

## **Health Law: A Constitution-Free Zone**

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Prof. Jost and Dr. Noll do an admirable job surveying a broad range of legal and regulatory issues relating to health care finance and delivery. I especially admire Noll's explanation of the inherent procedural burdens of traditional regulation, and Jost's thoughtful analysis of "federalism" issues. (Federalism is the under-developed topic in health law that explores the proper allocation of responsibilities between state and federal governments.) Because I agree with most of what Prof. Jost and much of what Dr. Noll say, I won't bore the audience with repeating the points of agreement or waste its time nit-picking on the points of disagreement.<sup>1</sup> Instead, I'll talk about a different set of legal issues that Jost and Noll do not develop: the constitutionality of health laws.<sup>2</sup>

I have good news for health policy reformers: health care finance and delivery is largely a constitution-free zone, meaning that, so far as the federal U.S. Constitution is concerned, lawmakers are free to do just about anything they want. Considering that some many other aspects of health law are problematic or dysfunctional, it is something to celebrate that the Constitution lets us go about doing what needs to be done. As the saying goes, either lead or get out of the way. The Constitution says nothing about health and so purports to lead nowhere. As constitutional lawyers put it, our Bill of Rights is a charter of negative, not positive, liberties, meaning that the government constitutionally owes us nothing as long as it leaves us alone.<sup>3</sup> Appropriately, then, constitutional law permits legislators, regulators, and courts to do (for the most part) what they think is best. (The major exception, noted below, is for state constitutions, which sometimes are more restrictive.)

Without turning this short comment into a constitutional treatise, it is necessary to summarize some basic constitutional doctrine for non-legal readers. In the early part of the last century, the

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<sup>1</sup> Except in footnotes, that is. Mostly, Prof. Jost focuses on legislative and regulatory law, rather than on judicial law. Other scholars have raised concerns that courts are likely to block health care reforms with legal attitudes adapted to the status quo Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. Pa. L. Rev. 431 (1988), but, fortunately, these concerns have so far proven largely unfounded, Peter Jacobson, *Strangers in the Night: Law and Medicine in the Managed Care Era* (2002). See generally William M. Sage, *Unfinished Business: How Litigation Relates to Health Care Regulation*, 28 J. Health Pol. Pol'y & L. 387, 399 (2003).

Dr. Noll focuses on traditional "command and control" regulation, to the neglect of alternative modes of regulation such as those that are market-facilitating rather than market-displacing. Compare, e.g., Kristin Madison, *Health Care Quality Regulation in an Information Age*, 40 U.C. DAVIS L. REV. 1577 (2007); Louise G. Trubek, *New Governance and Soft Law in Health Care Reform*, 3 Ind. Health L. Rev. 139 (2006).

<sup>2</sup> Noll refers to constitutional issues in passing, but they are only questions of procedural due process or delegation of legislative authority, which are easily-enough fixed, at least conceptually. This comment, in contrast, considers mainly issues of substantive constitutional rights.

<sup>3</sup> *Wideman v. Shallowford Community Hospital*, 826 F.2d 1030 (11th Cir. 1987); *DeShaney v. Winnebago County Department of Social Services*, 489 U.S. 189 (1989). See generally Orly Lobel, *The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought*, 89 Minn. L. Rev. 342 (2004).

Supreme Court took an “activist” approach to reviewing the constitutional validity of state economic and social regulation under the due process clause. In *Lochner v. New York*, 198 U.S. 45 (1905), the Court struck down a state’s regulation of maximum work hours as a violation of the fundamental right to contract. However, the onslaught of programs in the late 1930s designed to ameliorate the Depression caused the Court to retreat by substituting a more deferential, rational basis, standard of review of state economic regulation. Thereafter, the *Lochner* era of “substantive” or “economic” due process was thoroughly repudiated as a valid form of judicial review for most social regulation. It survived only for legislation that affects special categories of “fundamental” interests or liberties.

Health laws can also be challenged under the equal protection clause, since they inevitably draw lines or distinctions between permitted and impermissible activities or actors. Any such class-based legislation will be reviewed under one of three standards: (1) suspect classifications (those based on race, for example, or those that intrude on other fundamental rights) will be subjected to strict scrutiny; (2) quasi-suspect classifications (such as gender) will receive intermediate scrutiny; and (3) all other legislative classifications will be reviewed under the rational basis standard. Because most health law falls within this last, broad generic category of social and economic legislation, they usually receive only light constitutional scrutiny. States, may, for instance, draw fine and contentious distinctions such as funding some abortions but not others, or permitting palliative care for a patient who refuses life-support at the same time that the state criminalizes physician-assisted suicide.

