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## FOREWORD: THE POLITICS OF HEALTH LAW: ANY TIPPING POINTS IN VIEW?

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**SYMPOSIUM: THE POLITICS OF  
HEALTH LAW**

**FOREWORD: THE POLITICS OF HEALTH  
LAW: ANY *TIPPING POINTS* IN VIEW?**

FRANCES H. MILLER\*

Malcolm Gladwell explored the way certain ideas and behaviors can proliferate “just like viruses do” once they achieve a critical mass in *The Tipping Point*,<sup>1</sup> his best-seller about the sorts of widespread and rapidly adopted social phenomena he labels epidemics. Gladwell’s subtitle, “How Little Things Can Make a Big Difference,” indicates that he thinks it need not take much to get one of these social epidemics rolling. He does believe, however, that three factors are essential: getting “people with a particular and rare set of social gifts” involved,<sup>2</sup> packaging the ideas so they are “irresistible” under the circumstances,<sup>3</sup> and making sure that both the right people and the right presentation can be deployed in the perfect

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1. MALCOLM GLADWELL, *THE TIPPING POINT: HOW LITTLE THINGS CAN MAKE A BIG DIFFERENCE* (2000).

2. *Id.* at 33 (the example he cites is the success of Paul Revere on his Midnight Ride).

3. *Id.* at 132 (his example is the stunning success of *Sesame Street* in helping children’s learning).

context for change.<sup>4</sup> That usually means inheriting or creating a situation where one can “tinker[ ] with the smallest details of the immediate environment” to unleash the idea’s potential for reaching a tipping point, and thus morph into an epidemic leading to change.<sup>5</sup>

As I thought about tying the six thought-provoking essays included in this Symposium on *The Politics of Health Law* together under some sort of unifying theme, Gladwell’s theories kept coming back to me. How would the issues these distinguished authors address—the *Schiavo* imbroglio, the constitutionality or criminality of palliative care, organ donation from minors, medical tourism and outsourcing, the way political ideology affects health care access, and pending federal legislation to expand individual insurance—fare when examined through the lens of Gladwell’s analytical theories? Are any of the health care issues explored in this Symposium heading for the kind of tipping point that might change the way society traditionally grapples with them? The more I thought about using this organizing theme for knitting these seemingly disparate essays together, the more I came to view the articles as sorting themselves onto a continuum moving away from a theoretical potential for tipping point status, depending on how many of Gladwell’s three conditions for epidemic status were present. Whether Tipping Point theory really has anything predictive to say about the future course of these issues I cannot say, but the exercise has been an interesting way to tease apart their differences.

Once a tipping point is reached, mere possibilities or exhortations for change can gain momentum and become transformed into full-blown new ways of handling problems. In extraordinary cases, unleashing “epidemic potential” can work paradigm shifts in the way people think and behave about health care issues. The famous health care tipping point that first leaps to mind concerns the radical transformation occasioned by the launch of Britain’s National Health Service.<sup>6</sup> After a century of tinkering with hospital reform on the local level, Big Bang health care change came almost all at

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4. *Id.* at 139-46 (here his case in point involved cleaning up New York City graffiti and broken windows to trigger the decline of violent crime during the 1990s).

5. *Id.* at 146.

6. See generally CHARLES WEBSTER, *THE NATIONAL HEALTH SERVICE: A POLITICAL HISTORY* (1998).

once to Britain when the central government officially assumed ownership of the nation's public hospitals on July 5, 1948.<sup>7</sup>

Radical structural reform was accomplished so swiftly and completely in Post-War Britain because many factors coalesced, including experience during the government's unavoidable takeover of hospitals while hostilities were continuing. But once peacetime came, the efforts of just one man, Labour's politically adroit and extraordinarily persuasive Minister of Health, Aneurin Bevan, were key to public and political acceptance of fundamental structural change.<sup>8</sup> By way of contrast, the Clinton Health Care reforms went down to defeat in flames in the mid-1990s, despite a charismatic and persuasive national leader elected at least in part on his pledge to reform our health insurance system, primarily because they were presented in a complicated form and dialogue that amounted to the antithesis of irresistible packaging.<sup>9</sup>

