

Michigan Law Review

Volume 102 | Issue 6

2004

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Recommended Citation

Frances H. Miller, *Why Don't Doctors & Lawyers (Strangers in the Night) Get Their Act Together?*, 102 MICH. L. REV. 1295 (2004).

Available at: <https://repository.law.umich.edu/mlr/vol102/iss6/14>

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WHY DON'T DOCTORS & LAWYERS (STRANGERS IN THE NIGHT) GET THEIR ACT TOGETHER?

*Frances H. Miller**

STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA. By *Peter D. Jacobson*. New York: Oxford University Press. 2002. Pp. xvii, 296. \$36.

I. INTRODUCTION

Health care in America is an expensive, complicated, inefficient, tangled mess — everybody says so. Patients decry its complexity,¹ health care executives bemoan its lack of coherence,² physicians plead for universal coverage to simplify their lives so they can just get on with taking care of patients,³ and everyone complains about health care costs.⁴ The best health care in the world is theoretically available here,⁵ but we deliver and pay for it in some of the world's worst ways.⁶

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1. For a recent example, Medicare beneficiaries express confusion and frustration trying to distinguish among seventy-three competing Medicare-approved prescription-drug discount cards which became available on June 1, 2004. John Leland, *73 Options for Medicare Plan Fuel Chaos, Not Prescriptions*, N.Y. TIMES, May 12, 2004, at A1.

2. ROGER K. HOWE, *WHERE HAVE WE FAILED?: A SYSTEMIC ANALYSIS OF U.S. HEALTH CARE* (2002).

3. *Proposal of the Physicians' Working Group for Single-Payer National Health Insurance*, 290 JAMA 798 (2003).

4. James E. Dalen, *Health Care in America: The Good, the Bad, and the Ugly*, 160 ARCHIVES INTERNAL MED. 2573 (2000) (explaining why health care is more expensive in United States than in any other industrialized nation); Arnold M. Epstein et. al., *Health Policy 2001 — A New Series*, 344 NEW ENGL. J. MED. 673 (2001) (commenting on the excessive cost of health care in the United States).

5. See, e.g., President George W. Bush, *The State of the Union* (Jan. 20, 2004), at <http://www.whitehouse.gov/news/releases/2004/01/20040120-7.html> (declaring that "America's health care [is] the best in the world"). But see Peter S. Hussey et al., *How Does The Quality Of Care Compare In Five Countries?*, HEALTH AFF., May-June 2004, at 89-99 (finding that contrary to the common "mantra" recited by U.S. policymakers and clinicians — "Americans have the best medical care in the world" — recent empirical data on quality of healthcare worldwide rank United States in the "bottom quartile of industrialized countries"); Barbara Starfield, *Is US Health Really the Best in the World?*, 284 JAMA 483

Occam's razor ("Among competing hypotheses, favor the simplest one")⁷ is of little help here. There are no simple hypotheses — everything seems to conspire to make a bad situation worse. Moreover, despite abundant speculation, no one has yet come up with the silver bullet for reform.⁸ So why don't doctors and lawyers, who consume health care themselves, get their act together and do something about it?

Into this morass comes Peter D. Jacobson⁹ to offer cold comfort and a fiduciary band-aid with *Strangers in the Night: Law and Medicine in the Managed Care Era*, which illuminates why doctors and lawyers often have a hard time working with each other. The book promises to "explain . . . how the legal system helps shape health care delivery and policy, explore . . . new ways of looking at the relationship between law and medicine, and reflect . . . on why it all matters" (book jacket). Professor Jacobson does manage to do that in the course of this purportedly limited examination of law and managed care, which he defines as "the generic name for the new health care delivery system . . . characterized by large patient populations within integrated [i.e., combining financing and provisions of health services in one entity] delivery systems" (p. 7). By the end of the book, however, one is left with a depressed sense that things could get a whole lot worse for all of us, not just for doctors and lawyers, before we just might — with luck — restructure the whole shooting match into a more humane and efficient health care delivery system.¹⁰

(2000) (citing several recent studies indicating the "poor position of the United States in health worldwide"); *but cf.* William J. Broad, *U.S. Is Losing Its Dominance In the Sciences*, N.Y. TIMES, May, 3 2004, at A1.

