Keynote Address: Patients' Rights without Health Rights

Sylvia Law
Symposium 2001

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Today I argue that rights are both tremendously important, particularly for vulnerable people, and, at the same time, often promise more than they deliver. Most of my talk examines the federal Patients’ Bill of Rights dispute that has dominated federal attention to health care since the defeat of the Clinton Health Security proposal in 1993. While this legislation is vitally important, patients’ rights bills in the Congress—even in their most patient protective Democratic form—do little to address the core problems of access to, quality of, or costs of health services. The restrictive form of the federal “patients’ rights” legislation, promoted by the White House and adopted by the House in August 2001, would actually restrict patients’ rights in important ways. The second part of my talk considers some innovative approaches to promoting health, particularly for low-income people, women, and minorities. These positive models are less focused on rights, but nonetheless are unable to break out of the central importance of rights.

The week before the Fourth of July, 2001, Tom Daschle, flush with his new power as head of the Senate Democratic majority, announced that the Senate was not going home until it had passed the Patients’ Bill of Rights. Around the nation many families with Washington connections, including mine, worried whether our weekend would be sabotaged by patients’ rights. In the end, the Senate acted and we had a great holiday.

Patients’ rights were central items of dispute in the Presidential debates of 2000 and have been a source of major conflict between the Republican House and White House and the Democratic Senate. But even to a confirmed health policy wonk, the media and academic coverage of this...
dispute has been both incomprehensible and thin. Media coverage mostly focuses on whether particular actors are willing to compromise, whether the President will veto, and possible political advantages of passing or not passing a bill. But it does not tell us the content of the compromise.

Until August 1, 2001, Dr. Charles Norwood, a Georgia Republican and dentist, had been a leader in the bipartisan effort in support of the bill passed by the Senate. On July 28, George W. Bush offered an alternative that Norwood condemned as “complex, unworkable and unfair to patients.” A few days later, in a secret session, Norwood agreed to the Bush proposal he had so recently condemned.

What is an ordinary citizen to think about this discussion? The Henry J. Kaiser Family Foundation confirms my sense that Americans have trouble following the debate. Only seventeen percent of the public followed the issue closely, as opposed to, for example, the thirty-four percent who were closely attentive to the delay in the execution of Timothy McVeigh. Even more disturbing, only a quarter of those who said they followed the issue closely understood correctly that the federal law is about allowing patients to sue health insurance plans that behave irresponsibly. Another quarter of those who said they followed the issue closely believed, wrongly, that the federal law is about how much health plans can charge; and another eighteen percent thought, wrongly, that it protects the privacy of medical records.

So what is the federal Patients’ Bill of Rights? While I am critical of the emptiness of media and academic coverage of the bill, I am also empathetic. The problems that Congress seeks to address in the Patients’ Bill of Rights are incredibly dense. Therefore, I may be about to bore you, but I hope for a good cause.

These complex problems were created by Congress, with the help of the U.S. Supreme Court, through the Employment Retirement Security Act of 1974 (ERISA). Traditionally, states have been responsible for the regulation of insurance, including health insurance, through legislation, regulation, and state common law of tort and contract. In addition, states have been traditionally responsible for the regulation of medical care, through licensing of doctors, hospitals and other health care providers. Finally, and most importantly, states define what is unreasonably negligent behavior, though common law and statute. These bodies of state law are intricate and complex. States take divergent approaches to these common problems.

ERISA was adopted by Congress in 1975 to address the plight of workers denied expected pension benefits. Its central provisions require that employer-sponsored pension plans meet substantive federal standards. Congress also recognized employee welfare benefit plans, including employer-sponsored health insurance. But here, rather than providing
federal regulation, Congress, in § 514 of the Act, simply preempted all state laws that "relate to" employee benefit plans.

In addition to the general federal preemption of state law, § 502(a) of the Act allows a plan participant to bring a civil action "to recover benefits due to him under the terms of his plan or for breach of fiduciary duty." In 1987, the U.S. Supreme Court concluded that the federal civil enforcement provisions of § 502 are the exclusive vehicle for actions by ERISA plan participants asserting a claim for benefits.