A more successful example of American Tipping Point behavior concerns the transformation of the Veterans Administration hospital network from the scorned stepchild of U.S. hospital systems<sup>10</sup> into an institution delivering "top-notch healthcare"<sup>11</sup> in little more than a decade.<sup>12</sup> An energetic and persuasive Under Secretary for Health, Kenneth Kizer, led the transformation beginning in the mid-1990s with publication of a vision statement<sup>13</sup> and a roadmap for accomplishing reform.<sup>14</sup> But the factor that made transformation irresistible was that Kizer managed to convince everyone concerned that the system either had to change or die. The VA's 200,000 employees came to understand that their jobs were at

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7. See generally GEOFFREY RIVETT, *THE DEVELOPMENT OF THE LONDON HOSPITAL SYSTEM 1823-1982* (1986).

8. *Id.* at 264-78.

9. Daniel Yankelovich, *The Debate That Wasn't: The Public and the Clinton Plan*, *HEALTH AFF.*, Spring 1995, at 7, 7-23.

10. For a negative portrayal of VA health care, see the Oscar-winning movie *BORN ON THE FOURTH OF JULY* (Universal Studios 1989).

11. Christopher J. Gearon, *Military Might: Today's VA Hospitals are Models of Top-Notch Care*, *U.S. NEWS & WORLD REP.*, July 18, 2005, at 100-06 (appearing as part of the annual special report, *America's Best Hospitals*).

12. Jonathan B. Perlin, Guest Editorial, *Transformation of the U.S. Veterans Health Administration*, 1 *HEALTH ECON. POL. & L.* 99 (2006); Gilbert M. Gaul, *Revamped Veterans' Health Care Now a Model*, *WASH. POST*, Aug. 22, 2005, at A1, available at 2005 WLNR 13195602 (Westlaw).

13. KENNETH KIZER, *VISION FOR CHANGE: A PLAN TO RESTRUCTURE THE VETERANS HEALTH ADMINISTRATION* (1995).

14. KENNETH KIZER, *PRESCRIPTION FOR CHANGE: THE GUIDING PRINCIPLES AND STRATEGIC OBJECTIVES UNDERLYING THE TRANSFORMATION OF THE VETERANS HEALTHCARE SYSTEM* (1996).

stake if, for example, they did not facilitate a switch to electronic medical records. Electronic records in turn permitted performance measurement and systems improvement. Little changes like that were the key to massive progress for the whole enterprise. All three of Gladwell's essential factors coalesced to constitute the tipping point that set the VA improvement epidemic in motion.

Among these Symposium articles, my most plausible candidate for Tipping Point status in the foreseeable future is examined in Professor Kathy L. Cerminara's *Collateral Damage: The Aftermath of the Political Culture Wars in Schiavo*.<sup>15</sup> Professor Cerminara delves deeply into the dismaying facts surrounding the politically postponed death of Terri Schiavo as "an example of a more general politicization of bioethics."<sup>16</sup> In so doing, she illuminates how very strongly the majority of the American public reacted against outsider and government intrusion into what it regards as the intensely personal dying process. Cerminara describes the near-incredible saga of the *Schiavo* case as it made its tortuous journey through state and federal courts and legislatures, ultimately attracting the official involvement<sup>17</sup> of both a governor and a sitting President.<sup>18</sup> The full impact of what transpired on the route toward obtaining the release this powerless woman sought from a sadly diminished life makes for chilling reading indeed.<sup>19</sup>

Professor Cerminara then probes the aftermath of *Schiavo* to see what lessons can be drawn from its tragic facts for individuals, for "the tone and pattern of end-of-life decisions,"<sup>20</sup> for bioethics, and about our "constitutional republican form of government."<sup>21</sup> Her exploration of these issues leads her to conclude that because of the *Schiavo* case's very high visibility in the media, "it heightened citizens' awareness"<sup>22</sup> of the possibility that a person's end-of-life wishes can be politically thwarted, and by outsiders at that. It thus propelled the right-to-die issue into public consciousness in a

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15. See Kathy L. Cerminara, *Collateral Damage: The Aftermath of the Political Culture Wars in Schiavo*, 29 W. NEW ENG. L. REV. 279 (2007).