6. For a particularly sinister take on that point, see David A. Hyman, *Medicare Meets Mephistopheles*, 60 WASH. & LEE L. REV. 1165 (2003).

7. David A. Drachman, *Occam's Razor, Geriatric Syndromes, and the Dizzy Patient*, 132 ANNALS OF INTERNAL MED. 403 (2000).

8. Some purport to have a silver bullet, but on close examination their ideas often turn out to be either impracticable because health care truly is "different" from other commercial products, or old chestnuts dressed up in trendy new rhetoric. *See, e.g.*, Michael E. Porter & Elizabeth Olmsted Teisberg, *Redefining Competition in Health Care*, HARV. BUS. REV., June 2004, at 65 (advocating competition at the level of specific diseases and health conditions rather than at the level of health-insurance plans, networks, providers and payors).

9. Associate Professor, Department of Health Management & Policy, University of Michigan School of Public Health.

10. This dismal thought was echoed in Jonathan Oberlander's conclusion to his recent book: "[A]fter thirty-seven years of policy innovations, political upheaval, changing economic circumstances, and a radically altered health care system, Medicare politics is back where it started [i.e., battling over the role of government v. markets in public policy]." JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* 196 (2003); *cf.* Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 190-96 (2004); Hillary Rodham Clinton, *Now Can We Talk About Health Care?*, N.Y. TIMES, Apr. 18, 2004,

II. HISTORY

Managed care is not the only battleground on which legal dilemmas involving doctors and lawyers have played out over the years, and *Strangers in the Night* traces these other controversies in brief historical arc to show that medical and legal professionals have sometimes worked in concert (i.e., on public health issues and ridding the profession of charlatans) (p. 33), whereas at other times they have been at swords' point (i.e., during malpractice lawsuits or antitrust litigation) (p. 28). Too often overlooked, they have also long worked in relative harmony on routine contract and other legal matters. Professor Jacobson points out that notwithstanding the ebb and flow of various legal problems over the years, relationships between the two professions had more or less stabilized by 1965, with clearly understood rules relating primarily to medical malpractice litigation. But then Medicare and Medicaid interjected a monumental federal presence into health care financing through the Social Security Act of 1965,¹¹ and that "changed everything" (p. 57).

Strangers in the Night explores the way the relationship between law and medicine evolved as regulation designed to protect the government's substantial post-1965 financial investment in health care proliferated over the intervening years. The book shows how, in response to the massive influx of federal money into health-service reimbursement, accompanied by increasing government oversight over expenditures, the law's focus on health issues has shifted from its former preoccupation with liability questions to its present focus on issues more related to the functioning of a \$1.7 trillion dollar business sector.¹² Professor Jacobson opines that law itself has "become a central force in the development of health care" in the process (p. 35).

Both doctors and lawyers are inevitably involved in many of the controversies associated with managed care in general and Medicare and Medicaid in particular. These problems tend to play out primarily and often uncomfortably for doctors on legal and political turf, and therein lies much of the problem so far as cooperative problem solving is concerned. Doctors, educated to exercise control in medical environments, feel understandably ill-at-ease, vulnerable, and often resentful because lawyers control the rules of the legal games in which they are forced to participate. In fact, one especially aggrieved member of the American Medical Association's House of Delegates

(Magazine), at 26 ("No, it's not 1994; it's 2004. And believe it or not, we have more problems today than we had back then.").

