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MANAGED CARE, ASSISTED SUICIDE, AND VULNERABLE POPULATIONS

*M. Cathleen Kaveny**

I. INTRODUCTION

Some of the most memorable figures in our heated national debate about physician-assisted suicide are the seriously ill persons who have publicly advocated its legitimacy, drawing their authority from the power of their own experiences. In certain respects, their stories evoke venerable American ideals: the idealistic revolutionary and the moral iconoclast. For example, consider Noel Earley, whose story was extensively chronicled in the press and on *Nightline*.¹ He used his untimely affliction with Lou Gehrig's Disease as the occasion to advocate the legalization of assisted suicide. Earley, a forty-eight year old Vietnam veteran and recipient of the Purple Heart and the Bronze Star, clearly appeared to be making his own choices, for his own reasons, up to the very end—including his ultimate choice to forgo aid-in-dying and let the disease take its natural, deadly course.

Or consider Diane, the patient whom Dr. Timothy Quill provided with a lethal dose of barbiturates and whose story he recounts in a famous article in the *New England Journal of Medicine*. She ended her own life rather than submit to the ravages of chemotherapy or suffer the end stages of acute myelomonocytic leukemia. As Quill tells the story, it is difficult to doubt that Diane, who forged a successful work and family life after overcoming earlier bouts with cancer, alcoholism, and depression, had made her own, carefully considered decision to die.²

Even Janet Adkins, the fifty-four year old member of the Hemlock Society who became the first patient to use Dr. Jack Kevorkian's "suicide machine" in order to avoid the degeneration caused by Alzheimer's Disease, seems to have made an independent decision to

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1 See Felice Freyer, *A Time to Die*, PROVIDENCE J. BULL., Feb. 16, 1997, at 11 (a five part special report).

2 See Timothy E. Quill, M.D., *Death and Dignity—A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991).

end her life after experimental drug treatment failed her. A woman who went trekking in the Himalayas in order to celebrate the onset of middle age, Adkins lived—and died—on her own terms. She played tennis with her grown son the week before she took her life and spent a last, loving weekend with her husband before walking into Dr. Kevorkian's van. At the end, she profusely thanked Kevorkian for his help.³

We do not have to agree with the choices made by Noel Earley, Diane, or Janet Adkins to have at least a grudging respect for their courage, their independence, and their willingness to live their last days in accordance with their own beliefs and in defiance of settled law and convention. But even so, we should be extremely cautious about changing public policy on the basis of their stories. It is important to recognize that even as these three rebels refused to comply with the prevailing morals of the health care financing and delivery system, they were also not forced to conform to some of its practical limitations. Perhaps because of his threat to kill himself, Noel Earley received the very best in palliative care, as a dedicated team of health care workers and friends attempted to make his waning days as comfortable as possible. In Dr. Quill, Diane found sensitivity and compassion, not the impersonal ministrations of bureaucratic medicine. And Janet Adkins, who lived in a wealthy suburb of Portland, Oregon, had the financial resources to arrange for competent, constant care if she chose to continue living with Alzheimer's Disease. Having the means as well as the motives to be true rebels, all three made their decisions for assisted suicide insulated and apart from the constraints imposed by the American health care system.

But the rest of us might not be so fortunate. Once assisted suicide⁴ is legalized, it will quickly become routinized.⁵ The choice to

3 See Timothy Egan, *As Memory and Music Faded, Oregon Woman Chose Death*, N.Y. TIMES, June 7, 1990, at A1.

4 Physician-assisted suicide is commonly defined as occurring when a patient ends her own life by ingesting lethal medication prescribed for that purpose by a physician. If the physician administers the lethal medication to the patient in order to end her life, it is no longer physician assisted suicide, but euthanasia. One of the most difficult aspects of the contemporary debate is the significant divergence in the way such terms as euthanasia are used. For a discussion of the moral meaning of the terms and their relation to decision-making in a legal context, see M. Cathleen Kaveny, *Assisted Suicide, Euthanasia, and the Law*, 58 THEOLOGICAL STUD. 124 (1997).

5 The Task Force to Improve the Care of Terminally Ill Oregonians has recently issued a guidebook of professional standards for physician-assisted suicide. See TASK FORCE TO IMPROVE THE CARE OF TERMINALLY ILL OREGONIANS, OREGON DEATH WITH DIGNITY ACT: A GUIDEBOOK FOR HEALTH CARE PROVIDERS (1998). The Guidebook is published by the Center for Ethics in Health Care at Oregon Health Sciences Univer-

end one's own life will not be the iconoclastic statement of a few strong rebels, but one more decision to avail oneself of one more health care service commonly reimbursed by third-party payors. Rather than a choice made *against* the health care system, an option for assisted suicide will be a choice made fully *within* that system—and subject to all the dangers of abuse that it contains.

In the summer of 1997, the United States Supreme Court overturned the decisions of two circuit courts that held unconstitutional state laws prohibiting competent, terminally ill adults from ending their own lives by taking medication proscribed for that purpose by a physician.⁶ The majority emphasized the importance of the state interests furthered by the prohibition, which are not limited to preventing the “abuse, neglect, or mistakes” that impede an individual's autonomous choice for or against assisted suicide. According to the Court, “The State's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and ‘societal indifference.’”⁷

The Court did not decide the mirror image question whether laws *permitting* assisted suicide are unconstitutional, because that question was not before it. Nonetheless, dicta in the majority opinion strongly suggests that the Court does not intend to constitutionalize the thorny issues arising from end-of-life decision making, but to leave them for the states to decide. “Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.”⁸

sity. In my view, developing guidebooks on such matters as assisted suicide is very much a double-edged sword. On the one hand, they may detail procedures that are helpful in minimizing abuses of the law. On the other hand, they encourage physicians to treat this as one more health care decision folded into a web of policies and procedures that increasingly engulf the practice of medicine today. I fear that after the novelty of the practice wears off, physicians will follow—or ignore—policies and procedures in the case of physician assisted suicide precisely to the same degree that they do so with respect to other policies and procedures.

6 *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997); *Vacco v. Quill*, 117 S. Ct. 2293 (1997); *Washington v. Glucksberg*, 117 S. Ct. 2302 (1997) (O'Connor, Stevens, Ginsburg, and Breyer, JJ., concurring in judgments) (concurrences to both *Glucksberg* and *Vacco* were published separately from the majority opinions).

7 *Glucksberg*, 117 S. Ct. at 2273. For a discussion of the pedagogical value of the Supreme Court's opinions, particularly with respect to the equal dignity of all persons, see M. Cathleen Kaveny, *Assisted Suicide, the Supreme Court, and the Constitutive Function of the Law*, HASTINGS CENTER REP., Sept.–Oct. 1997, at 29.

8 *Glucksberg*, 117 S. Ct. at 2275.

As of March 1998, only the state of Oregon has legalized physician assisted suicide,⁹ although legislation that would permit the practice was proposed in at least twelve state legislature in 1997 and the first three months of 1998.¹⁰ As the citizens of each state continue to ponder whether or not to legalize assisted suicide, they need to consider the actual situation of the health care system in which most people will be confronted with that option. For a growing number of Americans, the world of managed care provides the medical and financial context in which they will make life and death decisions for themselves and their loved ones. Moreover, managed care is being implemented at the same time our society has not only declined to

9 By a ballot initiative authorized by the Oregon Constitution, Oregon voters narrowly approved the Oregon Death with Dignity Act in November 1994, which legalized physician-assisted suicide for competent, terminally ill persons. The Act is codified at Oregon Revised Statutes 127.800-897. Three years later, in the fall of 1997, Oregon voters rejected a heavily contested ballot initiative that would repeal the Death with Dignity Act (Ballot Measure 51, Or. H.B. 2954-1997).

During the time period between the first and second ballot initiatives, the Act was subjected to a constitutional challenge that postponed its implementation. Judge Michael Hogan issued an injunction permanently barring the implementation of the Act, on the grounds that it violated the equal protection clause of the Constitution. See *Lee v. Oregon*, 891 F. Supp.1429 (D. Or. 1995) (equal protection opinion and declaratory judgment and permanent injunction). In *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997), the Ninth Circuit vacated the injunction and remanded with instructions to dismiss the plaintiff's claims on the grounds that they did not have standing to bring the suit. In October 1997, the Supreme Court declined to hear the plaintiff's appeal from the Ninth Circuit, thereby clearing the way for the implementation of the Act in the late fall of 1997. See *Lee v. Harclerod*, 118 S. Ct. 328 (1997). However, opponents of the Act have recently asked Judge Hogan to add a new plaintiff to the suit rather than dismissing it. On February 17, 1998, he asked them for additional briefing on their motion to add a new plaintiff to the case. Experts do not expect a ruling from Judge Hogan until April 1998. See *Federal Judge Postpones Final Decision on Fate of Controversial Assisted Suicide Law*, Health Care Daily Rep. (BNA) (Feb. 19, 1998).

In addition to challenging the Act on constitutional grounds, its opponents also contend that physicians who prescribe lethal doses of medication will violate the Federal Controlled Substances Act. In the fall of 1997, Thomas Constantine, the head of the Drug Enforcement Agency, expressed his opinion that the Oregon Act conflicted with the federal law. In response, Attorney General Janet Reno appointed an internal review team at the Department of Justice to investigate the matter. As of March 10, 1998, she has issued no final report, although Oregon Senator Ron Wyden has indicated that the internal review team has concluded that no conflict exists. See American Political Network, Inc., *Oregon: Will DEA Be Overruled on Assisted-Suicide?*, HEALTH LINE, Jan. 26, 1998.