16. *Id.* at 289.

17. The majority of the American public viewed this as meddling, not mere "involvement."

18. That these men happened to be brothers is not unrelated [pun intended].

19. This essay takes as a given that, as her husband maintained and as every court which examined the facts found, Terri Schiavo would not have wanted to continue living under the circumstances of her irreversible medical condition.

20. Cerminara, *supra* note 16, at 289.

21. *Id.*

22. *Id.* at 307.

way that might make political interference in such inherently private decisions far less likely in the future.

If we apply Gladwell's criteria to the *Schiavo* situation, Terri Schiavo's unsought celebrity—the ubiquity of her picture in the media for months on end as the drama played out—transformed her into a mute but highly effective spokeswoman for others sharing her sad predicament. The fact that she could *not* speak for herself was the very thing that made her so charismatic as a poster child for personal autonomy, the right to choose to let life go at the point where we are most helpless to accomplish it on our own. Secondly, members of the public could identify easily with the plight of an attractive young woman plunged suddenly into a physical and mental limbo where she could no longer speak, hear, think, feel, or rebel. Most people identifying with her condition believed that had they been in the same situation they, too, would have chosen “death as a management option.”<sup>23</sup> In other words, the right-to-die dilemma emblazoned itself onto public consciousness in a framework that made its intellectual and emotional appeal very hard to resist.

Finally, the context in which these end-of-life decision points arise is usually below the public radar screen—notwithstanding Terri Schiavo's very public travails—and the case itself made clear that the future prospects of successful interference in a death that it can at least be reasonably inferred a patient would want under the circumstances, are exceedingly slim. This, and the fact that death-and-dying situations ordinarily arise in highly private circumstances, make it less likely that such a public travesty will play out again in the near future. In this case, tipping point analysis would point toward a reduction in outsider interference and a corresponding increase in public confidence that these personal and painful decisions according substance and credence to personal autonomy, will continue to be respected.

Professor Stephen Arons in a sense both foreshadows and amplifies the *Schiavo* controversies as he sounds a note of serious concern with his Article, *Palliative Care in the U.S. Healthcare System: Constitutional Right or Criminal Act?*<sup>24</sup> Focusing on the ideological

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23. Cf. John A. Robertston, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 213 (1975) (analyzing the dilemma confronted by parents who choose not to seek routine surgical or medical care for babies born with other severe developmental disabilities).

24. See Stephen Arons, *Palliative Care in the U.S. Healthcare System: Constitutional Right or Criminal Act?*, 29 W. NEW ENG. L. REV. 309 (2007).

polarization he states has led to a depressing state of “acceptable collateral damage of the culture wars,” Professor Arons warns about our increasing propensity for turning private medical decisions into “intemperate and ill-informed public struggle[s].”<sup>25</sup> Most specifically, he is concerned about unwarranted interference in those situations where terminal patients have decided to eschew life-sustaining medical intervention and seek only palliative measures. This interference was exemplified by the former U.S. Attorney General’s threat to use his powers under the Controlled Substances Act<sup>26</sup> to examine physicians’ intent in prescribing controlled substances to terminal patients.

Professor Arons theorizes that the principle of personal autonomy “is being deconstructed . . . to promote beneficent paternalism or to advance concepts . . . held by various religious or interest groups.”<sup>27</sup> He examines the landmark *Cruzan*,<sup>28</sup> *Glucksberg*,<sup>29</sup> and *Quill*<sup>30</sup> cases to tease out the constitutional implications of administering palliative care that could hasten the death of terminal patients in the course of relieving pain. He also criticizes state and federal initiatives—including the report of President Bush’s Commission on Bioethics<sup>31</sup>—that would interfere with the physician-patient relationship in terminal situations. His overall perspective is wary and cautionary about the prospect that widely accepted constitutional liberties will be eroded.

If one applied Malcolm Gladwell’s Tipping Point theory to Professor Arons’s analysis, the first question would have to be: “From which direction are we viewing palliative care as a problem?” Stating the question that way probably tips the answer as well. On neither side of the issue do there appear to be “people with a particular and rare set of social gifts” who can motivate enough others to jump onto the palliative care bandwagon—either way—to set an epidemic in motion. John Ashcroft, the Attorney General who tried to use the Controlled Substances Act to undercut Oregon’s Death with Dignity Act,<sup>32</sup> would no longer seem to fit

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25. *Id.* at 309.