11. The Social Security Act of 1965, 42 U.S.C.A. § 1395 (West 2003).

12. *Health Care Spending Reaches \$1.6 Trillion in 2002*, Center for Medicare and Medicaid Services (Jan. 8, 2004), <http://www.cms.hhs.gov/media/press/release.asp?Counter=935>.

introduced a policy resolution for debate at the 2004 annual meeting stating that, notwithstanding the Hippocratic Oath, a physician's outright refusal to provide medical care for plaintiffs' lawyers and their spouses should not rise to the level of unethical conduct.¹³

Although physicians usually have little problem dealing with the kinds of ambiguity and uncertainty inherent in medical practice that make patients anxious, doctors feel acutely at risk when unfamiliar legal processes and strange legal rules govern their own destinies.¹⁴ The lawyer's stock answer of "that depends" when queried about what "reasonable" professional conduct or patient expectations means does not reassure them. This physician uneasiness in alien professional territory is not irrational given medical training encouraging them to take control of illness, and it can be downright disabling when doctors have a personal stake in the medical controversy at hand. Moreover, a plaintiff's allegation of carelessness regarding human life and health cuts far more deeply into a defendant-physician's psyche in medical malpractice litigation than does a garden-variety negligence claim alleging mere disregard of responsibilities relating to property. For these and many other reasons, doctors do not usually regard lawyers as their natural allies when it comes to problem solving, and lawyers often return the compliment.

Although Professor Jacobson's introduction forthrightly professes a restricted scope for his book, don't let that deceive you. He states that his inquiry "is concerned with the cases brought by patients to recover damages after the failure to receive expected health benefits or after medical intervention went awry" (p. 1), but the scope of the book extends far beyond the cases themselves. Intentionally or not, it spotlights the inadequacies of our fragmented and competitive system for delivering health care in the course of proffering a way to balance the conflicting claims of individuals and societal groups for limited health care resources.

III. COMPETITION IN HEALTH CARE

For better or for worse, the United States has structured its health care delivery system on the competitive model. Once the command-and-control regulatory measures the government passed in the 1970s as an exercise in fiscal self-preservation when Medicare and Medicaid

13. Stephanie Francis Ward, *Lawyer, Heal Thyself: AMA Proposal Advocates Refusing Medical Treatment to Plaintiffs' Lawyers*, ABA J. E-REPORT (June 11, 2004), <http://www.abanet.org/journal/ereport/jn11ama.html>. Many physicians at the annual meeting denounced the proposal, and the sponsor asked that it be withdrawn. *Doctor's Proposal on Lawyers Assailed*, BOSTON GLOBE, June 14, 2004, at A4.

14. See generally David Sclar & Michael Housman, *Medical Malpractice and Physician Liability: Examining Alternatives to Defensive Medicine*, HARV. HEALTH POL'Y REV., Spring 2003, at 1.

were enacted failed to tame rapidly escalating health care costs, competition was seen as the answer.¹⁵ Instead of performing according to the neoclassical paradigm to drive the price of health care services down and the quality up, however, health care competition has been famously unsuccessful in its attempt to rein in still relentlessly increasing costs.¹⁶ Moreover, widely publicized medical-systems errors,¹⁷ among other problems, testify to this country's many deficiencies in health care quality.¹⁸ Many physicians blame managed care for precipitating these deficiencies by circumscribing their clinical autonomy, but little evidence exists that patient care has deteriorated since the advent of managed care.¹⁹

Many doctors have a hard time grappling with the fact that competition creates losers as well as winners, and doctors rebel against sometimes being on the losing end of things under managed care. Lawyers, on the other hand, have been trained to expect and accept the inevitability of winning and losing in their professional lives. In the words of Daniel Oliver, former Federal Trade Commission Chairman, part of the explanation for widespread physician dissatisfaction with managed care lies in the fact that “[a]ll of these years doctors have spent their political energies fighting socialized medicine. Now suddenly, they find they’ve been blind-sided by capitalism.”²⁰

15. Victor R. Fuchs, *The “Competition Revolution” in Health Care*, HEALTH AFF., Summer 1988, at 5 (1988) (discussing how, during the 1980s, the government adopted the philosophy that “America’s health sphere could position itself best for the future by employing market principles to allocate scarce resources”).