10 These states include Colorado, Connecticut, Hawaii, Illinois, Maine, Massachusetts, Michigan, Nevada, New Hampshire, Rhode Island, Vermont, and Wisconsin. As of March 1998, it does not appear likely that any of these states will legalize assisted suicide in the immediate future.

provide all persons with basic health insurance, but also has determined to cut back on publicly-sponsored programs such as Medicare and Medicaid.

In the remainder of this essay, I would like to discuss four issues pertaining to assisted suicide and euthanasia in the new American health care system. First, what exactly is managed care? Most people are familiar with the term, and know vaguely that it is connected with Health Maintenance Organizations (HMOs). They may even belong to a managed care plan themselves. But how exactly does managed care work? Second, what are the temptations to wrongdoing that are inherent in managed care, and how adequate are the safeguards now in place to counteract these temptations? No institutional framework for organizing human behavior is invulnerable to abuse by persons determined to put their own advantage ahead of the common good; all social systems, whether they are educational systems, judicial systems, or health care systems, can be abused in some way unless effective measures are implemented to deter such behavior. Third, we can judge an institutional system by how well—or badly—it treats its weakest members. How, then, do vulnerable populations—the elderly, the poor, women, and disabled persons—fare under managed care? Fourth and finally, what dangers might we face if assisted suicide is legalized at this point in the evolution of the health care financing and delivery system?

I will not hide my conclusions. My concern is not primarily for the social pioneers and moral rebels in our midst. Almost by definition, they can take care of themselves. Rather, I am worried about those of us, our friends, and our near and distant neighbors, who do not have such independent temperaments, such good medical care, or such copious economic means as Noel Earley, Diane, or Janet Adkins. I believe that legalizing physician assisted suicide, particularly at this point in the evolution of managed care, will be extremely dangerous to the most vulnerable members of our society, who already are badly served by the American health care system. To put the matter bluntly, I believe that legalizing assisted suicide in the current health care environment is the moral equivalent of throwing a torch on an oil slick.

II. MANAGED CARE

A. *History*

In order to understand the nature of managed care, some historical background is helpful. From the 1960s through the mid 1980s, the health care industry was dominated by a fee-for-service reimburse-

ment system, in which a health care provider charged for each discrete service rendered. Apart from the relatively few HMOs, third-party payors exerted relatively little control over the utilization of medical services. In the realm of private insurance, employers purchased coverage for their employees from indemnity insurers, who in turn paid their portion of the health care costs incurred by their beneficiaries. As those costs rose, insurers simply passed them on to employers or other purchasers in the form of higher premiums. Government payors were equally generous. For example, in the golden days of the Medicare program inaugurated in the mid-1960s, physicians were reimbursed at eighty percent of their reasonable charges, while hospitals were reimbursed at a hundred percent of the costs they incurred, including allowances for depreciation on assets.¹¹

The incentives under this reimbursement system conspired to produce a rapid increase in both the number and technical sophistication of medical services. Hospitals and other health-care providers were revenue centers; the more services they provided, the more money they made. Providers were prompted to introduce new services, knowing that the cost would largely be absorbed by the insurers and the federal government. Fueled in large part by these unchecked incentives to provide more and more medical care, health care spending in this country spiraled out of control. In 1960, it constituted about five percent of the gross domestic product; by 1994, health care spending in this country had reached an astonishing fourteen percent of the GDP.¹²

B. Three Characteristics of Managed Care

“Managed care” is the label given to a number of health care delivery and financing techniques designed to counter the incentives to use medical resources in an inefficient and even wasteful manner. It is not any one technique or method, but a number of interrelated ideas and approaches. Generally speaking, managed care organizations (MCOs) employ three distinct but interrelated strategies in order to achieve their goals. All of these strategies are employed with great effectiveness by HMOs, the stereotypical but by no means only form in which managed care is delivered. They include: 1) adopting techniques to limit access to health care; 2) restructuring the reim-

11 For a fuller description of the shift from fee-for-service to managed care, see M. Cathleen Kaveny & James Keenan, S.J., *Ethical Issues in Health-Care Restructuring*, 56 THEOLOGICAL STUD. 136-50 (1995).

12 See Katharine R. Levit et al., *Health Care Spending in 1994: Slowest in Decades*, HEALTH AFFAIRS, Summer 1996, at 132.

bursement system to include incentives to control costs; and 3) implementing cost-effective care. Each strategy is briefly described below.

1. Adopting Techniques to Limit Access to Health Care

Under fee-for-service medicine and indemnity insurance, patients and their treating physicians controlled the utilization of medical resources. This type of unchecked or unmonitored access to expensive medical services resulted in spiraling costs and more than a few unnecessary procedures. For example, a patient who had a back problem might simply make an appointment with a high-priced orthopedic surgeon, despite the fact that his family doctor could have told him it was caused by too strenuous a game of weekend football. To combat this phenomenon, managed care has developed a number of ways to control the use of medical resources. For example, a patient in an HMO might need the approval of a "gate-keeping" general practitioner before being allowed to see a more expensive specialist. In addition, an MCO might employ techniques of utilization review that monitor and evaluate on an ongoing basis whether the medical services provided to a patient are necessary and appropriate. Frequently, ongoing utilization review is performed while a patient is undergoing a course of hospitalization or other treatment. If the treatment is deemed inappropriate or unnecessary, it will not be covered by the MCO.

2. Restructuring the Reimbursement System to Include Incentives to Control Costs.

In a fee-for-service system, the more services providers furnish, the more money they make. In order to combat the incentives to provide more treatment than necessary that are inherent in the fee-for-service system, MCOs implemented new payment systems with very different incentives and very different structures. Like insurers, many MCOs are paid on a capitated basis; they receive a fixed sum per month for each member enrolled, whether that person is sick or well. For its part, the MCO agrees actually to furnish each enrollee with the care called for in her benefit package. It keeps as profit any amount above and beyond the cost of providing care. Under capitation, the financial incentives for a provider are precisely the opposite to those in fee-for-service medicine; a capitated entity *makes* money by providing as little treatment as possible. HMOs and other MCOs are not alone in being paid on a capitated basis. Increasingly, *providers* who contract to furnish services to such organizations are also being capitated in order to bring their financial incentives in line with those of

the organization as a whole. According to a recent study, ninety percent of physicians expect to have at least one capitated contract by 1999.¹³

In addition to capitation, managed care providers have developed a number of other payment systems designed to control costs. For example, in most cases the federal government now pays hospitals a set amount of money for substantially all of the inpatient care it provides to a Medicare beneficiary, which is based on the diagnosis with which the patient is admitted to the facility. This payment structure creates an incentive for hospitals to admit patients, but then to discharge them as quickly as possible. Alternatively, MCOs may pay a hospital a flat, per diem rate for all the services provided to a patient; this approach creates an incentive to keep a patient in the hospital as long as possible while doing only as many expensive procedures as are strictly necessary. Physicians are also subject to a variety of payment methods in addition to capitation. For example, an MCO may agree to pay a physician group at a rate discounted off its normal fee schedule, while at the same time withholding a certain percentage of the group's compensation throughout the plan year. At the end of the year, the MCO will release that so-called "withhold" if the group has met designated targets for limiting their utilization of plan resources.

3. Implementing Cost-Effective Care

The third technique commonly used by MCOs is the development and implementation of strategies to make health care delivery more cost-effective. This can be done both at the level of the individual patient and at the level of the MCO's patient population as a whole. At the level of the individual patient, the best MCOs place a high priority on the *integration* of care; they insure that providers coordinate their efforts on behalf of persons who simultaneously suffer from more than one ailment. By requiring such coordination, they can eliminate redundant procedures and minimize the possibility that the various specialists treating the patient will work at cross-purposes with one another. At the level of the general population, many MCOs are striving to develop and implement "clinical pathways" or "practice guidelines" that describe a recommended course of cost-effective treatment for common diseases. By so doing, they can eliminate the real inefficiency of a system in which each health care provider insists upon its own way of doing things, no matter how tenuous the scientific basis for such insistence.

13 See *Increase in Capitation Likely*, 2 Managed Care Rep. (BNA) No. 43, at 1039 (Oct. 30, 1996).

Closely connected with the development of practice guidelines is the collection and evaluation of data taken from large numbers of cases in order to compare the outcomes of various possible treatment protocols; this data is used to improve and refine practice guidelines as part of the process of "continuous quality improvement." Great efforts are underway to measure and compare the quality of care furnished by various providers; recall the proposals for *Consumer Reports*-like HMO report cards that received so much attention a few years ago. For example, beginning in 1997, the Health Care Financing Association (HCFA) has required each Medicare HMO to administer member satisfaction surveys, as well as to analyze statistics pertaining to plan performance using a computer program known as HEDIS (Health Plan Employer Data and Information Set), which was developed by the National Committee on Quality Assurance, a not-for-profit organization dedicated to fostering accountability and quality in health care plans.¹⁴ The current version of the program, HEDIS 3.0, emphasizes health care outcomes and attempts to address the full spectrum of health care, ranging from prevention of diseases to chronic care.¹⁵ Needless to say, this new emphasis on collecting and comparing outcomes data will require MCOs to devote great energy and expense to purchasing and installing management information systems that are capable of gathering and analyzing vast amounts of data.

It is this third facet of managed care that promises to make it worthy of its name; without efforts to standardize and improve the quality of medical treatment, managed care would be nothing more than managed cost-cutting. Unfortunately, we are at least several years away from having reliable, easy-to-use practice guidelines that cover a substantial amount of ailments.¹⁶ Furthermore, at present there are substantial limits to the accuracy of even the most sophisticated quality reports, like HEDIS 3.0, for at least two reasons. First, it

14 The HCFA press release announcing these requirements can be found at <<http://www.hcfa.gov/news/n961018b.htm>>.

15 Visit <<http://www.ncqa.org/hedis/30exsum.htm>> for a summary of HEDIS 3.0.

16 See, e.g., William L. Roper & Charles M. Cutler, *Health Plan Accountability and Reporting: Issues and Challenges: Despite the New Measures of Health Plan Performance, the "Accountability Movement" is Still Less than a Unified Front*, HEALTH AFFAIRS, Mar.-Apr. 1998.