The thick federal preemption of state law is not limited to "laws dealing with the subject matters covered by ERISA." For example, states long have recognized that insured people are vulnerable and insurance companies sometimes take advantage of them. Insurance companies too often denied benefits to which insured people were legitimately entitled and most insured people did not have the resources to fight back. Even if someone did protest, ordinary contract law would only give them the benefits to which they were entitled under the policy. States recognized that this legal regime encouraged insurance companies to deny benefits, hoping that people would not protest and knowing that, if they did, the company would only have to pay the benefits guaranteed by the contract. So states, as a matter of common law and statute, recognized that when an insurance company wrongfully denied benefits, the insured person could recover attorneys fees and scheduled or punitive damages, in addition to the contract payments that had wrongfully been denied.

In 1987, the Supreme Court interpreted ERISA to preempt state law remedies for wrongful denial of insurance. The Court acknowledged that federal law provided no remedy for egregiously wrongful insurance company practices, beyond payment of the benefits promised by the contract, and, at the same time, denied state power to address these problems.

In short, ERISA places employee benefit plans in a regulatory vacuum, outside of either federal or state legal regulation or social control. Why would Congress prohibit states from applying ordinary common law norms or special statutory insurance principles to employment based health insurance plans? If Congress preempts state authority, why doesn't Congress regulate? Because big business and big labor persuaded Congress that a state and federal regulatory vacuum would allow them to negotiate more fair and effective medical insurance plans than either the federal or state governments would mandate.

When ERISA was adopted, most Americans had coverage that allowed them free choice of providers at the time of care and that paid doctors and hospitals on a fairly open-ended fee for service or reasonable cost basis. In the 1980s, in an effort to hold down costs, managed care organizations began to require prior authorization for many treatments, restrict access to specialists, restrict the numbers of doctors and hospitals from whom people could obtain care, provide doctors with financial in-
centives to limit care, restrict coverage of prescription drugs, and impose limits on benefits.

The rise of managed care, when combined with the regulatory vacuum created by ERISA, has left tens of thousands of American patients without any redress for the death or injury they suffer when health management organizations (HMOs) wrongfully deny care. Consider Florence Corcoran, who was a long time employee of Bell Tell and became pregnant in 1989. During Mrs. Corcoran's first pregnancy, Dr. Collins had recommended hospitalization for the final weeks of pregnancy, and when the fetus went into distress, her baby was delivered by cesarean section. Her obstetrician, Dr. Jason Collins, recommended that she be placed in the hospital for the final months of her second pregnancy so that the fetus could be monitored. Dr. Collins communicated with the medical director of Bell explaining the factors that put Mrs. Corcoran at risk. Bell's medical director sought a second opinion from another obstetrician who said that Dr. Collins' recommendation was correct. Bell rejected the recommendations of both Dr. Collins and their own outside expert and denied approval for hospitalization. Mrs. Corcoran stayed in bed at home, and was attended to few hours a day by a visiting nurse. While the nurse was not there, the fetus went into distress and died.

Mrs. Corcoran filed a negligence claim in state court. But ERISA allowed Bell to remove her claim to federal court and to argue that her state claims were preempted by federal law. The Fifth Circuit Court of Appeals accepted that argument, finding that Bell's determination denying coverage for hospitalization was a "mixed medical and coverage decision" that "related to" the administration of an ERISA plan; hence, state law remedies were preempted. Further, the federal circuit court held that under the ERISA statute, the Corcorans could not obtain monetary damages for the emotional distress and mental anguish resulting from the loss of their baby.

In the past decade, dozens of federal court decisions have reached the same conclusions, holding ERISA to mean that patients who are insured through employment-based insurance have no remedy under either state or federal law when they suffer serious injury or death when HMOs deny care, however egregious the defendant's actions. But for ERISA, Mrs. Corcoran could have sued her HMO in state court, arguing that their actions (rejecting the recommendations of her doctor and their own expert) were unreasonable and caused her to lose her baby. Depending on the state, the trial judge, and perhaps the jury, she might have received substantial damages or nothing.