16. Mark V. Pauly, *Is Medical Care Different? Old Questions, New Answers*, 13 J. HEALTH POL. POL’Y & L. 227-237 (1988), reprinted in COMPETITION IN THE HEALTH CARE SECTOR: TEN YEARS LATER (Warren Greenberg ed., 1988).

17. COMM. ON QUALITY OF HEALTH CARE IN AMERICA, INST. OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM (Linda T. Kohn et al. eds., 2000).

18. See generally *Perspectives on Medical Error: Reactions to the IOM Report*, 27 AM. J.L. & MED. 145 (2001) (symposium issue dealing with health care quality).

19. See, e.g., Bruce E. Landon et al., *Comparison of Performance of Traditional Medicare vs. Medicare Managed Care*, 291 JAMA 1744 (2004) (finding the difference in quality between fee-for-service Medicare and Medicare managed care to be similar in magnitude to that between competing health plans); Mary E. Seddon et al., *Quality of Ambulatory Care After Myocardial Infarction Among Medicare Patients by Type of Insurance and Region*, 111 AM. J. MED. 24, 32 (2001) (finding the quality of ambulatory care received by MCO and fee-for-service patients to be relatively comparable).

20. Frances H. Miller, *Antitrust Laws: Protecting Competition in an Era of Oversupply*, 2 MASS. MED. 23, 24 (1987) (quoting Commissioner Oliver’s speech to the National Health Lawyers Association 1987 Conference on Antitrust in the Health Sector).

IV. MANAGED CARE AND THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (“ERISA”)

The cost/quality tradeoff inherent in competition that produces winners and losers is actually nothing new in health care, although it used to be relatively hidden. Professor Jacobson traces the relationship between law and medicine through a great swath of history — the years 1800-1965 — reiterating his theme that the professions have not always been antagonistic to one another. As he rightly notes, the 1965 enactment of the Medicare and Medicaid programs²¹ injected a substantial government presence into the health care mix. It set the stage for expansion of managed care twenty-five years later by pumping vast new sums of money into the health sector and the government increased its oversight because it didn't want to pay for unnecessary services.²² In recent years, however, managed-care organizations (“MCOs”) have been stung by the well-publicized subscriber backlash against their cost-containment efforts, most famously articulated by Helen Hunt's character's diatribe against her son's health insurer, which drew cheers from movie audiences in *As Good as It Gets*.²³ As a result of this consumer backlash — and other factors²⁴ — managed-care plans have now pulled back on their more aggressive cost-containment practices²⁵ and scholars are writing articles with titles like “The Death of Managed Care as We Know It.”²⁶

Cost pressures can hardly disappear, however, for an industry that is primarily financed by government and employers, and accounts for approximately — depending on the state of the economy at any given moment — fourteen percent of gross domestic product.²⁷ With managed care now in retreat and payors in revolt, these pressures will inevitably have to be addressed by other cost-containment mechanisms, such as the larger co-pays and deductibles that are

21. See generally John Larkin Thompson, *Medicare Play-by-Play: A Review of Theodore Marmor's The Politics of Medicare*, 26 AM. J.L. & MED. 475 (2000).

22. BARRY R. FURROW ET AL., HEALTH LAW: CASES MATERIALS AND PROBLEMS 506 (4th ed. 2001).

23. The exact quote is quite explicit: “Fucking HMO bastard pieces of shit!” AS GOOD AS IT GETS (Columbia/Tristar Studios 1997), available at <http://us.imdb.com/title/tt0119822/> quotes.

24. Mark Hall, *The “Death” of Managed Care: A Regulatory Autopsy* (forthcoming 2004) (concluding that a mix of social, market, and legislative forces diluted cost-containment forces in managed care around the turn of the twentieth century).