The idea of a system that can produce useful, comparative information about health plans and services and that can track changes in performance over time is clearly appealing. However, what some saw a few years ago as a readily accomplishable agenda for outcomes management and improvement has turned out to be much more difficult to achieve in actual practice.

is hard to measure the quality of care furnished by a provider without accurately taking into account the severity of the patient's illness in a way that we have not yet been able to achieve. Second, it is possible for providers familiar with the indicia of quality under a given evaluation system to "game" that system by devoting a disproportionate amount of their resources to the items upon which the report focuses as indicators of overall quality.¹⁷

C. *A Complicated and Changing Industry*

While the three-fold strategy of managed care is fairly easy to understand, the organizational structure of many MCOs is not. When they think of managed care, most people think of an old-style staff-model HMO. In this model, the HMO owns a hospital or two and employs a certain number of primary care physicians and specialists. All HMO enrollees must obtain their care from the HMO's hospitals and physicians; they all pay their premiums to the HMO's main office. Because the hospital, the physician offices, and the HMO headquarters are all located within a block or two, it is not difficult to think of managed care as a distinct, easily identifiable entity.

But this is too simplistic a picture of contemporary managed care. First, HMOs are far from the only type of managed care entities on the market. According to the American Association of Health Plans, the major trade organization for MCOs, in 1996 only 67.5 million Americans were enrolled in HMOs, while approximately 98 million were insured by preferred provider organizations, a more loosely organized form of managed care. Even traditional indemnity insurers now employ some of the tools of managed care, such as utilization review, and may require pre-authorization for very expensive services. At the beginning of 1997, thirty-three percent of all persons who obtained health insurance through their employers were in HMOs; but half of these were in "point of service" plans, which allow enrollees to choose an out-of-network doctor in exchange for a lower rate of coverage for services provided.¹⁸

Second, the relationship among various components of a managed care organization may be extremely complicated. Furthermore, as of January 1997, only two percent of the 651 HMOs in the United States were "staff model" HMOs that could possibly correspond to the

17 Arnold Epstein, *Performance Reports on Quality—Prototypes, Problems, and Prospects*, 333 NEW ENG. J. MED. 1, 58–59 (1995).

18 See American Association of Health Plans, *Managed Care Facts* (visited Jan. 1998) <<http://www.aahp.org/menu/index.cfm>>.

stereotype described above.¹⁹ An employer may contract with an MCO on a capitated basis, which might subcontract on a capitated basis with a physician-hospital organization to provide services in a particular area. The physician-hospital association may in turn have an arrangement with its member hospitals and physicians to pay them on a discounted fee-for-service basis. The main offices of the MCO may be far removed from the hospital, and the participating physicians may be scattered across town. In many cases, the MCO is no longer a physically distinct entity, clearly correlated with a number of identifiable hospitals, office buildings, and people. It is a "virtual organization" comprised of an invisible web of frequently shifting contractual arrangements.

Consequently, in today's world, a patient going to see her primary care doctor may know that her care is somehow "covered," but will have very little sense of how her physician is paid, the exact nature of the relationship of her physician with the MCO, and even who is ultimately responsible for the costs of her care. This last issue can be very important. Many employers decide to pay the actual costs of providing their employees with health care themselves, rather than purchasing insurance or HMO benefits for their employees. In such instances, the employer will often contract with an insurance company to "rent" its network of preferred providers, and to provide claims processing services. However, the employer, not the insurance company, is responsible for paying the patients' bills. In this instance, the question of whether a patient is inappropriately denied coverage may not be addressed under more stringent state law, but by a more lenient federal law governing employer-sponsored benefit plans, commonly known as ERISA.²⁰

Third, not only are the relationships among the various components of a managed care organization complicated, they are also very fluid. Many hospitals are closing. Others are deciding to participate in "integrated delivery networks" (IDNs) in the hopes of being able to attract the attention of MCOs looking to expand their provider base,

19 See *id.*

20 Employee Retirement Security Act (ERISA) of 1974, 29 U.S.C.A. §§1001-461 (1998). In general, a claim that benefits were wrongly denied would fall under ERISA, which limits a plaintiff's damages to the cost of the wrongly denied treatment. State tort law continues to apply to malpractice claims. The law is unsettled about whether an ERISA plan can be held vicariously liable for the treatment decisions made by providers under contract with them. For further discussion, see Karl Polzer & Patricia A. Butler, *Employee Health Plan Protections Under ERISA; How Well Are Consumers Protected Under Managed Care and "Self-Insured" Employer Insurance Plans?*, HEALTH AFFAIRS, Sep.-Oct. 1997.

or even to accept capitation directly from employer groups. More generally, in the rush to make themselves ready for managed care, there is a real danger that some IDNs, or even individual providers, will accept capitation without any firm knowledge of how to manage the associated risk.²¹ State and federal regulatory agencies are scrambling simply to keep up with the ever-evolving forms of managed care that are emerging in the industry. Furthermore, it is not clear how much authority the states have to regulate the solvency of IDNs that contract solely with self-funded ERISA plans.²²

Fourth, money can be made by squeezing the inefficiencies out of our nation's bloated health care system. Consequently, for-profit providers have become an increasingly important presence in the health care arena. The moral importance of the distinction between for-profit and not-for-profit health care should not be absolutized. Some not-for-profit institutions have attempted to avoid their obligation to contribute to the community in exchange for their exemption from corporate taxation.²³ In addition to contributing to the common good by paying taxes (the highest average corporate tax rate is currently 35 percent), some for-profit health care facilities have also committed themselves to providing some level of charity care. Nonetheless, there are significant differences in the ultimate fiduciary obli-

21 Sections 1855 and 1856 of the Balanced Budget Act of 1997 allow HCFA to contract with risk-bearing provider-sponsored organizations (PSOs), which are essentially IDNs formed by providers. Generally speaking, those organizations must be licensed under state law. However, the Secretary of the Department of Health and Human Services is directed to develop solvency standards for PSOs, and to grant time-limited exemptions from state solvency requirements to PSOs that meet the federal standards. The HCFA is expected to issue its proposed rule regarding such standards by April 1998. *Medicare PSO Panel Reaches Consensus; Sends Outline of Rule to HCFA*, Health Care Daily (BNA) (March 9, 1998).

22 See Alicia Ault Barnett, *Who Needs the Middleman? Third-Party Players in the Doctor-Patient Relationship*, 15 BUS. & HEALTH 34 (1997). But see *supra* note 21 (explaining that the Balanced Budget Act of 1997 directs the HCFA to set solvency requirements for provider-sponsored networks with Medicare managed care contracts).

23 The Internal Revenue Service has set forth certain community benefit requirements that hospitals must meet in order to preserve their tax-exempt status. See, e.g., Rev. Rul. 69-545, 1969-2 C.B. 117. See also Gen. Couns. Mem. 38,669 (March 30, 1981). These criteria are also relevant to the tax-exempt status of HMOs, the basic test for which is based on *Sound Health Ass'n v. Commissioner*, 71 T.C. 158 (1978), *acq.*, 1981-2 C.B. 2, as amplified by *Sound Health Association*, Gen. Couns. Mem. 38,735, (May 29, 1981) and by Rev. Rul. 69-545, 1969-2 C.B. 117. Some local governments have questioned the claim of hospitals to be exempt from property taxes, attempting to exact payments in lieu of taxes. In the fall of 1997, the state of Pennsylvania became the first in the nation to enact a law specifying the criteria a hospital must meet in order to be exempt from local taxation. The Institution of Purely Public Charity Act, H.R. 55, 181st Leg., 1st Reg. Sess. (Pa. 1997).

gation of tax-exempt and for-profit organizations, which cannot help but affect their sense of mission.²⁴ A tax-exempt organization is obligated to use its resources to further its charitable purposes, while the ultimate obligation of a for-profit corporation is to make money for its shareholders. The health care sector attracted 12.4 percent of the \$2.2 billion in private equity invested by venture capital companies in the first quarter of 1996. Generally, such companies seek annual returns of sixteen to seventeen percent on their total investments.²⁵ Nonetheless, management may be hard pressed to meet these objectives in the years to come, because the large inefficiencies have already been eliminated from the health care.²⁶ There is evidence that investors are now becoming wary about putting their money in MCOs.²⁷ It may be tempting for the more unscrupulous providers to shore up their profit margins in difficult times by denying necessary care.

III. MANAGED CARE: TEMPTATIONS AND RESPONSES

No way of organizing human behavior is free from temptations to wrongdoing. In school, the great emphasis placed on grades creates incentives for students to cheat; in the courtroom, the tremendous weight given to sworn testimony creates incentives for witnesses to perjure themselves. The questions that we must ask ourselves about any organizational system are: 1) What temptations to wrongdoing does it involve? and 2) What sorts of checks and balances should be put in place to deter and detect wrongdoing?

Medical ethicists and health care lawyers and administrators worked through very comprehensive answers to these questions with

24 The differences in mission likely have widespread influence on how the institutions are run. A recent study by the American Hospital Association and the Ernst & Young accounting firm showed that for-profit and non-profit institutions can have significantly different approaches to issues ranging from how trustees are selected to what is expected of management. Ron Shinkman, *Governance Gap: For-Profits, Not-for-Profits Run Differently*, MODERN HEALTHCARE, Feb. 23, 1998, at 44.

25 See Karen Pallarito, *Venture Capitalists Letting Bets Ride on Healthcare Firms*, MODERN HEALTHCARE, May 20, 1996, at 108, 110.