26. 21 U.S.C. §§ 801-904 (2000).

27. Arons, *supra* note 24, at 312.

28. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990).

29. *Washington v. Glucksberg*, 521 U.S. 702 (1997).

30. *Vacco v. Quill*, 521 U.S. 793 (1997).

31. PRESIDENT’S COUNCIL ON BIOETHICS, *TAKING CARE: ETHICAL CAREGIVING IN OUR SOCIETY* (2005), available at [http://www.bioethics.gov/reports/taking\\_care/taking\\_care.pdf](http://www.bioethics.gov/reports/taking_care/taking_care.pdf).

32. OR. REV. STAT. §§ 127.800-.897 (2005).

the bill—if he ever did.<sup>33</sup> Moreover, it would be hard to package either side of the issue in a way that would make it seem irresistible to enough people to get the ball rolling.

Physician-assisted suicide is still highly controversial, yet prohibiting doctors from trying to relieve the pain of their patients' terminal illnesses would offend large segments of the population.<sup>34</sup> Nonetheless, the context in which most palliative care decisions are made is not usually likely to attract public attention, and double-effect palliative treatment has in fact been medically commonplace, albeit low-profile, for many decades.<sup>35</sup> Because Gladwell's three Tipping Point factors point in inconsistent directions here, the palliative care issue does not seem poised for epidemic movement in either direction—at least not at the present time. If, however, a compelling factual situation arose wherein a patient sympathetic and famous enough to put an identifiable face on the issue were forced to suffer because palliative care was denied, I could envision public momentum building toward a tipping point for the kind of legal clarification that would bring above-board social acceptance for this right-to-die issue.

Professor Michele Goodwin's Essay *My Sister's Keeper?: Law, Children, and Compelled Donation*,<sup>36</sup> tackles the bioethical underpinnings of compelling organ and tissue donation from children. The title and the foregoing sentence read literally as semantic oxymorons, and Professor Goodwin intends us to think of her subject that way. Compulsion and donation are linguistically opposed concepts, yet most readers familiar with cases involving minors as organ and tissue donors are conditioned not to take those words literally. Goodwin seeks to shake her readers into analyzing exactly what is at stake when we *use* children—compel them to donate parts of their physical selves—for the purpose of medical interventions designed solely to help others, even though we usually disguise that compulsion in best-interests terminology.

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33. David Sclar, *U.S. Supreme Court Ruling in Gonzales v. Oregon Upholds the Oregon Death With Dignity Act*, 34 J.L. MED. & ETHICS 639, 639 (2006).

34. See, e.g., Hospice Patients Alliance, *Pain Control: Methods and Standards of Care*, <http://hospicepatients.org/hospic29.html> (last visited Feb. 10, 2007) (“Most patients and families who use hospice services expect that the hospice will make every effort to relieve the pain which afflicts their loved one.”).

35. Cf. Daniel P. Sulmasy, *Commentary, The Rule of Double Effect: Clearing Up the Double Talk*, 159 ARCHIVES INTERNAL MED. 545 (1999).

36. See Michele Goodwin, *My Sister's Keeper?: Law, Children, and Compelled Donation*, 29 W. NEW ENG. L. REV. 357 (2007).



Donation is a volitional concept, whereas compulsion requires the application of force—volition's opposite—to achieve its objectives. The public is not conditioned to think that courts and loving parents lawfully apply force to remove physical parts of children's bodies solely for other people's benefit, but Professor Goodwin's article requires us to confront the fact that best-interests rhetoric often obscures that uncomfortable truth. Her extensive examination reveals that the rationales traditionally trotted out to justify *taking* tissue and organs from children for the medical rescue of third parties on the basis of parental consent stem from cases involving the mentally deficient and mentally ill. The best-interests justification simply does not stand up well to searching legal or ethical analysis where child donors are involved.