25. See, e.g., James C. Robinson, *The End of Managed Care*, 285 JAMA 2622 (2001); Katherine Swartz, *The Death of Managed Care as We Know It*, 24 J. HEALTH POL. POL'Y & L. 1201, 1204 (1999).

26. Swartz, *supra* note 25.

27. National Center for Health Statistics, *Health Expenditures* (2001), at <http://www.cdc.gov/nchs/fastats/hexpense.htm>.

increasingly common in today's health insurance plans.²⁸ Whatever method is instituted to control costs, however, is surely guaranteed to generate a whole new round of legal controversies. These disputes may have to be adjudicated with slightly different rules, but once again they will force medical professionals onto legal turf to help resolve them. The trick will be for insurers to come up with cost containment mechanisms that come as close as possible to a win/win scenario for all relevant parties. Professor Jacobson believes he can take us in that direction with his fiduciary theories.

Strangers in the Night uses the negligence cases set forth in the introduction to highlight the conflicting legal positions of otherwise similarly situated patients attempting to recover against the managed-care health insurers who have denied them the purportedly necessary care advocated by their physicians. In Professor Jacobson's view, the marked differences in their litigation outcomes depended solely on whether they were subscribers to an ERISA-qualifying employer-underwritten plan. He uses the artificial bifurcation of subscriber/patient remedies these cases expose as a springboard to explore the many ways in which managed care has affected health care delivery over the past two decades.

The ERISA conflict has arisen because Congress preempted state tort-law recovery (and state insurance regulation) against ERISA-qualifying "employee welfare benefit plans" when it enacted ERISA to effectuate pension reform.²⁹ In lieu of state tort recovery, Congress provided a federal remedy to employees claiming wrongful denial of benefits; that provision forces the employer to provide any benefits courts deem to have been wrongly withheld.³⁰ ERISA was passed in 1972, a full decade before managed care began to take hold in comprehensive fashion in this country. Thus Congress almost certainly did not specifically intend its statutory prohibition against state-court tort recovery to apply to ERISA-qualifying health-insurance plans, those "employee welfare benefit" plans which just happen to be employer funded instead of underwritten by third-party insurers. Lower federal courts, increasingly unhappy with the anomaly of bifurcated remedies, have kept trying to find ways to circumvent preemption and permit tort recovery against ERISA insurers in order to

28. John K. Iglehart, *Changing Health Insurance Trends*, 347 NEW ENG. J. MED. 956 (2002) (describing how insurance companies have responded to increasing health care costs by requiring consumers to "assume greater financial responsibility for the decisions they make when selecting insurance benefits and seeking medical treatment").

29. The Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1001-1461 (2004).

30. *Id.* at § 1144(a) (providing that ERISA "supersede[s] any and all State laws insofar as they may . . . relate to any employee benefit plan").

permit recovery for their hapless insureds.³¹ Congress has had ample opportunity to amend ERISA if it believed judicial interpretation of the statutory wording to be erroneous, but has not chosen to do so thus far.³² Among the reasons is the fear that an onslaught of litigation against managed care plans will raise overall health care costs, which in turn will end up having to be reflected in higher Medicare and Medicaid payouts for health care.

MCOs fly the banner of contract law (supported by ERISA) to uphold their coverage limitation decisions, while allegedly harmed subscriber/patients keep trying to challenge insurer decisions to deny them “necessary” care via tort liability. Subscriber/patients have on the whole been relatively unsuccessful in getting past ERISA’s bar on state tort recovery, but some courts have been chipping away at ERISA’s blanket immunity nonetheless.³³ Professor Jacobson believes that the fiduciary concept, imposing “duties on health care plans to ensure that medical decisions are not compromised by cost containment objectives” (p. 5), points to an easier way for us to extricate ourselves from this legal dilemma, and he builds a plausible case to support his proposal.