For example, in 2000, the Illinois Supreme Court held that the doctrine of institutional or corporate negligence allowed Shawndale Jones and her mother to hold their HMO accountable for institutional wrongdoing. Three-month-old Shawndale was feverish, constipated, and fussy. Her
mother called Dr. Jordon, the HMO doctor to whom she had been assigned. He returned the call several hours later and recommended castor oil. The next day Shawndale was doing worse, and her mother took her to the emergency room where she was diagnosed with meningitis. She is permanently disabled.

Investigation revealed that Dr. Jordon was designated as the primary care physician—and collected per captia payments—for 4,500 HMO members. The medical director of the defendant HMO conceded that under professional standards and the HMO's promotional promises this was far too many patients for one doctor. The court found the HMO negligent. Ms. Jones was able to sue only because she was insured through Medicaid and her claim was hence not preempted by ERISA. Because she was not subject to the ERISA preemption, she was able to collect realistic damage remedies for the serious permanent injuries that her daughter had suffered. In addition, her ability to sue helped to provide HMOs with incentives to exercise reasonable care in constructing insurance plans.

In another recent case, the Wisconsin Supreme Court allowed a claim for the common law tort of bad faith refusal to pay an insurance claim to proceed against Group Health Cooperative of Eau Claire. Thirteen-year-old Angela McEvoys suffered from anorexia. No one in the small group health plan had ever treated this condition. Her doctors recommended that she receive treatment at a special clinic at the University of Minnesota. The HMO approved six weeks of treatment and then refused to consider allowing more, despite the recommendations of all of her treating doctors. Rather the HMO urged the girl to join a newly-formed outpatient group therapy session for compulsive overeaters that met only once a week. When her weight fell from ninety-six pounds to seventy-four pounds in two months, her mother took her back to the University of Minnesota program and paid for her care out-of-pocket. Because Ms. McEvoys was a state employee, her claim was not preempted by ERISA, and she was able to sue for bad faith failure to pay an insurance claim. Like Ms. Jones in Chicago, Ms. McEvoys was able to collect fair damages for the injuries she and her daughter suffered and to hold the HMO accountable.

In the 1990s, growing voices protested the seeming injustice of ERISA's unusual regulatory immunity for managed care organizations. First, the federal courts, including the Supreme Court, began to find chinks in ERISA's armor of immunity to allow some form of accountability for employment based managed care insurance. Second, despite ERISA's broad preemption of state remedies, virtually all states adopted patients' rights bills, designed to allow insured people to hold managed care organizations accountable for unreasonable denials of coverage and care.

Federal courts' increased willingness to examine the sweep of ERISA's preemption of both state and federal remedies was infatuated by
a 1995 case, *New York State Blue Cross v. Travelers Insurance Co.* In *Travelers*, a unanimous Supreme Court held that New York’s comprehensive hospital cost rate regulation law did not “relate to” ERISA plans. Prior to this decision, lower federal courts had held that ERISA preempted innovative state programs designed both to constrain hospital costs and to provide enhanced reimbursement to hospitals that served a disproportionate number of people without insurance. The Supreme Court’s decision in *Travelers* signaled a new willingness to examine the regulatory vacuum created by ERISA’s § 514 prohibition on state regulation that “relates to” an ERISA plan.

In 2000, a unanimous Supreme Court held that federal law provides no remedy for an ERISA plan participant challenging “treatment decisions made by a health maintenance organization, acting through its physician employees.” On first blush this sounds like a loss for consumers and patients. But it is not so clear. Cynthia Herdrich had insurance with a physician-controlled HMO. Herdrich experienced acute pain and consulted her HMO doctor, Lori Pegram. Dr. Pegram found an eight inch inflamed mass in her abdomen. The doctor decided that Herdrich needed an ultrasound diagnostic test, but that she could wait for eight days to have the test done at a facility fifty miles away controlled by the HMO. While waiting for her test, her appendix burst, causing peritonitis. Herdrich was understandably angry. She sued Dr. Pegram in state court for medical malpractice and won a verdict of $35,000.