Goodwin would proscribe taking organs from children younger than age thirteen altogether, always appoint a guardian ad litem to protect the interests of those prospective minor donors older than thirteen, and require family and independent counseling for the prospective donor and parents, to force them to understand both the immediate and the longer run physical and psychological implications of their actions. She would also require an independent physician for the prospective donor. Finally, she would require prospective minor donors to explain to the court their reasons for wanting to make such extraordinarily altruistic gestures. Presumably if those statements were not sufficiently persuasive—volitional in fact?—judicial approval for their “donations” would not be granted. Professor Goodwin acknowledges that her proposal would shrink the available pool of minor donors, but she intends that result. She wants to push us toward a tipping point that will force reconsideration of our “altruistically based procurement regime.”<sup>37</sup>

How close are we to the point of rethinking compelled organ and tissue donations from children whose parents consent in their “best interests”? Probably not very close if we apply Gladwell's Tipping Point criteria. In the first place, no advocate with the extraordinary social skills needed to move the cause to public prominence has thus far emerged. Nor does compelled donation from minors usually arise in a context ripe for Gladwell's little changes that could set an epidemic for rethinking the legal response in motion. Moreover, situations conducive to compelling donation from minors tend to arise rarely, privately, and in isolation from one another. Where the potential donor's parents are in accord on supply-

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37. *Id.* at 404.

ing consent for the donation in the presumed best interests of their child, we are not likely to see high-profile portrayals of the situation as the kind of child exploitation merely for the benefit of another that would become one of Gladwell's irresistible spurs to public action.

To the contrary in fact; the media spotlight has been primarily on appealing patients—often children—in desperate need of rescue via tissue or organ donation from others, rather than on their potential rescuers.<sup>38</sup> When the potential rescuer is a Good Samaritan child 'asked' to undergo an inherently dangerous medical procedure but unable to give legal consent on her own, and no proffered benefit to her can stand up to critical evaluation, the public—and legal—reaction might be different if a passionate advocate appeared on her behalf. One could imagine a compelling set of facts that would shift the mind-set of an American public more conditioned to embrace technological intervention framed in the best interests of a child who can facilitate it by donating “non-essential” bodily tissue, than to question the donation's ethical ambiguities. But bringing the issue to public consciousness would still require skilled advocacy, and when the parents supply consent supporting the donation, outsiders have trouble being perceived as carrying moral authority to intervene on the child's behalf.

Professor Barry Furrow's pull-no-punches Essay, *Access to Health Care and Political Ideology: Wouldn't You Really Rather Have a Pony?*,<sup>39</sup> constitutes a forthright plea for ideological change to “repair our system from the top down.”<sup>40</sup> Professor Furrow begins by rehearsing the well-known high costs (an “epidemic” itself in Gladwell's phraseology) and in many cases questionable quality of the health care delivered in this country. He then zeroes right in on the access problems that permeate our system to terrify those without health insurance, and to worry many others who have coverage now, but fear it is either inadequate or they will lose it altogether in the future. In a wonderful turn of both phrase and metaphor, he muses that “a large part of the population want[s] to

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38. See, e.g., Kyla Dunn, *Cloning Trevor*, ATLANTIC MONTHLY, June 2002, at 31-52 (telling the story, complete with cover photograph, of an extremely appealing little boy suffering from adrenoleukodystrophy, “a rare and underdiagnosed genetic disorder”).

39. See Barry Furrow, *Access to Health Care and Political Ideology: Wouldn't You Really Rather Have a Pony?*, 29 W. NEW ENG. L. REV. 405 (2007).

40. *Id.* at 406.

age more rapidly, a perverse quest for the Fountain of Age,”<sup>41</sup> in order to become Medicare-eligible and thus sure of guaranteed coverage.

Professor Furrow’s real target in this piece is the siren song of choice market theorists aver that competition brings to health care, along with its much-vaunted efficiency and reduced waste. He exposes the hollowness of choice rhetoric for those with limited or non-existent health insurance, and considers it a serious “stumbling block” to improving access to care. He also considers choice rhetoric “cartoonish” because of its strong superficial appeal to the individual in all of us, which in turn makes us resist questioning the value of what we really get in the way of options. What Furrow really wants is for us to question the market ideology on which much of our current health policy rests.