26 One of the most dramatic stories of 1997 was the precipitous decline and fall of Columbia/HCA Healthcare Corp., which had led the industry in profitability in 1996. See 1997: *The Year in Review*, MODERN HEALTHCARE, Dec. 22, 1997, at 52. Significant losses were also experienced in 1997 by not-for-profit Kaiser Permanente and the for-profit Oxford Health Plans, due in part to the inability of these plans to manage the enormous growth in enrollment. See Louise Kertesz, *Enrollment Albatross: Kaiser's 1997 Loss Shows Downside of Record Growth*, MODERN HEALTHCARE, Feb. 23, 1998, at 12.

27 For trade analysis, see *Outlook '98: Industry Faces Assaults on All Fronts; Fights Back with Premium Hikes, Flexible Products, Risk-Shifting*, MANAGED CARE WEEK, Jan. 12, 1998, at 8.

respect to the old regime of fee-for-service medicine and indemnity insurance. Briefly stated, the incentives under that system conspired toward over-treatment: the more services providers furnished, the more money they made. The common law doctrine of battery provides a powerful tool to combat these incentives. Essentially, that doctrine teaches that no one may touch a person without her consent, even a physician who wishes to perform a beneficial medical procedure. Medical ethics and health care law began to stress that patients have the right *to refuse* medical treatment—and also began to emphasize that care-givers must obtain a patient's informed consent before going ahead with any medical procedure. Moreover, the federal government began to develop and enforce its laws against fraud and abuse in the Medicare and Medicaid programs, which were designed to deter, detect, and punish arrangements in which providers gave one another some type of valuable "remuneration" in exchange for referrals.²⁸ Other federal laws were implemented that, with certain narrow exceptions, prohibited physicians from referring patients for laboratory or other services to facilities in which they have a financial interest.²⁹ These programs attempted to combat incentives for unscrupulous providers to make money by taking advantage of any opportunity to provide program participants with covered services, even unnecessary ones.³⁰

The incentives under managed care, however, are substantially different than those under fee-for-service medicine. Generally speaking, they stem from the fact that providers make money by providing less care, rather than more care. Consequently, as described below, they center around *undertreatment*. Furthermore, these incentives need to be analyzed at two basic levels: that of the MCO itself, and that of its participating providers.

28 42 U.S.C. §1320a-7b (1994) (commonly called the federal Anti-Kickback Law).

29 See 42 U.S.C. §1395nn (1994) (commonly called the Stark Law). A useful survey of state and federal laws prohibiting physician self-referral can be found in James C. Dechene & Karen P. O'Neill, "Stark II" and State Self-Referral Restrictions, 29 J. HEALTH & HOSP. L. 65 (1996).

30 Some scholars suggest that health fraud costs private and public payors some \$80 billion per year. See Theodore R. Marmor & Jerry L. Mashaw, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare Spending*, 11 YALE J. REG. 455, 487-88 (1994). For a practical description of the different fraudulent practices likely to arise under managed care by a lawyer who represents a managed care entity, see Alan D.B. Bloom, *Fraud in Managed Care—New Games by Old Players*, 1 NO. 10 MEALY'S LITIG. REP.: MANAGED CARE 16 (1997).

A. *The MCO Level*

An MCO that is paid on a capitated basis will make more money if it enrolls as many persons as possible and provides them with as few services as possible. Consequently, an MCO has every incentive to enroll young, healthy persons who need very little care and to avoid enrolling elderly persons or individuals who suffer from expensive, chronic illnesses. Even in situations where MCOs are legally prohibited from directly excluding enrollees on the basis of their potential costs (a practice known as "medical underwriting"), there are subtle ways to attract a desirable population and discourage an undesirable one (a practice known colloquially as "cherry-picking"). For example, an MCO might advertise its Saturday afternoon fitness benefits and well-baby care, rather than its chronic blood pressure clinic. Or it might develop extensive panels in sports medicine, while contracting with very few cardiac care specialists.³¹

Furthermore, in its quest for efficiency, an MCO might be tempted to approve or deny care on the basis of hastily developed or otherwise inadequate practice guidelines. Some MCOs, in the intense competition for business, may be formulating their own "home-grown" practice guidelines without adequate scientific basis. Assuming the purpose of these guidelines is to attract cost-conscious benefits managers, they are likely to err on the side of saving money rather than providing comprehensive care. Furthermore, even well-developed practice guidelines will be faced with "outlying" cases from time to time, which can only be identified by sound clinical judgment. Unfortunately, not all MCOs train, encourage, and reward competent individuals to identify these "outlying" cases. Too often, the MCO representatives responsible for authorizing out-of-the-ordinary treatment protocols are inadequately prepared to make the decisions confronting them and, consequently, are inclined to defer to the practice guidelines in ambiguous cases.

31 The Balanced Budget Act of 1997 requires the Health Care Financing Administration (HCFA) to implement a risk-adjusted payment system for all Medicare managed care plans, which will tie a plan's capitation rate to the health of the population it serves. The HCFA is currently working on the project, with the goal of initiating it in the year 2000. However, there are significant drawbacks to the risk-adjustment process that the HCFA will likely adopt, including the fact that it factors in the costs of chronic illness only in the case of patients who are hospitalized. Because only twenty percent of beneficiaries are hospitalized in any given year, payment for the other eighty percent will remain tied to traditional demographic factors that do not try to account for health status. Consequently, accurate risk adjustment in setting Medicare capitation rates is years away. See *Medicare HCFA Eyeing Inpatient Risk Adjuster for Managed Care Payments in 2000*, Health Care Daily (BNA) (Feb. 2, 1998).

Third, an MCO might be tempted to discourage patients from using expensive services, or to place stringent limits on a patient's available options in seeking care from specialty providers. Theoretically, in situations where MCOs could be assured of a stable population base, they would have a financial incentive to invest in expensive treatment that might improve the long-term health status of their enrollees. However, that incentive evaporates in a volatile market, such as the current one. Because many employer groups change their coverage from year to year in search of the lowest prices, MCOs worry that the investment they make now in maintaining or improving the health of their enrollees will be reaped by their competitors in the future.

Fourth, in the old days of fee-for-service medicine, health care providers provided charity care to those unable to pay, funding such services by shifting the costs to paying patients in the form of increased rates. As employers and the government place increasing pressure on providers to slash their costs, however, providers have had fewer extra dollars to cover the costs of patients in need of free care. The failure of health care reform to provide all citizens with a basic level of health benefits, as well as the drastic cutbacks to most state Medicaid programs, has only exacerbated the problem. Moreover, the increasing presence of for-profit institutions in the health care arena does not ameliorate the situation. Because for-profit systems pay taxes, they do not consider themselves under the same obligation to provide charity care that legally (and morally) binds non-profit, tax-exempt providers. According to an annual survey conducted by *Modern Healthcare*, the five for-profit systems responding to this question on its annual survey reported charity care costs at 1.1 percent of total net patient revenues in 1996, down from 1.3 percent in 1995. In contrast, the charity care provided by 124 reporting not-for-profit systems remained at the level of three percent. The charity care furnished by seventeen reporting public systems during 1996 was twelve percent of net patient revenues.³²

B. *The Physician Level*

Similar temptations to wrongdoing exist at the level of physicians working in the context of managed care. The precise temptations depend upon how a physician's compensation package is structured. If she is paid a capitated rate that factors in the costs of referrals for

32 See Bruce Japsen & Lisa Scott, *System Growth a Close Race: 1997 Multi-Unit Providers Survey Finds Not-for-Profits Ahead by a Nose*, 26 MODERN HEALTHCARE, May 26, 1997, at 51, 58.

specialty or hospital care, a physician may have some financial incentive to deny care or a necessary referral. The extent of that incentive depends upon what reinsurance arrangements are in place to limit the physician's exposure to financial loss if the patient population she cares for turns out to be in need of a great deal of expensive services. Alternatively, some physicians may have an arrangement with an MCO that tracks their use of outside tests, speciality referrals, and other resources for purposes of considering whether or not to pay them a bonus, or even to renew their status as participating providers. However, still other physicians may continue to be paid on a discounted fee-for-service basis by the MCO in which they participate, particularly if they are specialists.

Given the wide variety of ways in which physicians may be compensated in the realm of managed care, one patient may be confronted with several physicians who will each make their respective treatment recommendations against a background of conflicting financial incentives. Moreover, as Susan Wolf has pointed out, participation in MCOs confronts physicians not only with conflicts of interest, but also new conflicts of *obligation*. They have obligations, of course, to their patients. In addition, however, in the new regime of managed care, they may acquire contractual duties to the MCO that employs them or with whom they have entered into an independent contractor relationship. Finally, physicians may have an obligation to ensure that sufficient funds are available for other enrollees of the MCO who may need medical care.³³ At the same time, physicians may believe that their own financial interest and continuing job security are at stake in the decisions they make. Nothing in their training or socialization has prepared them for assessing these competing obligations or meeting the ethical challenge that they pose. More specifically, physicians who have been socialized to function in the quickly disappearing medical culture that protects a dyadic physician-patient relationship may find themselves extremely uncertain of the nature and scope of their responsibilities in the increasingly common situation where they function as one of a number of parties who have some influence over the care provided to a patient.

C. *Systemic Responses to Counteract Managed Care's Temptations*

As I noted previously, medical ethicists and health care lawyers have devoted the past twenty years to counteracting systemic incentives to overtreatment. Unfortunately, the work has barely begun on

³³ See Susan M. Wolf, *Health Care Reform and the Future of Physician Ethics*, 24 *HASTINGS CENTER REP.* 28-41 (1994).

the new challenges of counteracting managed care's systemic incentives to undertreatment.³⁴ These challenges are likely to prove far more difficult than their predecessors. Most patients are aware of potential instances of overtreatment simply because they involve a health care provider wanting *to do something to them*. In contrast, identifying instances of undertreatment generally involves the much more difficult task of attempting to prove a negative; to prove that beneficial care was *not* offered to a patient. How, in most instances, can a patient know whether or not she is being steered away from potentially helpful treatment? The practical difficulties are enormous.