Some courts have shaped — some might say warped — the legal doctrine applying to MCOs in order to cope with ERISA-imposed legal constraints. These constraints are, in the exasperated words of Judge William Young, “tragic . . . [and] cry out for relief,”³⁴ because the federal legislation requires courts to treat similarly harmed patients insured by ERISA-qualifying plans differently from their non-ERISA-insured counterparts.³⁵ Furthermore, within the category

31. See, e.g., *Horvath v. Keystone Health Plan E., Inc.*, 333 F.3d 450, 463 n.11 (3d Cir. 2003) (construing ERISA’s preemption clause to exclude cases involving claims over treatment or quality of care); *Roark v. Humana, Inc.*, 307 F.3d 298, 302 (5th Cir. 2002), cert. granted sub nom, *Aetna Health Inc. v. Davila*, 124 S. Ct. 462 (2003) (identifying plaintiff’s claims as mixed eligibility and treatment decisions subject to Texas medical malpractice law permitting lawsuits against managed-care plans); *Lazorko v. Pa. Hosp.*, 237 F.3d 242, 249 (3d Cir. 2000) (finding that decisions to deny treatment are subject to “claim[s] about the quality — and not the quantity — of benefits provided” and fall “outside the scope of ERISA’s express preemption”).

32. Perhaps Justice Ginsburg’s concurring opinion in the Supreme Court’s most recent ERISA case, holding that ERISA pre-empts claims made under Texas statute imposing duty of care on HMOs, will prompt it to do so. See *Aetna Health*, 124 S. Ct. at 2503 (2004) (“I also join ‘the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.’” (citing *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (3d Cir. 2003))).

33. See, e.g., M. Gregg Bloche & David M. Studdert, *A Quiet Revolution: Law as an Agent of Health System Change: A trilogy of Supreme Court Cases Reshaped the Regulatory Environment, But Law’s Larger Influence Was Indirect*, HEALTH AFF., Mar./Apr. 2004, at 24, 29, 39 (2004) (discussing the “dissolution of managed care’s ERISA-based immunity from state regulation and tort liability”).

34. *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 52 (D. Mass. 1997).

35. See, e.g., Dahlia Schwartz, *Breathing Lessons for the ERISA Vacuum: Toward a Reconciliation of ERISA’S Competing Objectives in the Health Benefits Arena*, 79 B.U. L.

of ERISA insureds courts make further distinctions; some patients seeking recovery after receiving poor-quality care may be permitted access to state court to press their tort claims, but those challenging benefit determinations before services are rendered are theoretically limited to the ERISA federal remedies. Professor Jacobson proposes to apply fiduciary responsibilities to managed-care insurers to cope with these anomalies.

Unfortunately for his proposal, the Supreme Court has been busily undercutting this potential remedy with its recent decisions, at least for ERISA-qualifying plans. In the Court's 2000 opinion in *Pegram v. Herdich*,³⁶ it held that an insurer's mixed treatment-/benefit-eligibility determinations do not qualify as just fiduciary decisions for purposes of triggering ERISA's more generous fiduciary remedies.³⁷

Subscribers to non-ERISA plans are, however, still free to invoke fiduciary remedies in state court when they believe they have wrongfully been denied care. Although a national managed care patients' rights statute could effectively repeal ERISA's ban on state tort recovery, the events of 9/11 diverted Congressional attention from proposed patients' rights legislation which would have done just that. The proposed legislation had passed both houses but had not yet been reconciled in a final bill.³⁸ A federal managed-care patients' bill of rights may now be in danger of becoming an idea whose time has passed. Nonetheless, federal courts could conceivably still continue cutting back on the ERISA ban's effectiveness with increasingly narrow interpretations of the statutory language.³⁹

Strangers in the Night makes an interesting foray into historical precursors to the current relationship between the judiciary and managed care by analogizing to the way the judges have reacted to other quickly emerging industries and to sweeping transformations of

REV. 631, 638-39 (1999) (illustrating this discrepancy by showing how ERISA insurers can exempt themselves from liability under state laws requiring a "bare minimum of health benefits for employees" — such as mandatory coverage for pregnant women — whereas non-ERISA insurers cannot); *The Supreme Court, 2001 Term — Leading Cases*, 116 HARV. L. REV. 200, 421 (2002) (describing how ERISA's preemption provisions — which insulate ERISA-qualifying plans from state laws designed to protect patients — "have triggered a "litigation bonanza").