How do Professor Furrow’s ideas fare when subjected to Malcolm Gladwell’s Tipping Point factors? Not very well, I’m afraid. For better or for worse, competition principles structure our health care delivery system, and Furrow seeks nothing less than to change the “rooted ideology” that brought market theories to medicine. That’s a tall order—one could even call it tilting at a windmill these days—and no champion with “exceptionally persuasive social skills” appears anxious to take on that task. President Clinton might have done it when he was first elected with what most thought was a mandate to reform health care, but as noted previously, the Clintons blew the opportunity and the moment passed.

One could argue that presenting universal coverage reform in humanitarian terms, augmented by hard data about the human and financial costs of inadequate access to health care, could attract adherents in the manner of one of Gladwell’s irresistible ideas. However, that idea would have to come up head-to-head against the health care choice rhetoric already shown to be extremely hard for most Americans to resist. Moreover, the concept of greater choice is quite simple for most people to grasp, whereas universal coverage has many moving parts that have to be coordinated before it could be implemented. This makes it much more difficult for the public to understand and thus espouse the cause.

Finally, we do not yet (or again?) have the perfect context for change Gladwell believes is necessary to set fundamental structural change in motion for health care. Everyone realizes our health care system has many problem areas, but the public does not perceive

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41. *Id.* at 408.

these as part of larger systemic failures. It certainly does not view these problems as the sort that challenge our ideological predilections and cry out for structural reform. No one realizes that more clearly than Professor Furrow, but he is in no frame of mind to give up on the effort. He believes that ideology can be remade, and that most people would probably be willing to swap a little choice—the pony, if you will—for better health if they really understood what the stakes were.

The subject matter Professor Nicolas Terry explores in *Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*,<sup>42</sup> is probably among the least likely issues examined in this Symposium to attract Tipping Point treatment any time soon. The (mostly) international health care transactions he analyzes generally operate so far beneath the radar screen of public perception that few people are aware of them, let alone consider them a problem in need of better regulation. Professor Terry examines the behind-the-scenes re-structuring of health care going on *de facto* when patients travel, often to other countries, to get medical services, and when insurers and providers outsource medically related ancillary services to foreign venues. The common motivation for both phenomena is the universal search for lower health care costs, and in a small but growing number of cases those practices overlap when domestic payors actively promote medical tourism for their insureds.

Professor Terry sets forth chapter and verse documenting the past decade's explosion of medical tourism and ancillary medical service outsourcing. Defining medical tourism as "treatments or surgery that have been planned in advance to take place outside a patient's usual place of residence,"<sup>43</sup> he observes that much of this travel reverses prior trends and moves from affluent countries to those where labor costs are cheaper but no less professional. Thus certain foreign countries (South Africa, India, Mexico, Thailand, and Indonesia, for example) have promoted themselves as dual-purpose destinations, providing high quality medical and dental services, plus a vacation before or after you have received care.

With regard to medical outsourcing of non-clinical work, many foreign countries (India, Israel, and Pakistan, for instance) can offer not only cheaper costs but a highly skilled workforce accustomed to

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42. See Nicolas P. Terry, *Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. NEW ENG. L. REV. 421 (2007).

43. *Id.* at 422.

providing around-the-clock transcription, IT, medical interpretation (reading EKGs and radiology scans), and other services needed by health care insurers and (usually institutional) providers. Professor Terry tells us medical outsourcing is not only increasing rapidly, but expanding in scope to include such high-level functions as strategic planning, pharmaceutical benefits management, and systems design.

The problem with all of this foreign involvement in U.S. medical care is that much of it takes place in a physical and political context that makes it extremely difficult to regulate effectively. Noting that the United States does not even have national licensing for physicians, Terry reminds us of the problems that Internet prescribing presents for intra-state regulation, let alone attempting to regulate physician services internationally. Quality of care, clinical trials, and the privacy and confidentiality of medical information are but three other areas where trying to regulate the bioethical, cost, quality, and other aspects of health care internationally constitutes a legal and logistical nightmare for all concerned. In Terry's matter-of-fact words, "Outsourcing is essentially unregulated and is likely to remain that way."<sup>44</sup> That summation pretty much forecloses any tipping point inquiry on my part. None of Gladwell's three factors are present to indicate any potential for imminent social change, so in the short run we will just continue to muddle through. Perhaps some major catastrophe—or stunning success—will transpire to focus public attention on these extra-territorial and essentially unregulated phenomena, but the global nature of any attempt to Make Things Better makes that possibility accordingly harder to accomplish.