Thus far, many efforts to detect and deter undertreatment have been piecemeal. For example, in order to prevent "drive-through" deliveries, Congress enacted legislation in 1996 requiring MCOs to provide minimum hospital stays for maternity patients.³⁵ In 1997, several states considered a new round of "managed care" which dealt with other highly publicized issues, ranging from requiring minimum hospital stays for mastectomies to outlawing contractual "gag clauses" that prohibit managed care physicians from speaking freely to their patients about matters ranging from treatment options to the workings of the MCO itself.³⁶ While these legislative initiatives may be motivated by the best of intentions, they are not likely to be completely successful. Cost-conscious managed care companies will simply direct their efforts to economize toward other services not affected by the new legislation.

A second problem is that it is extremely difficult for legislators and regulators to keep up with the rapidly changing structures of the health care financing and delivery system; yet doing so is essential if they are to implement effective counterweights to the temptations to wrongdoing currently in place. For example, the negotiated rule committee, through which the HCFA is developing the "safe harbor" identifying criteria that MCOs can meet in order to assure themselves of compliance with the anti-kickback laws, did not agree on an interim

34 For example, the HCFA did not issue its final rule pertaining to physician incentive plans used by HMOs serving Medicare and Medicaid HMOs until December 31, 1996. The rule can be found at 61 C.F.R. 69034. These regulations were called for by sections 4204(a) and 4731 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990), which also set forth other requirements, effective January 1, 1992, for regulating such plans.

35 Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (1996).

36 See *New Round of "Anti-Managed Care Bills Await Action in States," Blues Survey Finds*, 3 Managed Care Rep. (BNA) No. 8, at 174 (Feb. 2, 1997).

final rule until January 1998.³⁷ Representatives of the health care industry have criticized the narrow scope of the rule as serving only to complicate the already complicated contracting process in the industry, rather than providing helpful guidance in current market conditions.³⁸ A similar problem exists with respect to the regulations implementing the expanded law prohibiting physicians from referring patients to health care entities in which they or their immediate family members have a financial interest.³⁹ Consequently, in the current environment, many laws designed to provide helpful paths through the maze of incentives to wrongdoing may provide little if any practical help to MCOs of good will, and may encourage those of bad will to take advantage of the lack of clear, workable guidelines.

A third problem is that the preemption provisions of ERISA generally prevent state and federal regulators from exerting substantial control over benefits provided by the 2.5 million employer-funded health benefit plans, through which approximately 124 million Americans obtain their health care coverage.⁴⁰ Thus, even states that want to enact comprehensive legislation regulating new forms of managed care will be extremely frustrated in their goals. To gain a sense of the scope of the problem, consider that Medicare, Medicaid, and other federally subsidized programs cover only seventy-four million beneficiaries.⁴¹ For example, in February 1998, President Clinton directed a series of steps designed to bring federally funded health programs into compliance with the patient protections proposed in the Health Care Consumer Bill of Rights, which was proposed by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry.⁴² The President's directive was based on a report prepared for him by Vice President Gore, which surveyed the possibilities of

37 See Ursula Himali, *Fraud and Abuse: Advisory Group Gives Seal of Approval to Managed Care Anti-Kickback Safe-Harbor*, 7 Health Law Rep. (BNA) No. 5, at 155 (Jan. 29, 1998). The HCFA was required to develop a safe-harbor through a negotiated rule-making process by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 2007 (1996).

38 See *Soon-to-be-Released Anti-Kickback Safe Harbor to Offer Narrow Exception*, 7 Health Law Rep. (BNA) No. 1, at 17 (Jan. 1, 1998).

39 See Lisa M. Rockelli, *Fraud and Abuse: Self-Referral: HCFA Stark II Proposal Seeks Zero Risk of Abuse From Self-Referrals*, 7 Health Law Rep. (BNA) No. 7, at 245 (Feb. 12, 1998).

40 See *infra* note 43. This statistic was taken from Vice-President Gore's report to the President.

41 See <<http://www.hcfa.gov>>.

42 See David Nather, *Quality Assurance: Clinton Orders Federal Health Programs to Comply with "Consumer Bill of Rights"*, 6 Health Care Policy Rep. (BNA) No. 9, at 359 (Mar. 2, 1998).

bringing the various federal programs into compliance without additional federal legislation. With respect to ERISA plans, the Vice President concluded that "the Department of Labor has little to no ability under current law to ensure that ERISA-covered health plans have sufficient consumer protections." More specifically, he stated that "the Department does not have the authority to ensure that private plans assure access to specialists, access to emergency room services, participation in treatment decisions, confidentiality of information, or an external appeals process." State consumer protections also do not apply to such plans.⁴³

A key component in deterring temptations to underutilization will be to empower patients by creating an affirmative duty on the part of health care providers to disclose information about all possible treatment options, not simply the ones included in the MCO's practice guidelines. In addition, it will be important to ensure that appropriate grievance procedures are in place for enrollees dissatisfied with their services. But such procedures will do little good unless they are implemented in a comprehensive, effective manner. We are far from discovering how to achieve such a high level of implementation. For example, according to a report released in October 1996, the HCFA badly needs to improve the grievance process available to Medicare beneficiaries, particularly those enrolled in HMOs. HCFA officials have admitted that many HMOs neither have nor use adequate grievance procedures, despite the fact that they are mandated by federal law.⁴⁴ Furthermore, a moment's reflection suggests that grievance procedures are likely to be of limited usefulness unless special effort is made to render them accessible and non-threatening to the average beneficiary. Just like any bureaucratic process, grievance procedures favor those who have the energy, knowledge, and determination to advocate their own case in a persistent manner. How many sick or uneducated persons will unhesitatingly avail themselves of an adversarial proceeding against the health care provider responsible for caring for them? Will not most persons simply acquiesce in resignation and in hope to the recommendations of their caregivers?

In short, the temptations to wrongdoing inherent in managed care are not likely to be alleviated by the legislative efforts currently underway at both the state and federal levels. It is my own belief that

43 *Highlights of Reports of Five Agencies' Record of Compliance with Consumer Bill of Rights in Implementation of Federal Health Programs, Forwarded from Vice-President Gore to President Clinton, Feb. 20, 1998*, 6 Health Care Policy Rep. (BNA) No. 9, at 390 (Mar. 2, 1998).

44 *See HMO Grievance and Appeals Process Is Top HCFA Priority, Conference Told*, 2 Managed Care Rep. (BNA) No. 38, at 912-13 (Sept. 25, 1996).

we will not be able effectively to combat these temptations without a thorough-going reform of the health care system to ensure that all persons have access to basic health care, and that the costs of providing such care are equitably distributed. Unfortunately, our nation allowed that opportunity to pass us by several years ago. It seems unlikely to return to us in the near future. According to the U.S. Census Bureau, approximately 40.6 million people, or 15.4 percent of the population, lacked health care insurance in 1995.⁴⁵ A disproportionate amount of these individuals were poor. Of persons living at or below the poverty line, 30.2 percent were uninsured.⁴⁶ As described below, it is the poor and other groups of vulnerable persons who have the most cause to worry in the new regime of managed care.

IV. MANAGED CARE AND VULNERABLE POPULATIONS

How do vulnerable populations fare under managed care? To the extent that there is less money available for uncompensated care for those without insurance, not very well at all.⁴⁷ But what about vulnerable populations who *do* have some form of health coverage? In particular, what is the fate of the elderly, the poor, and the chronically ill who seek their health services from MCOs? These questions have become increasingly important in light of recent and ongoing changes to the Medicare and Medicaid programs.

In order to control costs, more and more states are moving their Medicaid population into managed care programs, which have the potential of saving as much as thirty percent in health care costs.⁴⁸ The number of Medicaid beneficiaries enrolled in managed care has expanded dramatically, from 800,000 in 1983 to twelve million in 1996.

45 Congress took a significant step toward stabilizing eligibility for insurance for those who receive it through their employment by enacting the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1937 (1996). Among other things, this Act greatly limited the ability of group health plans to exclude persons from coverage on the basis of pre-existing conditions, or to discriminate on the basis of health status in offering coverage. A major consequence is that persons insured through one employer will be able to change jobs without worrying that the plan offered by their new employer will impose onerous waiting periods or exclusions before covering them. However, the law does not prevent insurers from charging premiums commensurate with the costs of insuring high-risk patients.

46 See 22 HEALTH LEGIS. & REG., Oct. 2, 1996, at 3.

47 For an argument that the burgeoning of Medicaid managed care programs harms the uninsured segment of the population by reducing the funds available for providers to construct a "safety net" for those without coverage, see Note, *The Impact of Medicaid Managed Care on the Uninsured*, 110 HARV. L. REV. 751 (1997).

48 See *Managed Care Can Save States Over 30 Percent, Actuaries Say*, 2 Managed Care Rep. (BNA) No. 18, at 427 (May 1, 1996).

The Medicaid population poses special challenges to managed care. Their health status is substantially worse than that of the general population; Medicaid enrollees include significant numbers of persons with HIV/AIDS, as well as the elderly, the disabled, and those suffering from chronic physical or mental illness. Many of them may not speak English well and may have trouble negotiating the bureaucracy.