In all these cases in which managed care organizations press doctors to deny or delay medically necessary care, the patient can sue the doctor in state court for medical malpractice. If the doctor violates professional medical standards, he or she can be held liable even if the managed care organization refuses to cover necessary care. So, for example, despite ERISA, Florence Corcoran could have sued Dr. Collins for not refusing to discharge her from the hospital, despite the HMO’s determination that the bill would not be paid. For understandable reasons, Mrs. Corcoran was not eager to sue Dr. Collins who had worked so hard to obtain coverage for the care he believed that she needed. The fact that doctors remain subject to state malpractice claims if they fail to provide recommended care when the HMO refuses to pay has led the American Medical Association to join forces with consumers in seeking reform of ERISA.

Cynthia Herdrich was less sympathetic to her doctor. Dr. Pegram, who decided that despite the inflamed abdominal mass, Herdrich could wait eight days for an ultrasound, was also a co-owner of the managed care organization and could increase her year-end bonus by limiting testing. Herdrich sought to hold the managed care organization accountable for negligence and fraud. Under ERISA, the HMO successfully argued that state claims against it were preempted, removed to federal court, and forced Herdrich to formulate a claim for breach of fiduciary duty under
ERISA's § 502. The Seventh Circuit held that a federal claim for breach of fiduciary duty can be stated "where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses."

A unanimous Supreme Court reversed. Justice Souter, writing for the Court, observed that managed care organizations always "take steps to control costs," and that Congress has expressed a policy judgment favoring managed care organizations. ERISA plans as fiduciaries are odd in that they always have conflicts between saving money and providing care. While the Court rejected Ms. Herdrich's effort to hold the HMO liable on a federal claim for breach of fiduciary duty, it also seemed to acknowledge that a state law claim for negligence, malpractice and vicarious liability would not be preempted by ERISA. The Court said:

[The defense of any HMO [to a federal claim of breach of fiduciary duty] would be that its physician did not act out of financial interest but for good medical reasons, the plausibility of which would require reference to standards of reasonable and customary medical practice in like circumstances. That, of course, is the traditional standard of the common law. . . . Thus, for all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians.

What would be the value to the plan participant of having this kind of ERISA fiduciary action? It would simply apply the law already available in state courts and federal diversity actions today. (emphasis added)

Now, it would of course come as news to Ms. Corcoran that she had a cause of action, in negligence in state court against the HMO that made a mixed eligibility/medical necessity decision, refusing the hospitalization recommended by her physician and leading to the unnecessary loss of her baby, and that such a claim was not preempted by ERISA. In denying the federal claim for breach of fiduciary duty, the Supreme Court in *Pegram* affirms the availability of state negligence law to test the reasonableness of mixed medical and eligibility decisions made by ERISA plans. Finally, the *Pegram* court says, "*Travelers* throws some cold water on the preemption theory; there, we held that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose."

Lower federal courts have disagreed about the sweep of the *Pegram* dicta. On the one hand, the Fifth Circuit (author of the *Corcoran* decision) reads the Supreme Court decision narrowly to hold that while ERISA does not preempt state negligence claims against physicians making treatment decisions, it does preempt state laws creating a system of independent review of HMO denials of care on grounds of lack of medical ne-
cessity. By contrast, the Seventh Circuit has read Pegram to say that state laws mandating external review of ERISA plan determinations of medical necessity are not preempted by the federal law. The Supreme Court has agreed to hear an appeal from the Seventh Circuit to resolve this conflict in the federal circuits.