Finally, Professor Elizabeth Pendo's submission to this Symposium, *The Health Care Choice Act: The Individual Insurance Market and the Politics of "Choice"*,<sup>45</sup> is my candidate for the subject matter its author would least like to see come to a tipping point. Given the recent congressional election results, putting Democrats in control of both the House and the Senate, I predict she will get her wish—at least in the short run. Professor Pendo's Article analyzes pending federal legislation, The Health Care Choice Act of 2005 (the Act),<sup>46</sup> designed to permit health insurers to market individual

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44. *Id.* at 470.

45. See Elizabeth Pendo, *The Health Care Choice Act: The Individual Insurance Market and the Politics of "Choice"*, 29 W. NEW ENG. L. REV. 473 (2007).

46. Health Care Choice Act of 2005, H.R. 2355, 109th Cong. (2005); Health Care Choice Act of 2005, S. 1015, 109th Cong. (2005).

policies approved in any state without having to comply with any additional regulatory strictures imposed by the insured's state of residence. In essence, the Act enables insurers to market (presumably cheaper) individual policies without having to comply with the benefits that may be mandated by the state in which they want to sell their product. Thus, under the Act, a policy now marketed in California without infertility treatment benefits, for example, could be sold in Massachusetts without that coverage as well, even though Massachusetts (but not California) mandates that infertility coverage<sup>47</sup> be offered by all insurers currently doing business in the Commonwealth.

Professor Pendo acknowledges the grave obstacles the uninsured of this country must surmount in order to obtain and pay for non-group health insurance, but she makes a persuasive case that the Act is hardly the solution for that problem. She shows that not only will the cost of coverage for these individual policies be unlikely to fall, but that they are also unlikely to increase access to medical services or offer adequate benefits to most subscribers who purchase them either. As was the case with Professor Furrow's article, Professor Pendo's real target here is the illusion of individual choice and freedom that the plan's proponents utilize to sell their idea. She believes that free choice rhetoric appealing to a beneficiary's self-interest is fundamentally at odds with the social solidarity underpinnings of insurance that make it such an effective risk-spreading mechanism for the ordinary subscriber.

I do not think Professor Pendo needs to worry that we are anywhere near a tipping point that would transform the Act she opposes into the law of the land. Recent changes in the political control of Congress should see to that, for choice rhetoric and individual responsibility for obtaining health insurance are not usually considered touchstones of the Democratic Party's approach to health care policy. Moreover, the Act's presentation certainly has not arrived in packaging that would be irresistible to most uninsured people who lack resources to buy ordinary health insurance, nor has an effective and charismatic spokesperson appeared to propel the idea to public prominence among others. Finally, the present context in which the idea would have to gain momentum simply is not charged enough with regard to health insurance problems to produce this kind of incremental change. Those without insurance constitute a small and relatively powerless interest

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47. MASS. GEN. LAWS ch. 175, § 47H (2004).

group, and those who have it are as a group relatively indifferent—despite rhetoric to the contrary by many—about making coverage more widely available for others. Moreover, no powerful interest groups would seem to see their fortunes improve enough, were the bill passed, to invest in making that happen. There simply is not enough political juice currently in the issue to get this particular ball rolling toward enactment at the present time—a Very Good Thing in Professor Pendo's eyes.

So there you have it with regard to these essays and Tipping Point analysis. Although Malcolm Gladwell believes it does not have to take much to get an epidemic for social change moving, it does take a very special set of circumstances to produce a health care tipping point. I hope this exercise has shown that those circumstances are not so easy to come by where health care transformations are concerned—a reality that we probably all know instinctively. But we do have many thoughtful and creative scholars, such as those whose articles appear in this Symposium, working to help us understand, illuminate, and resolve our continuing health care problems.