Thus far, however, the majority of persons moved into Medicaid managed care have not been beneficiaries who have suffered from complex health problems, such as the elderly or the disabled. That is about to change. The next several years will bring a greater number of attempts to move expensive populations into Medicaid managed care. According to a recent *Health Trends* report, "managed care's ability to reap savings for the Medicaid program will depend on the success of these efforts," because this population consumes a large percentage of the program's resources.⁴⁹ In 1995, Medicaid beneficiaries with disabilities consumed almost forty percent of Medicaid's expenditures, although they constituted only seventeen percent of the beneficiaries of that program.⁵⁰ Unfortunately, managed care providers have little experience in serving the population mix they are likely to encounter among Medicaid beneficiaries.⁵¹ A recent report by Mathematic Policy Research, Inc. found that the early experiences of Hawaii, Rhode Island, and Tennessee with Medicaid managed care suggest these states needed more time to plan and implement the programs, in part because of managed care's lack of experience with the relevant patient groups.⁵²

Managed care is also a crucial component of the future of the Medicare program. In 1995, about seven percent of all Medicare beneficiaries were enrolled in risk-bearing HMOs; that percentage is predicted to rise to fifteen percent by the year 2002. Furthermore, Medicare will not only be required to move a greater number of enrollees into managed care, it will be forced to do so with less money. In order to ensure the solvency of the program, the Balanced Budget

49 *Managed Care: Report Predicts Rocky Industry Future Despite Continued Short Term Growth*, Health Care Policy Rep. (BNA) at 2 (Feb. 9, 1998), quoting HEALTH TRENDS' 1998 GUIDE TO MANAGED CARE MARKETS (1998).

50 See *Medicaid: HHS IG Suggests Research Needed on Aiming Cost Control at Disabled*, Health Care Policy Rep. (BNA) at 2 (Aug. 11, 1997) (quoting Report, Office of the Inspector General, Department of Health and Human Services, Aug. 11, 1997).

51 For a discussion of the challenges facing states as they move Medicaid populations into managed care, see Arnold M. Epstein, *Medicaid Managed Care and High Quality: Can We Have Both?*, 278 JAMA 1617 (1997).

52 See *States Confront Major Challenges as Medicaid Embraces Managed Care*, 3 Managed Care Rep. (BNA) No. 8, at 170-72 (Feb. 19, 1997).

Act of 1997 was enacted with the intention of cutting Medicare spending by \$115 billion over the next five years; about one-third of this amount will come from its managed care programs.⁵³

As with Medicaid, the challenges faced by Medicare managed care will also be considerable. Like Medicaid enrollees, Medicare beneficiaries also have a special set of needs; they utilize more services, require more intense specialty care, and suffer from a larger number of chronic conditions than does the general population of HMO members.⁵⁴ Furthermore, it would not be surprising if both regulators and beneficiaries experienced some disruption as a result of the massive restructuring of the Medicare program inaugurated by the Balanced Budget Act of 1997. Current Medicare managed care contracts will be phased out as enrollees transfer to one of eight types of "Medicare + Choice" plans. The HCFA is required by this legislation to produce a whole range of new regulation for these plans, including developing solvency standards for "provider sponsored organizations" that wish to obtain managed care contracts without associating with an insurance company. In its semiannual regulatory agenda in the fall of 1997, the HCFA enumerated the rule-making required in order to implement the Act, which included thirty-four proposed rules under development, forty-six final rules, and forty-one long-term actions.⁵⁵

How have Medicare and Medicaid populations fared under managed care thus far? The results are mixed.⁵⁶ It appears that for healthy enrollees and those with commonly occurring acute illnesses, managed care is an acceptable option. A recent study of New York's Medicaid managed care program concludes that "managed care enrollees have greater odds of having a usual source of care and seeing the same provider there; enrollees have usually better and at least as good access to care; and they rate satisfaction with care higher or at

53 See D. Ward Pimley, *Legislation and Other Developments*, Medicare Rep. (BNA) No. 32, at 18 (Aug. 8, 1997).

54 See *MCOs Face Opportunities, Challenges, in Medicare, Medicaid Markets*, Report Says, 2 Managed Care Rep. (BNA) No. 45, at 1078-81 (Nov. 13, 1996).

55 See Unified Agenda of Federal Regulatory and Deregulatory Actions, 62 Fed. Reg. 57,458 (1997).

56 For example, a recent study concludes that although most disabled persons in Medicare HMOs do not experience access problems and they are more likely to report such problems than disabled persons in fee-for-service Medicare plans. See Marsha Gold et al., *Disabled Medicare Beneficiaries In HMOs: The First Comprehensive Look at how Disabled Medicare Beneficiaries Fare Under Medicare Managed Care*, HEALTH AFFAIRS, July-Aug. 1997.

least as high as conventional Medicaid beneficiaries.”⁵⁷ Another positive study concluded that elderly HMO enrollees who were hospitalized for acute myocardial infarction received health care that was better in terms of process, and equal in terms of mortality outcomes, than the care received by fee-for-service patients.⁵⁸

On the other hand, other studies suggest that those with serious and long-term health problems may have real cause to worry. A large, long-term study published in the October 2, 1996 issue of JAMA, the Journal of the American Medical Association, concluded that chronically ill elderly and poor patients enrolled in HMOs were twice as likely to experience an unfavorable health outcome as fee-for-service patients in the four year period from 1986 through 1990.⁵⁹ Furthermore, a study conducted by the Physician Payment Review Commission, entitled “Access to Care in Medicare Managed Care: Results from a 1996 Survey of Enrollees and Disenrollees,” concluded that special groups, such as the non-elderly disabled and individuals in fair or poor health, had significantly higher rates of difficulty in accessing care in Medicare HMOs than persons in better health.⁶⁰ Particularly poignant are the results of a recent survey concluding that stroke victims enrolled in managed care are significantly less likely to be discharged to rehabilitation programs or to return home than their fee-for-service counterparts.⁶¹ A recent national survey found that twenty-six percent of Medicare-HMO enrollees would not recommend their health plans to persons suffering from serious ill health.⁶²

These studies are particularly troublesome because vulnerable groups are not as likely to be able to protect themselves in the increasingly bureaucratized world of managed care. There is evidence that the elderly are more likely to cede decision-making authority to their physicians, which could be a dangerous practice in a world where phy-

57 Jane E. Sisk et al., *Evaluation of Medicaid Managed Care: Satisfaction, Access, and Use*, 276 JAMA 54 (1996).

58 See David M. Carlisle, *HMO vs. Fee-for-Service Care of Older Persons with Acute Myocardial Infarction*, 82 AM. J. PUB. HEALTH 1626-30 (1992).

59 See John E. Ware, Jr. et al., *Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-For-Service Systems: Results from the Medical Outcomes Study*, 276 JAMA 1039-47 (1996).

60 See *Federal Oversight Needed to Ensure Managed Care Quality*, Senate Panel Told, 2 Managed Care Rep. (BNA) No. 46, at 1106 (Nov. 20, 1996).

61 See James R. Webster, Jr. & Joseph Feinglass, *Stroke Patients, “Managed Care,” and Distributive Justice*, 278 JAMA 161 (1997).

62 See Lyle Nelson et al., *Access to Care in Medicare HMOs, 1996: Elderly Americans Give Medicare Managed Care a Mixed Assessment*, HEALTH AFFAIRS, March-Apr. 1997.

sicians have financial incentives to withhold treatment.⁶³ Battling an adverse treatment decision may take more energy and persistence than chronically ill persons can muster. Furthermore, informing and empowering Medicaid recipients will take special efforts, as well as sensitivity to the cultural differences of various minority populations. A recent article examining the waiver applications submitted by several states to the federal government in order to move their Medicaid populations into managed care concluded that the programs designed by the states largely have failed to address the special needs and possibilities for abuse of poor and minority populations.⁶⁴

Thus statistics suggest that the most vulnerable members of our population—the sickest of the elderly and poor—are at higher risk in Medicare and Medicaid managed care. These are precisely the groups who have the most to fear with the legalization of physician-assisted suicide.

V. LEGALIZING ASSISTED SUICIDE: THROWING A TORCH ON THE OIL SLICK

To summarize, the current health care system, dominated as it is by managed care, is volatile. It is also dangerous, particularly for vulnerable populations. Efforts to achieve universal health insurance by some sort of thoroughgoing *reform* of that system have broken down. At the same time, activities designed to *restructure* the health care system have continued unabated in response to the unrelenting imperatives of both private payors (employers) and public payors (state and federal governments) to contain costs. Because of the failure of health care reform, legislative efforts to curb the worst tendencies of managed care are likely to be a patchwork of experiments. The poor and the elderly are likely to bear the brunt of their failures. Some of the reasons we have cause for concern about introducing physician assisted suicide into the volatile world of managed care are outlined below.

A. *The High Cost of Dying*

Dying is an expensive activity. Care for the terminally ill has been estimated to constitute ten percent of the nation's health care expenditures; it consumes an estimated twenty-seven percent of the Medicare program's budget. Forty percent of that amount is incurred

63 See Analee E. Beisecker, *Aging and the Desire for Information and Input in Medical Decisions: Patient Consumerism in Medical Encounters*, 28 GERONTOLOGIST 330 (1988).

64 See Vernellia Randall et al., *Section 1155 Medicaid Waivers: Critiquing the State Applications*, 26 SETON HALL L. REV. 1069, 1140-42 (1996).

during the final month of an elderly patient's life.⁶⁵ Unfortunately, the highly publicized alternatives of choosing hospice care and eschewing all use of expensive technological measures that only serve to prolong the dying process are not likely to save much money. Recent studies suggest that such measures barely make a dent in the costs of end-of-life care; they are estimated to save as little as zero to ten percent of the costs of dying.⁶⁶

From a purely financial perspective, it is clear that MCOs—and more importantly, the public and private health care purchasers whom they serve—could find it very tempting to encourage a dying patient to avail herself of physician-assisted suicide. Furthermore, this temptation could be strengthened, and perhaps even rationalized, by the manner in which advocates of assisted suicide have justified the practice. More specifically, many of those advocates construe the choice of assisted suicide to be rooted in autonomy, in an individual's right to determine a fitting ending for her life.⁶⁷ At the same time, advocates also present assisted suicide as offering a real benefit to the terminally ill by allowing them to circumvent what is portrayed as the personal disintegration and degrading dependency associated with the process of dying. Consequently, it would not be difficult for cost-conscious benefits managers to rationalize an approach that facilitated a patient's choice of assisted suicide by seeing it as beneficial both to the plan and to the patient herself. There is reason to fear that a patient might be subtly encouraged to exercise her "right," in the words of Ninth Circuit Judge Reinhardt, "to determine the time and manner of one's own death"⁶⁸—and to do it in the most cost-efficient time and manner possible.