Thus, in considering the federal Patients’ Bill of Rights, Congress acts against a background of considerable uncertainty about the Supreme Court’s current understanding of the sweep of the ERISA preemption. If the central purpose of the Patients’ Bill of Rights is to provide a remedy to people like Mrs. Corcoran who are wrongfully denied necessary care, it is possible that the Supreme Court, in its unanimous Pegram decision, has already solved the problem by holding that where the federal ERISA law provides no remedy, ordinary state negligence law controls.

The picture is further complicated by the fact that in the past decade virtually all states have adopted state patients’ rights bills. For example, forty states and the District of Columbia have established “external review” systems, where consumers can appeal certain health plan denials to independent experts. These laws provide consumers remedies when managed care organizations act unreasonably. Early experience shows that the independent review overturns or modifies plan decisions denying care in over half the claims presented. In addition, the threat of independent review seems to inspire HMOs to act more reasonably. But the big question that remains is whether and when these state efforts are preempted by ERISA.

The core dispute in the federal patients’ rights debate is about whether and how plan beneficiaries can hold managed care organizations accountable for unreasonable behavior. Can Mrs. Corcoran recover for the loss of her baby, or at least have a shot at proving that the managed care organization acted unreasonably? And, secondary to this, can states that have traditionally regulated negligence, health care, and insurance continue to do so?

The Senate and House bills have much in common. Each would allow patients to sue health plans in state court to challenge decisions involving medical judgment. Both bills would require creation of a system of independent external review of HMO decisions about medical necessity and would require that these administrative remedies be exhausted before filing suit. With respect to plan decisions about eligibility or coverage not involving issues of medical judgment, both bills allow plan defendants to insist that claims be heard in federal court.

Nonetheless, there are important differences between the Senate and House bills. First, the Senate would establish minimum standards for independent review organizations, but would allow states to go further in assuring that external review was informed, unbiased, and fair. By contrast, the House would override or preempt state rules governing internal and
external appeals. Second, under the House bill, if an independent review panel upholds a plan’s decision to deny a claim for benefits, the burden of proof would be on the enrollee to demonstrate through “clear and convincing evidence” that the plan did not exercise “ordinary care” in making its decision. Under the Senate’s bill, the burden of proof would be governed by state law and in most states the common burden in civil lawsuits requires that the enrollee show that it is “more likely than not” that the plan’s negligence caused the harm, i.e. the traditional preponderance of the evidence standard. Third, the Senate bill would allow states to follow their own traditional rules with respect to damages, including damages for pain and suffering and punitive damages. By contrast, the House bill places a cap of $1.5 million on damages for pain and suffering. Finally, and most importantly, under the Senate bill, a plaintiff must show that a health plan was negligent and that such negligence was “a proximate cause” of personal injury or death. By contrast, the House bill requires that a plaintiff show that the insurer’s negligence was “the proximate cause” of injury or death. The difference between “a” cause and “the” cause is big. By definition, these people are ill and their underlying condition is partially a cause of their injury.

So, in sum, the Republican version of the so-called Patients’ Bill of Rights, far from protecting patients’ rights, takes them away. In *Pegram*, the Court seems to allow patients to sue in state court, with the full range of traditional state remedies and ordinary standards of negligence and causation. The House bill reverses the Supreme Court and reasserts HMOs’ bubble of immunity for wrongdoing. Further, despite their traditional embrace of states’ rights, the Republican version of the bill would repeal state sponsored independent review programs that seem to be working well. Governors around the United States are expressing their dismay that the Republican House and White House would thwart state efforts to protect patients’ rights.