Courts have been especially deferential to a state’s power to protect public health. They have upheld states’ public health actions so long as they are not “arbitrary” or “unreasonable” or “unnecessary” to protect public health. Thus, for instance, courts have upheld the constitutionality of every form of professional and facility licensure -- from banning alternative practitioners to barring inefficient facilities.<sup>4</sup> Other, everyday health laws that have passed constitutional muster include those that require autopsies, that allow the removal of corneas for transplantation, and, most dramatically, that redefine the very essence of death, and therefore life.<sup>5</sup> Despite their obvious and sometimes profound impact on individual liberties, they require no extraordinary justification under prevailing constitutional analysis.

Most health care regulation is easily justified because the Constitution has no general protection for individuals’ “pursuit of health,” or their freedom to make medical decisions as they wish. For a time, there was thought that *Roe v. Wade*, 410 U.S. 113 (1973), could expand into a more generalized constitutional protection of privacy in medical decisionmaking, because that decision stressed the freedom of doctors and patients to exercise medical judgment without state interference when fetuses are non-viable. Subsequent abortion decisions, however, have phrased the protected right solely in terms of the woman’s individual interest in avoiding procreation.

Instead of a sweeping right to pursue health, “fundamental rights” under current doctrine are limited to bodily integrity (that is, refusing unwanted treatment, e.g., *v. Cruzan v. Director*,

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<sup>4</sup> *Williamson v. Lee Optical of Oklahoma*, 348 U.S. 483, 485 (1955); *UNITED STATES v. RUTHERFORD*, 442 U.S. 544 (1979); *Sherman v. Cryns*, 786 N.E.2d 139 (Ill. 2003); *Mitchell v. Clayton*, 995 F.2d 772, 775-776 (7th Cir. 1993); *Albany Surgical, P.C. v. Georgia Dept. of Community Health*, 602 S.E.2d 648 (Ga. 2004).

<sup>5</sup> *State v. Powell*, 497 So. 2d 1188 (Fla. 1986); *State v. Schaffer*, 574 P.2d 205 (1977).

Missouri Department of Health, 497 U.S. 261 (1990)), and certain specially-protected “privacy” arenas such as procreation and parenting.<sup>6</sup> Also, persons subjected to state confinement have special constitutional protections,<sup>7</sup> and health laws can implicate the First Amendment right to the free exercise of religion, the Fourth Amendment right to be free from unreasonable searches and seizures, and the right to “just compensation” if the government takes private property. Despite this tapestry of protected arenas, coercive health laws that impinge these freedoms are often justified because they serve a compelling public interest and are narrowly tailored to meet that interest.

Accordingly, courts have repeatedly upheld invasions of these strong substantive protections in order to promote either individual or public health. With appropriate safeguards, the government may, for instance, require small pox vaccinations (despite the inevitable risks), commit psychiatric patients to forced treatment, force-feed comatose patients who have not clearly refused such treatment, quarantine people with infectious disease, or intervene surgically to save a full-term fetus.<sup>8</sup> In each instance, the justifications and analyses differ, and there are limits to what the government can require, but these precedents are notable for their breadth and permissiveness.

Legislatures also gain considerable constitutional leeway when they condition government spending or privileges on obeying health policy requirements. Therefore, laws that might not be upheld standing alone are easily upheld if they are imposed as qualifications for receiving optional government benefits. On this basis, for instance, the federal government requires hospitals to treat emergency patients for free and it once forbade Planned Parenthood from discussing abortions,<sup>9</sup> there are no constitutional issues created by setting Medicare rates too low,<sup>10</sup> and states can require doctors to accept Medicaid patients at reduced rates.<sup>11</sup>

Some conservative or libertarian justices and constitutional scholars call for fundamental change to this conventional constitutional regime. They would revive some version of the economic or substantive due process approach of the *Lochner* era by expanding the range of fundamental interests or tightening the justifications for restrictions of individual liberty. For instance, a panel of the D.C. Circuit sent shock waves through the health policy establishment with its 2006 decision in *Abigail Alliance v. Eschenbach*, 445 F.3d 470 (D.C. Cir. 2006), holding that the FDA must make experimental drugs more readily available to terminally ill patients for whom there

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<sup>6</sup> E.g., *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992). In *Washington v. Glucksberg*, 521 U.S. 702 (1997), the Court explained that, “in addition to the specific freedoms protected by the Bill of Rights, the “liberty” specially protected by the due process clause includes the rights to marry, to have children, to direct the education and upbringing of one’s children, to marital privacy, to use contraception, to bodily integrity, and to abortion. We have also assumed, and strongly suggested, that the due process clause protects the traditional right to refuse unwanted lifesaving medical treatment.”