36. 530 U.S. 211, 237 (2000) (holding that "mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA").

37. In an opinion rendered in June 2004, the Court flatly held that "if an individual . . . could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA § 502(a)(1)(B)." *Aetna Health*, 124 S. Ct. at 2496 (2004).

38. S. 1052, 107th Cong. (2001); H.R. 2563, 107th Cong. (2001).

39. See David L. Trueman, *Will the Supreme Court Finally Eliminate ERISA Preemption?*, 13 ANNALS HEALTH L. 427 (2004) (analyzing and commenting on two ERISA cases on which the Court heard oral argument this term).

existing industries. Jacobson shows that courts tend to modify their legal reasoning over time in a gradual process which at first protects the nascent industry by relying on contract law principles. That process gradually evolves, as the industry matures, into a more sophisticated jurisprudence more accommodating to injured plaintiffs. Courts do this by recognizing tort remedies as a way to impose accountability on these new ways of doing business (pp. 70-91). Taking the emergence of railroads in the nineteenth century along with the manufacturing transformations wrought by the introduction of mass production in the early twentieth century as his examples, Professor Jacobson analyzes the way courts have tended in the past to adapted contract and tort legal rules to fit the new economic realities. He suggests that today's judges might study their history in order to think more creatively about the possibilities for fiduciary remedies. If they do, they might achieve "a more sustainable legal regime for challenging policy conflicts created by managed care" (p. 31).

After examining legal doctrine "at the boundary of tort and contract" for lay readers, Professor Jacobson fleshes out his reader's understanding of those sometimes-slippery concepts in the context of litigation against managed-care organizations. These entities, like the railroads and mass production of prior centuries, offer "something new" because they integrate health care financing with service delivery. He also does a crisp, workmanlike job exploring the nuances of a complex set of relationships among, and interests held by, the various current stakeholders in the health care enterprise (p. 218).

Strangers in the Night takes on the task of figuring out what the judicial and legislative responses to managed care actually mean to doctors and patients as two of these major stakeholders. According to Professor Jacobson, "[b]y not interfering with managed care's financial incentives, the courts have subordinated the physician-patient relationship to the dictates of the marketplace" (p. 2). The decided cases show that many, if not most, patients find it difficult, if not impossible, to hold MCOs themselves accountable for the quality of care they so prominently advertise and finance. Physicians have achieved no greater success in their attempts to challenge the MCO cost-containment policies that they allege compromise patient well-being, though one might well question the assertions of these stakeholders that quality of care has really been compromised in specific cases.⁴⁰ The author's general point that courts have not been particularly friendly to these lawsuits, in at least some small part because they fail to appreciate the complexities of modern health care delivery, rings true nonetheless.

40. See, e.g., *Wickline v. California*, 239 Cal. Rptr. 810 (Cal. Ct. App. 1986) (landmark non-ERISA case finding no negligence despite allegation that state Medicaid's cost-containment program compromised plaintiff's medical care).

Professor Jacobson finds this judicial deference to the power of managed care ironic, and offers the fiduciary-duty approach of the final part of his book as an alternative strategy for reconciling the tension between law and medicine in the era of managed (or “post-managed”) care. The unifying fiduciary concepts attempt to reconcile the individual patient’s “desires” for medical services with all patients’ “need” for care. The cost/quality dilemma again, but this time at a higher and better-informed level. The book revisits the torts/contracts debate permeating prior chapters, and concludes that “neither . . . is adequate for balancing resource allocation tradeoffs” (p. 4). Professor Jacobson acknowledges the “messiness” of his fairly amorphous fiduciary standard for resolving managed care disputes, but points out that its elastic contours are well-suited to the gradual emergence of judicial doctrine.