The Democratic version of the bill is better, but even it addresses only a very small subset of the concerns that fall within any reasonable concept of patients’ rights. In 1999, 15.5% of the U.S. population had no health insurance. The numbers of Americans without insurance grew enormously through the 1990s, even as the nation witnessed one of the greatest periods of sustained economic growth and creation of wealth it ever has experienced. And access is not simply a problem of insurance coverage. People in rural and poor communities lack medical services. Even for people with insurance, the Institute of Medicine has documented that the quality of care provided is often needlessly and appallingly low. Finally, after a period of cost stabilization in the 1990s, inflation in health care costs is taking off, hitting workers, hospitals and employers with enormous costs. The so-called Patients’ Bill of Rights does nothing to address these serious problems.
In addition, the doctor-patient relationship, the key to quality and access, is influenced by unexamined issues of race and gender. Mrs. Corcoran's compellingly sympathetic claim has become a centerpiece in the drive to adopt the federal Patients' Bill of Rights because Dr. Collins fought the managed care organization to get her the treatment he thought was necessary. For the most part, doctors, not managed care organizations, determine the care that we get.

Wholly apart from financial incentives, medical care is organized to allow and promote discrimination on the basis of race, gender, disability, and class. For example, epidemiological studies long have identified differences according to race and sex in the treatment of patients with cardiovascular disease in the United States. However, researchers have speculated that these differences might be explained by financial and organizational barriers to care, clinical differences among patients, or preferences of the patients. Further, it is widely understood that excess demand for hospital and other high technology services creates multiple internal queues for services. Doctors with the professional stature and political skills to push their patients to the head of the queue will do so on behalf of patients to whom they feel most committed. Patients who are privileged by reason of class, education, gender, race, and long-standing relations with high status doctors benefit from this arrangement, while those who are less privileged and have more casual relations with their doctors suffer.

In addition to these pervasive structural biases in the construction of doctor-patient relations, doctors, like all people, are sometimes influenced by considerations of race, gender, disability, and class. In 1999, the New England Journal of Medicine published an important new study offering strong evidence that physicians are influenced by race and gender in making recommendations for tests and treatment for patients complaining of chest pain. The researchers developed a computerized survey to assess physicians' recommendations for managing chest pain. Actors portrayed patients with particular characteristics in scripted interviews about their symptoms. The researchers constructed 144 descriptions using all possible combinations of experimental factors: race, sex, age, level of coronary risk, type of chest pain, and results of a stress test. In addition, each description included the same results of electrocardiography. The patient/actors were all dressed in identical hospital gowns and followed a text scripted for words, affect, and hand motion, and were described as having comparable insurance. The survey was administered to 720 physician volunteers at two national meetings of organizations of primary care physicians.

The study found that "the race and sex of the patient affected the physicians' decisions about whether to refer patients with chest pain for cardiac catheterization." White men were most likely to be referred for
testing. Black women—who presented physiologically identical symptoms—were strikingly less likely to be referred. The authors comment on their data, saying:

Our finding that the race and sex of the patient influence the recommendations of physicians independently of other factors may suggest bias on the part of the physicians. However, our study could not assess the form of bias. Bias may represent overt prejudice on the part of physicians or more likely could be the result of subconscious perceptions rather than deliberate actions or thoughts.

The relevance of this distinction between “overt prejudice” and “subconscious perceptions” is not obvious. Certainly the black women who suffer disability or death because their physicians do not treat them as aggressively as they treat white men with exactly the same symptoms are unlikely to be comforted by the knowledge that the doctor acted out of “subconscious perceptions” rather than “overt bias.” Nonetheless, the study documenting the fact that race and gender influence doctors’ recommendations—even when everything else is carefully controlled—precipitated a sharply defensive reaction from the medical profession. It is probably impossible to mobilize rights to address the problems of racial and gender disparity in discretionary physician referral decisions. State malpractice norms are unlikely to provide help. Lower intensity care provided to a particular patient can typically be defended as consistent with some widely accepted standard of care. Title VI of the Civil Rights Act of 1964 bars discrimination based on race by all who receive federal financial assistance. The federal Civil Rights Commission ruled that facially neutral policies with a racially disparate impact violate Title VI, if the disparate impact cannot be explained by some reason other than racial animus.