B. *The Value System of Managed Care*

In order to combat the inefficiency and waste of fee-for-service medicine and indemnity insurance, most MCOs have made "cost-effectiveness" their watchword. The power of this ideal is exemplified in the concept of outcomes measurement, which calls for the value of a discrete medical intervention to be measured in terms of the improvement that it brings about in a patient's condition.⁶⁹ From the per-

65 See Gloria Shur Bilchik, *Dollars and Death: Physician-Assisted Suicide and Spending for Critically Ill Patients*, HOSP. & HEALTH NETWORKS, Dec. 20, 1996, at 18.

66 See Ezekiel J. Emanuel, *Cost-Savings at the End of Life: What Do the Data Show?*, 275 JAMA 1907, 1913 (1996).

67 See RONALD DWORKIN, *LIFE'S DOMINION* (1993).

68 *Compassion in Dying v. Washington*, 79 F.3d 790, 793 (9th Cir. 1996).

69 The Joint Commission on the Accreditation of Healthcare Organizations is an independent, not-for-profit entity that evaluates and accredits more than 18,000

spective of the values animating the outcomes measurement movement, medical care does not have inherent value, but only instrumental value. Its worth can be judged solely in terms of the results it achieves and the resources it consumes in order to obtain them. This way of assessing the value of medical treatment has its uses. It works best, for example, with respect to immunization or screening programs designed to improve the health of an entire population. It also reminds us that health care consumes scarce resources that should not be wasted on expensive and useless procedures.

However, in determining what counts as an "expensive and useless procedure," it is important to remember that a significant part of what we mean by "health care" cannot be captured in the essentially utilitarian framework employed by the outcomes measurement movement. The care and comfort of the dying furnishes a perfect example of this fact. The dying process is extremely inefficient. The outcome, by definition, is always negative—death. Providing care—or not providing care—to patients during their period of dying does not change that outcome. Yet most of us would acknowledge that the value of medical attention provided to patients during this period cannot be determined solely with respect to the outcome produced, but is in many respects inherent to the care-giving process itself. That process includes, but encompasses more than, the effectiveness of various methods of controlling pain and maximizing patient function during a period of inevitable decline. At the core of caring for the dying is the refusal of the medical community to abandon a suffering human being, and its continuing determination to offer her company, guidance, and the benefits of their finite art. Assuming that medical care has intrinsic value, it *matters* that a patient's *physician* spends time with her during her dying process. The physician's role is not constricted to the high-cost technology she provides; it also encompasses the less tangible benefits conferred by her presence as a professional experienced in the way that embodied human beings take their leave from earthly existence.

It is not clear that the prevailing value system of managed care, in particular its overriding emphasis on cost-effectiveness, can accommodate this way of understanding the good of medical care. Unless we

health care providers in the United States, including hospitals, long-term care facilities, networks, and home care programs. In 1997, it launched the ORYX program, which aims to integrate outcomes measurement and other performance measures into the accreditation process. The program will be phased-in over time. For the year 1997, each accredited network is required to select and begin to use at least ten performance based measures. For more information on the ORYX program, visit <http://www.jcaho.org/perfmeas/oryx/oryx_frm.htm>.

take care to emphasize the importance of the wisdom that medical professionals can offer patients as a unique combination of their intelligence, training, and experience in caring for dying human beings, the value system of managed care might very well deem their spending a significant amount of time with terminally ill patients to be inefficient allocation of resources. The meaning of being a physician will be shriveled to its technical component, while the sustained human interaction that renders medicine a "profession" will be relegated to less expensive para-professionals (for example, nurses' aides).

Furthermore, the increasingly prevalent concept of "patient satisfaction" seems inadequate to capture the complexities of a dying patient's relationship with her physician. In order to supplement the outcomes-based measures that are used to track the "objective" success of medical care provided by HMOs, the concept of patient satisfaction is used to measure the subjective reaction of enrollees to the care that they receive.⁷⁰ However, the usefulness of measuring patient satisfaction presupposes a situation in which a customer's desires and objectives are stable and more or less well-defined before the good or service is provided, and that the customer can accurately evaluate the quality of that good or service in terms of how effectively those desires and objectives were satisfied. Yet drawing upon the care of the medical profession during a time of great crisis is not parallel to purchasing a car or a stereo system, cases where satisfaction may be an accurate measure of value. A patient who is seriously ill or dying is not likely to have a stable set of desires and objectives; instead, she is being forced radically to redefine her sense of priorities. Many psychologists (most notably, Elizabeth Kubler-Ross⁷¹) have explored the stages that terminally ill persons pass through in the process of letting go of life, which frequently involve significant moments of anger and denial. During this process, a dying patient will need to relinquish many old desires and cultivate new objectives that take into account the existential reality of her imminent death. For many of us, this will not be an easy

70 In developing Health Plan Employer Data and Information Set (HEDIS) 3.0, the set of performance measures designed to enable employers and other health care purchasers to compare the quality of managed care plans, the National Committee for Quality Assurance (NCQA) emphasized the inclusion of a number of measures designed to consider patient satisfaction. According to NCQA, this emphasis "reflects the opinion that encounters with the health plan should occur in a manner that is responsive to and respectful of the preferences and interests of its members, and that its members' satisfaction is the most revealing summary of the extent to which this is so." Visit <<http://www.ncqa.org/hedis/30exsum.htm>>, the NCQA's web page, which contains a helpful description of the goals of HEDIS.

71 See ELISABETH KUBLER-ROSS, *ON DEATH AND DYING* (1993).

task, or one untouched by conflict with others. If the physician and care-giving team accompanying the patient through this process do their jobs well, their relationship with the patient may at times include significant amounts of strain, if not outright antagonism, as they help the patient to face the reality of her illness and imminent death. If this is the case, then introducing "patient satisfaction" as a measure of quality may be detrimental to good care of the dying. Just as teachers may be tempted to value popularity over their professional obligation to inculcate sometimes difficult lessons in order to do well on student course evaluations, so physicians and health care systems may be tempted to avoid their obligations to challenge as well as comfort patients confronting serious illness or death, in order to achieve a higher score on the patient satisfaction tests that will in part determine their standing in the eyes of their MCO.

In short, unless we can articulate and defend a profound understanding of the intrinsic value of caring for persons who will never again become well, physician-assisted suicide will increasingly appear to be the preferred option to "treat" the dying process. It is fast, inexpensive, and minimizes the consumption of "useless" resources in caring for and comforting a person soon to die in any case.

C. The Limits on the Physician-Patient Relationship

Third, most advocates of assisted suicide presuppose that it will take place in the context of a caring, long-term physician-patient relationship, such as Dr. Quill had with Diane. However, for many patients, that type of relationship is quickly becoming the exception, rather than the rule. Because many employers frequently decide to shift health plans in an effort to obtain a better price, their employees may be forced to change physicians if their doctor is not a participating provider in their new plan. Furthermore, because physician time is valuable, most managed care plans do not allow significant opportunity for patients to get to know their physicians, or for their physicians to get to know them, in anything more than a superficial way. Consequently, it is extremely unrealistic to expect physicians in today's MCOs to be of significant help to patients grappling with the issues surrounding assisted suicide.

Unfortunately, the Oregon Death with Dignity Act, which no doubt serves as a model for other state legislatures that consider legalizing assisted suicide, utterly fails to take into account the radical way in which managed care will alter the physician-patient relationship. In effect, the Act naively presupposes that a terminally ill patient's physician will serve as a reliable and disinterested guide to the decision-

making process of a dying patient. For example, the Act includes no provision prohibiting a physician providing a patient with a lethal prescription from having a financial interest in the patient's early death, nor even a provision directing the prescribing physician to disclose the nature and extent of any such interest that she does possess. There is no requirement that each patient's request for a lethal prescription be reviewed by an independent body whose members are not subject to the managed care plan responsible for the patient's health care. While the Act requires witnesses to the patient's written request for a lethal prescription, it does not require witnesses to monitor all conversations between the physician and the patient about assisted suicide.⁷² As Daniel Callahan and Margot White have argued in their exhaustive critique of the Oregon Act and similar legislation in other states, it is impossible simultaneously to achieve the two objectives commonly articulated by advocates of legalizing assisted suicide: protecting the confidentiality of the physician-patient relationship and creating a vigilant system of oversight to prevent abuse.⁷³ Finally, the potential for abuse is compounded because the Act confers broad civil and criminal immunity for physicians who participate in an assisted suicide in good faith.⁷⁴

D. *The Plight of the Vulnerable*

Finally, I would like to suggest that the populations who are already vulnerable under managed care will be in particular jeopardy if physician-assisted suicide is legalized. In 1994, the blue-ribbon New York State Task Force on Life and the Law concluded that the practices of assisted suicide and euthanasia "would be profoundly dangerous for large segments of the population," particularly for, "those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group."⁷⁵ The policy judgment against legalizing assisted death

72 See OR. REV. STAT. 127.810 § 2.02 (Supp. 1996).

73 See Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICH. L. REV. 1 (1996).

74 See OR. REV. STAT. 127.885 § 4.01 (Supp. 1996). While the exertion of coercion and undue influence are specifically exempted from the immunity provided by the Act, OR. REV. STAT. 127.890 § 4.02(2) (Supp. 1996), it is not clear how these practices would be identified or proven in light of the fact that the Act imposes no duty to report suspected abuse. See Callahan & White, *supra* note 73, at 56-61. They contrast the lack of reporting requirements here with the existence of such requirements in many states with respect to child abuse and elder abuse.