<sup>7</sup> *O’Connor v. Donaldson*, 422 U.S. 563 (1975).

<sup>8</sup> *Jacobson v. Commonwealth Of Massachusetts*, 197 U.S. 11 (1905); *Washington v. Harper*, 494 U.S. 210 (1990); *Addington v. Texas*, 441 U.S. 418 (1979); *Pemberton*.

<sup>9</sup> *Burditt v. U.S. Department Of Health And Human Services*, 934 F.2d 1362 (5th Cir. 1991); *Rust v. Sullivan*, 500 U.S. 173 (1991).

<sup>10</sup> See *Nazareth Home of Franciscan Sisters v. Novello*, 7 N.Y.3d 538 (N.Y. 2006); *William Brewbaker, Health Care Price Controls and the Takings Clause*, 21 *Hastings Const. L. Q.* 669 (1994).

<sup>11</sup> *Dukakis v. Massachusetts Medical Society*, 815 F.2d 790 (1st Cir. 1987). *Downhour v. Somani*, 85 F.3d 261 (6th Cir. 1996).

are no other therapeutic options. Two of the three judges reasoned that seeking medical treatment that might save one's life is a fundamental right, the restriction of which was not adequately justified here. The full court reversed this decision a year later, but the original decision still reverberates.

Legal scholars have also noted the Canadian Supreme Court's 2005 decision striking down Quebec's ban on private health insurance that duplicates public coverage.<sup>12</sup> Using reasoning under the Quebec Charter of Human Rights and Freedoms that broadly tracks U.S. constitutional analysis under our Bill of Rights, the court reasoned similarly to the original *Abigail Alliance* decision that fundamental interests in pursuing health are at stake and that a sweeping ban on insurance is too broad.

Despite this noticeable undercurrent, substantial change in constitutional analysis of health care regulation is not likely to take hold in the U.S. any time soon. Only two of the court's thirteen judges adhered to the original decision in *Abigail Alliance*, and the Canadian court's scrutiny under Quebec's Charter is much more aggressive than what one would expect under the U.S. Constitution. As noted above, pursuing health has not been recognized as a fundamental right. Instead, U.S. courts are inclined to characterize asserted rights in extreme or technical ways that tend to defeat their being constitutionalized. For instance, *Washington v. Glucksberg*, 521 U.S. 702 (1997) characterized the right at issue as receiving assistance in committing suicide, rather than choosing a humane manner to die. Similarly, the full court in *Abigail Alliance* characterized the right at stake as access to investigational drugs rather than pursuing all available means to avoid death. Despite inevitable shifts in the political and social views of the federal judiciary, there is not likely to be any fundamental reversal in these basic attitudes favoring constitutional leeway to address pressing health policy concerns.

The primary risk that health reformers face is from state constitutions. They apply to state laws, in addition to any restrictions in the federal Constitution. State constitutions are written differently, and, just as important, their judiciaries are free to develop constitutional analysis differently. Therefore, patterns of decision and reasoning under the U.S. Constitution may not hold sway at all under state constitutional law.

A prime example is the great difficulty that many states have had in enacting medical malpractice reform statutes. Rather than view these as ordinary economic and social legislative subjection only to "rational basis" review, many states regard the right to seek compensation for personal injury as substantively protected by their constitutions, and therefore they subject malpractice reform statutes to heightened scrutiny. Accordingly, state courts have stricken a raft of these provisions. Several states, for instance, have struck down shortened statutes of limitations in their entirety, usually on grounds of equal protection, because they target only one type of tort action—medical malpractice.<sup>13</sup> Caps on damage have received the most constitutional scrutiny, with well over half the states having a supreme court decision on point, and half of these striking down the laws.<sup>14</sup>

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<sup>12</sup> *Chaoulli v. Quebec*, [2005] 1 S.C.R. 791.

<sup>13</sup> See, e.g., *Kenyon v. Hammer*, 688 P.2d 961 (Ariz. 1984); *Martin v. Richey*, 711 N.E.2d 1273 (Ind. 1999).

<sup>14</sup> Carly Kelly & Michelle Mello, *Are Medical Malpractice Damages Caps Unconstitutional?*, 33 J. L. Med. Ethics 515 (2005).

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The uncertain fate of health care reform laws in the states suggests an additional reason for uniform reform at the federal level. Despite this uncertainty, and regardless of which level of government takes the initiative, reformers of health care finance and delivery may be fairly confident that whatever measures they succeed in implementing will withstand constitutional challenge. With that potential worry set aside, it's now time to roll up our sleeves and get down to the hard work of deciding what options are feasible, sustainable, and least-worst.