However, Title VI is not likely to provide an effective legal remedy for the racial and gender disparities documented in the New England Journal of Medicine study for three reasons. First, it has never been clear that Title VI’s prohibition against racial discrimination extends to physicians. Second, in 2001, the Supreme Court held 5-4 that Congress had not authorized the federal civil rights agencies to create a private right of action to challenge practices that are racially discriminatory in effect. Third, and most important, even though the federal government and private insurance organizations gather massive amounts of standardized data about treatment and costs, they have chosen to avoid collecting information about race in the utilization of health care services.

Thus, there are no realistic rights-based remedies against physician referral practices that differentiate on the basis of race and gender. But it seems that physicians might be educated to be more sensitive to these issues. The New England Journal of Medicine study produced such a con-
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troversy precisely because decent Americans do not like to think of ourselves as racist or sexist, even on a subconscious level. Dr. John Wennberg and his colleagues have demonstrated that knowledge can change attitude and behavior. For two decades, Wennberg has gathered data on variations in medical treatment in seemingly similar communities and used that information to persuade clinicians to reconsider accepted practice patterns.

Is it naive to think that a similar process could be instituted in relation to racial and gender differentiation in referral patterns? Certainly information is important and that is precisely why the study was so controversial. A broader data base would be tremendously useful. But, more generally, the culture of medical care—particularly in the age of managed care—is not geared to pay attention to patients’ needs, especially across divides of race, class, and gender difference.

Let me finally explore one practical innovation to address these problems. Since the 1960s some of the most high quality, cost-effective, and patient responsive health services in the United States have been provided by neighborhood health centers that integrate medical and social services for vulnerable people. At the heart of the neighborhood health center movement is a recognition that access to food, housing, and child care is often as essential to health as medical care; and that social workers, community organizers, and lawyers are vital in obtaining these social services. Many of these neighborhood health center programs still flourish, but many have died, largely as a consequence of cuts in federal funding. In 1993, Dr. Barry Zuckerman, Chair of the Department of Pediatrics at Boston Medical Center, created a new model. The Family Advocacy Program (“FAP”) was born as a result of doctors’ frustrations with their inability to address the social and legal problems that contributed to the medical problems of their patients. The Boston Medical Center sees more poor people than any other hospital in Massachusetts. The program began with one attorney representing children and families seen in the hospital’s pediatric services, helping clients on issues of public benefits, family law, housing, special education, domestic violence, and immigration. It was funded by private foundations. The hospital provided an office, referrals, and support services, and local legal services provided back-up advice on specialized problems. The attorney trained hospital staff on laws that impact children’s health and these trainings were incorporated into the pediatric residency program. The program grew and now employs three lawyers and seven law students. Students attend weekly hospital rounds and clinical case conferences.

The interaction between legal and medical professionals helps to identify significant issues that might otherwise be ignored. FAP has created a network of pediatricians, nurses, and other pediatric health care clinicians who played a key role in persuading Massachusetts to pass a
progressive version of the federal Child Health Insurance Program. It developed an Asthma Initiative to address the link between poor housing conditions and asthma. Based on their experiences advocating for patients referred by their physicians, FAP lawyers have published thoughtful articles providing concrete advice on representing clients with problems with immigration, domestic violence, and welfare.

The FAP attorneys are employees of the hospital, though its organizers recognize that a local legal services program, or even a law school clinic, could employ such people. They urge that it is important that the lawyers be located in the hospital in order to allow doctors and lawyers to form collegial relations and to facilitate referrals. The fact that the lawyer is located in and employed by the hospital necessarily means that the lawyer will not sue the hospital or doctors, even if he or she observes substandard care or bias. Nonetheless, doctors and lawyers working collaboratively and proactively to develop holistic approaches to meet the needs of patients and clients appears to be highly effective. It incorporates many of the concepts that animated the earlier neighborhood health center movement and brings them into the mainstream of a large urban hospital.

The Massachusetts FAP has served as a model for others and similar programs have been initiated in Hartford, Connecticut, and Rochester, New York. Next year one of my favorite NYU law graduates of 2002 will create a similar program in Cleveland with the help of a Skadden Fellowship. Let a thousand flowers bloom.

**Relevant Sources**


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