-theoretical assault on the whole brain death standard. What seems to have moved us to NHBDs is the convergence of the principles of refusal of life-sustaining medical treatment and the determination of death. One plus one equals two: It is legal and moral for a person (or surrogate) to consent to the withdrawal of life-sustaining treatment *and* there is no legal or moral obligation to resuscitate a person who is dying because of the refusal of life-sustaining treatment; therefore, it is legal to declare them dead after waiting a very short time after removal of the ventilator even though the whole brain death criteria does not apply and the cessation of cardiopulmonary function is not irreversible.¹²

If the re-emergence of the determination of death standard is explained, at least in part, by the fusion of two legal principles, waxing and waning interest in other controversies depends in part on the revelation of a scandal as well as the resulting media coverage of the issues raised by the revelation of particular abuses. The "scandal syndrome" in regulation may help explain the recent focus on regulatory intervention in research on human participants. The legal framework for oversight of research with human subjects seemed to have become relatively well-settled around the Common Rule after considerable attention in the 1970s.¹³ Nevertheless, the question of the appropriate standards and oversight for such research exploded in the later 1990s as a critical issue once again. The intense growth of research in the clinical setting and the shift from public to private funding of research explain some of this review of standards. More influential, I think, were the high-profile scandals and the resulting media coverage of certain experiments, which triggered the establishment of a presiden-

NHBDs, see generally John A. Robertson, *Policy Issues in a Non-Heart-Beating Donor Protocol*, 3 KENNEDY INST. ETHICS J. 241 (1993). For more recent treatments of NHBD protocols see COMMITTEE ON THE NON-HEART-BEATING TRANSPLANTATION II, INSTITUTE OF MEDICINE, NON-HEART-BEATING ORGAN TRANSPLANTATION: PRACTICE AND PROTOCOLS (2000). See also James M. DuBois, *Is Organ Procurement Causing the Death of Patients?*, 18 ISSUES L. & MED. 21 (2002) (discussing the importance of defining death in the organ donor context).

¹² See BARRY R. FURROW ET AL., 2 HEALTH LAW 255-65 (Practitioner Treatise Ser., 2d ed. 2000) (describing the definitions of death and the policies for declaring the time of death).

¹³ See Jesse A. Goldner, *An Overview of Legal Controls on Human Experimentation and the Regulatory Implications of Taking Professor Katz Seriously*, 38 ST. LOUIS. U. L.J. 63 (1993) (providing a history of the enactment of regulations for human subject research).

tial commission and put a harsh spotlight on the previously established framework.¹⁴

A final example: A recurrent or reform-resistant “malpractice crisis” syndrome seemed to have been finally tamed by the tort reform efforts of the 1970s and 1980s, and the pattern of decennial crises was disrupted when it effectively skipped the 1990s. Now it is apparent that it simply may have been that the Clinton health reform plan pushed the crisis syndrome into a temporary remission. The solution for the first medical malpractice crisis of the twenty-first century is still not clear. Whatever the causes of this cycle are—an economic downturn that sours insurers’ investments, or ravenous plaintiffs’ lawyers, or overly generous juries, or the thirst for a nonjudgmental, systemic approach to medical error, or a Republican administration and Congress—the issue is front and center again after a quiescence of nearly two decades. The solutions that are put in place this time should come with a warranty of somewhat less than ten years.

PAYING THE PIPER AND CALLING THE TUNE

Message to the legal profession from health law: Do not ever buy into a federally funded program for the reimbursement of legal expenses to a large non-financially defined population unless you also want to feel the full force of regulatory activity under the federal spending authority.¹⁵ Much of health law, including the “transactional” areas such as reimbursement and fraud and abuse and the “quality” areas such as certification and fraud and abuse and the “patients’ rights” areas such as EMTALA, may be the house that Medicare built.¹⁶ Almost all federal regulation of health care, with few

¹⁴ See Greg Koski, *Research, Regulations, and Responsibility: Confronting the Compliance Myth – A Reaction to Professor Gatter*, 52 EMORY L.J. 403 (2003) (discussing the impetus for regulations for human subjects research and the concerns that still need to be addressed as part of a symposium issue on Human Subjects Research and Conflicts of Interest). See also, Jesse A. Goldner, *Symposium on Human Subjects Research: Redux*, 30 J. L. MED. & ETHICS 358 *passim* (2002) (giving an overview of the symposium). The Institute of Medicine has issued several reports recently concerning oversight of experimentation with human participants. See, e.g., COMMITTEE ON ASSESSING THE SYSTEM FOR PROTECTING HUMAN RESEARCH PARTICIPANTS, INSTITUTE OF MEDICINE, RESPONSIBLE RESEARCH: A SYSTEMS APPROACH TO PROTECTING RESEARCH PARTICIPANTS (Daniel D. Federman et al. eds., 2003).

¹⁵ Whether this message should have been heeded by the pharmaceutical industry, who are the apparent winners in the recent Medicare drug benefit amendments, remains to be seen. Although there are some restrictions on federal intervention in the amendments, these restrictions are only self-imposed by Congress. H.R. 1, 108th Cong. (2003).