Professor Jacobson’s prescription for balancing the competing claims of individual patients and societal groups to health care resources by applying fiduciary concepts is a creative but complicated halfway measure. Regrettably, it would probably require intensive judicial oversight at the outset until well-recognized standards develop. While Jacobson believes courts are up to that task, he may be overly optimistic about the enthusiasm of the judiciary for becoming deeply embroiled in mixed questions of economics and medicine on a regular basis. Nonetheless, he believes that “policymakers need not choose between polarized options of unfettered physician autonomy . . . versus strict cost containment” (p. 1). Instead, they can utilize his fiduciary approach to “maintain . . . managed care’s ability to control costs, but in a way that is far more deferential to physician autonomy and restores the primacy of the physician-patient relationship” (p. 1).

That certainly sounds like motherhood and apple pie to the medical profession, but the author then sets about explaining why the rest of us shouldn’t consider it just another slice of pie-in-the-sky. His analyses of the nature of the medical and legal professions and the differences between them are on point, and help to explain why they have not done a better job of working together on better resolving managed care issues (pp. 9-17). The section on ‘shared values’ is somewhat less successful and a bit strained in parts (pp. 17-22). For example, his sixth “shared value,” that both doctors and lawyers are solely responsible for the quality of services they provide (p. 22), is simply not so. The whole point of many patient lawsuits against MCOs is the allegation that MCOs can be equally responsible with doctors or even solely responsible for the poor quality of care some subscriber/patients receive.⁴¹

41. See *id.*

Professor Jacobson fails to take account of one of the biggest reasons for the managed-care industry's increased scrutiny of physician decisionmaking: doctors deliver a service that is by and large subsidized by third parties (employers and the government) who take a keen interest in ensuring that providers deliver value for money. Doctors complain about disproportionate oversight, especially as compared with lawyers, but they fail to appreciate that their patients' normal incentives to economize on purchasing medical services have been blunted by third-party coverage. On balance, however, Professor Jacobson mounts a good argument for the professions to reconcile their remaining differences and help policymakers assist them to get on with the task of delivering a reasonable quality of care to patients writ large at a reasonable cost.

Strangers in the Night could be influential in further judicial evolution of the law related to managed care, whether or not Congress ever enacts a managed-care patients' bill of rights or the Supreme Court ever resolves the ERISA issue in all its complexities. For everyone seeking to understand how we got ourselves into our present — and seemingly endless — difficulties with managed care, and for anyone interested in seeking a way for us to get out of them short of restructuring the whole health sector, this book can serve as a useful and important roadmap. Whether doctors and lawyers can work together to help “make things better”⁴² is still an open question.

42. Senator Claude Pepper often used that phrase to describe what we all should be doing to advance the interests of society. See, e.g., Speech, Jan. 1, 1950, available at Claude Pepper Library, http://pepper.cpb.fsu.edu/dbtw-wpd/exec/dbtwpub.dll?AC=GET_RECORD&XC=/dbtw-wpd/exec/dbtwpub.dll&BU=http%3A%2F%2Fpepper.cpb.fsu.edu%2Fpolaris%2Fspeeches.htm&TN=203&SN=AUTO4600&SE=2883&RN=0&MR=50&TR=0&TX=1000&ES=1&CS=1&XP=&RF=Sort+by+Folder&EF=&DF=View+Full+Record&RL=1&EL=0&DL=0&NP=3&ID=&MF=WPepperMsg.ini&MQ=&TI=0&DT=&ST=0&IR=2774&NR=0&NB=0&SV=0&BG=0&FG=0&QS=.