¹⁶ See Thomas Wm. Mayo, *The First Fifty Years: Health Law’s Greatest Hit*,

exceptions,¹⁷ emerges from the spending authority of the federal government. It would be a good exercise in reconstructive history to imagine what health law would be without the federal Medicare statute. We would be left with state law, medical malpractice and some of bioethics (the areas that are not reliant on problems that arise mostly because Medicare has funded more technologically intensive end-of-life care), for example. Health law as a field certainly would not have developed as it has without the robust growth of the industry that Medicare kindled.

THOSE WHO CAN, TEACH

I know that the sentiment is commonly stated as “those who can, do; those who can’t, teach.” That has not been my experience with the health law teachers who taught me while I was a student and thereafter, nor of the health lawyers who gift the field and our students as authors, adjunct faculty, and mentors.

I have had the benefit of great teachers in Health Law from the very beginning. Sylvia Law taught the first Health Law course I took at NYU in 1975. She was then, and continues to be, an inspired and inspiring teacher. I went on to take a course the next year in Social Security Disability hearings and appeals with Jerry Mashaw at Yale. His work in looking at process and procedure in one agency influ-

50 SYRACUSE L. REV. 1261 (2000) (discussing the impact of Medicare on many areas of health law that are seemingly unrelated to the original purpose of Medicare).

¹⁷ Several significant federal regulatory efforts directly applicable to health care endeavors are supported by the commerce power, including the Health Insurance Portability and Accountability Act, 29 U.S.C. § 1181 (2000) and the Federal Food, Drug and Cosmetic Act, 21 U.S.C. § 355 (2000). Although not directed solely toward health care, the Sherman Act, 15 U.S.C. §§ 1–2 (2000), which is supported by the commerce power, has certainly had a significant effect on it. The federal taxing power has also provided an entry for federal regulation of health care organizations especially through controls exerted over tax-exempt status. *See*, Internal Revenue Code of 1986, 26 U.S.C. § 501 (2000). While the federal government garnered tremendous power over health care through the Medicare statute, the struggle for power over medical practice as between the federal government and the state governments continues on other fronts. Currently, two issues regarding the allocation of power over the regulation of medical practice in the prescription of controlled substances are being litigated in *Conant v. Walters*, 309 F.3d 629, 632–639 (9th Cir. 2002), *petition for cert. filed*, 72 U.S.L.W. 3092 (U.S. July 7, 2003) (No. 03-40) (regarding federal investigations of physicians recommending medical marijuana to patients, in compliance with California law but arguably in violation of the federal Controlled Substances Act) and *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077 (D. Or. 2002) (regarding the preemption of the Oregon physician-assisted suicide statute by the federal Controlled Substances Act).

enced my own lifelong interest in the work of agencies in health care. When I began teaching at Saint Louis University School of Law in 1978, I found that it was already offering several health law courses taught by Michael Wolff, a great lawyer and generous colleague, now a judge on the Missouri Supreme Court, and Jesse Goldner, who remains a creative teacher, a strong scholar, and an ideal colleague. I've learned from my health law teacher colleagues throughout the country, but none more so than my co-authors on the casebook.¹⁸

Other authors in this special issue of Health Matrix are paying tribute to the leading lights in health law and rightfully so. I am grateful that they are providing us with the opportunity to pause a moment and appreciate those brilliant and generous teachers that created and enriched an entire field. Of course, some of our formative teachers were not standing behind the podium; they have been sitting in our classrooms sharing their enthusiasm for the field and challenging us to think harder and do better.

Finally, some of our most important teachers have been those individuals who taught us through their suffering: The patients who shared their personal stories with Elisabeth Kubler-Ross and changed the way we looked at dying.¹⁹ The patients like Dax Cowart who spoke openly about their pain and their personal choices.²⁰ Family members like Pete Busalacchi and Joe Cruzan who turned their grief into efforts to confront the system that exacerbated their personal tragedy.²¹ Those dozens or hundreds who have spoken to our health law and bioethics classes, at our conferences, or simply who shared their lives with us as we worked on ethics committees, or in litigation,

¹⁸ BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY S. JOST & ROBERT L. SCHWARTZ, *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* (4th ed. 2001).

¹⁹ ELISABETH KUBLER-ROSS, *ON DEATH AND DYING* (MacMillan 1970) (1969).

²⁰ *E.g.*, *Confronting Death: Who Chooses, Who Controls? A Dialogue Between Dax Cowart and Robert Burt*, *HASTINGS CENTER REP.*, Jan.-Feb. 1998, at 14.

²¹ The fathers of Christine Busalacchi and Nancy Cruzan, both from Missouri, participated in conferences and in efforts to enact legislation that would better serve families. In one memorable event during a conference jointly sponsored by the American Society of Law, Medicine & Ethics and Saint Louis University's Center for Health Law Studies, Pete Busalacchi went to the microphone during a question-and-answer period to ask the author of the Missouri Supreme Court's majority opinion in *Cruzan* to ask why he wanted to cause families such pain. Conference, *Ethics Committees and the Young: Families, Hospitals and the Courts Trying to Do the Right Thing*, sponsored by the American Society of Law, Medicine & Ethics and Saint Louis University Schools of Law, Medicine & Nursing (May 19-21, 1994) (Adam's Mark Hotel, St. Louis, Missouri). The exchange occurred during a session entitled "Who Has Authority to Speak for the Child?" on May 19.

or on legislation, or as we lived as sons and daughters. We owe a vast debt to them.