75 THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT vii-viii (1994).

was reached *unanimously* by a group whose members held differing positions on the morality of euthanasia and assisted suicide. Incredibly, in its opinion striking down a New York law prohibiting aiding and abetting suicide, the Second Circuit Court of Appeals did not mention, let alone refute, the Task Force's conclusion.⁷⁶

Disabled persons have particular cause to worry about the legalization of assisted suicide in the context of a managed healthcare system. As many ethicists have argued, there is no reason to think that a narrow decision to legalize assisted suicide in the case of competent, terminally ill patients will not rapidly expand to permit intentional killing in a much broader set of cases. Briefly, the argument for expansion runs as follows. First, if we allow assisted suicide but prohibit euthanasia, will we not discriminate against persons who are too debilitated to take the lethal medication on their own? Moreover, advocates of assisted suicide have argued that the unreliability of lethal prescriptions means that it will always be necessary for a physician to stand by and "administer the coup de grace if necessary."⁷⁷ Second, if we allow the terminally ill to take their own lives in order to avoid great suffering, why should we not do the same for those who are suffering greatly although their death is not imminent? One could argue that they stand in greater need of the service, because they are condemned to a longer period of suffering. Third, if relief of suffering is the aim of allowing the procedure, then why limit it to those who are competent? Just as surrogate decision-makers can make a wide range of other decisions for incompetent patients, so they should be able to make this decision as well.⁷⁸

Once "the right to die" has been so expanded, there is reason to fear that it will combine with two other factors to create undue pressure upon persons with disabilities to end their own lives. First, as many advocates for such persons have argued, the most significant barrier to their flourishing is not their disabilities themselves, but the prejudice and hostility that they encounter in the wider society on account of them. Persons newly confronted with a disability may have internalized these perceptions and seek to end their lives before attempting to adjust to their new limitations. Their caretakers may too

76 See *Quill v. Vacco*, 97 F.3d 708 (2nd Cir. 1996), *rev'd* 117 S. Ct. 2293 (1997).

77 Derek Humphry, Letter, N.Y. TIMES, Dec. 3, 1994, at 22. This was the position taken by Derek Humphry, the founder of the Hemlock Society, immediately after Oregon voters decided to legalize assisted suicide.

78 The roots of this expansion of the right are clearly identifiable in the overruled Ninth Circuit en banc opinion in *Compassion in Dying*, 85 F.3d 1440 (1996), *rev'd sub nom.* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997), as I have argued in M. Cathleen Kaveny, *Assisted Suicide, Euthanasia, and the Law*, *supra* note 4.

easily acquiesce to the "reasonableness" of their suicidal desires, failing to recognize that most persons with disabilities gradually adjust to their limitations and find that they can continue to live productive lives. Second, because of the prejudice, there may be scant popular support for continuing to devote so many societal resources to enabling persons with disabilities to live as full and productive lives as possible.⁷⁹

However, there is another group of persons who might be equally, if not more, vulnerable to societal pressures to end their own lives rather than consuming social resources. Demographic statistics suggest that the heaviest users of the option of assisted suicide will not be morally independent individuals confronting the inexorable decline of a tragic illness or accident that strikes them in their prime, such as Noel Earley, Diane, or Janet Adkins. Rather, those most likely to avail themselves of the "right to die" are poor, elderly women afflicted with the ordinary debilities of frail old age. First, women are more likely to live longer than men. According to 1990 census data, approximately two out of three people older than seventy-five were female.⁸⁰ Second and relatedly, elderly women are more likely to live alone and to dominate the nursing home population, largely because they outlive their husbands. In 1990, eight out of ten persons older than sixty-five and living by themselves are women,⁸¹ as are three out of four elderly residents of nursing homes.⁸² Third, elderly women are more likely to be poor than elderly men. Three out of four persons over the age of sixty-five who live in poverty are likely to be female. Women typically earn less than men, may spend less time in the workforce, and are still to some extent disfavored by a Social Security

79 For discussions critical of assisted suicide by advocates for persons with disabilities, see Stephen L. Mikochik, *Assisted Suicide and Disabled People*, 46 DEPAUL L. REV. 987 (1997) and Paul Steven Miller, *The Impact of Assisted Suicide on Persons with Disabilities—Is it a Right Without Freedom?*, 9 ISSUES L. & MED. 47 (1993). For a discussion supporting legal recognition of that right from the perspective of such an advocate, see Andrew I. Batavia, *Disability and Physician-Assisted Suicide*, 336 NEW ENG. J. MED. 1671-73 (1997). After surveying arguments on both sides of the issue, a position paper issued by the National Council on Disability concludes that it is too dangerous to legalize assisted suicide at the current time. See National Council on Disability, *Assisted Suicide: A Disability Perspective*, March 24, 1997.

80 This and other helpful statistics can be found in Cynthia M. Taeuber & Jessie Allen, *Women in Our Aging Society: The Demographic Outlook*, in *WOMEN ON THE FRONT LINES: MEETING THE CHALLENGE OF AN AGING AMERICA* 11-45 (Jessie Allen & Alan Pifer eds., 1993) [hereinafter *WOMEN*].

81 See *id.* at 28.

82 See BARBARA J. LOGUE, *LAST RIGHTS: DEATH CONTROL AND THE ELDERLY IN AMERICA* 268 (1993).

system which was set up in the 1930s to protect a family structure in which wives were supported by their husbands and there was very little divorce. Consequently, most women have a smaller nest egg to take care of them in old age.⁸³

How autonomous is such a woman's choice in favor of assisted suicide likely to be? Again, there is cause to worry. First, at almost all ages of life, women are more likely than men to suffer from depression that would impede their ability to assess their options in an accurate manner.⁸⁴ Second, as many feminists have pointed out, women are subject to strong social expectations that they sacrifice their own well-being for the good of others. For many women, this social expectation creates or reinforces a strong reluctance to be a "burden" on family members. In many instances, the burden of their care would fall on their own overworked, middle-aged daughters. It is estimated that fourteen million working-age Americans have a disabled parent (or spouse) age sixty-five or older. The vast majority of care-givers are women.⁸⁵ A recent study estimates that 40.8 percent of daughters involved in care-giving have quit their jobs or made other significant work adjustments to accommodate the demands of that care.⁸⁶ In such situations, how many elderly mothers might consider the choice of her own death to be the last, best sacrifice they can make for their own daughters? It is a sobering thought.

VI. CONCLUSION

As much as we Americans like to consider ourselves independent individualists, there is no escaping the fact that our choices are limited by the circumstances under which we find ourselves. There is no doubt that dying, particularly dying in a hospital, is a terrible thing. There is no doubt that most Americans do not receive treatment for depression and state-of-the-art palliative care that can alleviate the suffering of those who are dying.⁸⁷ Yet, it is possible to provide the dying with the type of care that honors their dignity even as they take their

83 See Patricia G. Miller, *Why Women Get Poorer With Age*, PITTSBURGH POST-GAZETTE, Oct. 21, 1995, at A9. See also AMANDA S. BARUSH, *Introduction to OLDER WOMEN IN POVERTY: PRIVATE LIVES AND PUBLIC POLICIES* (1994).

84 See Leslie Laurence, *Longevity a Mixed Blessing: Older Women Risk Depression*, ARIZONA REPUBLIC, Jan. 10, 1995, at D1.

85 See Susan E. Foster & Jack A. Brizius, *Caring Too Much? American Women and the Nation's Caregiving Crisis*, in *WOMEN*, *supra* note 80

86 See R. I. Stone & Peter Kemper, *Spouses and Children of Disabled Elders: How Large a Constituency for Long-Term Care Reform*, 67 MILBANK Q. 485-506 (1989).

87 See *Dying Well in the Hospital: The Lessons of SUPPORT*, 25 HASTINGS CENTER REP. S1-S36 (1995) (special supplement).

leave from this human community.⁸⁸ If assisted suicide is legalized, particularly in the moral and fiscal framework of managed care, there is good reason to fear that we will lose our ability to see the value in such care-taking, both for the dying person and for those she is leaving behind. That, I believe, would be the greatest tragedy of all.

Mary Ann Glendon, in whose honor this essay is published, has persistently explored the impact of positive law on the concrete well-being of human persons, particularly those who do not belong to the elite classes of their society. Never content to confine her analysis to the theoretical justification of the law in question, she also traces its practical effect upon the web of relationships they alter, often by examining sociological data relevant to its impact on various population groups. Time and again, her analysis reveals how a legal framework, that is theoretically justified by an appeal to increased individual autonomy, in fact results in a practical constriction of choices for many of those whom it affects. For example, in *Abortion and Divorce in Western Law*,⁸⁹ Glendon points out how liberalized "no-fault" divorce laws, championed by many legal academics as a victory for individual choice, actually placed many women in a financially desperate situation. Unwilling to jeopardize their own custody of their children in divorce negotiations with their estranged husbands, many women were pressured into accepting lower support payments in exchange for a promise not to contest custody. A change in law that was liberating for upper class populations worked significant harm to those with less means to protect themselves.

In effect, this essay has attempted to extend Glendon's abiding concern for the concrete impact of positive law on the most vulnerable members of our society to the question of assisted suicide. As evinced by the reasoning employed by the en banc majority opinion in *Compassion in Dying v. Washington*,⁹⁰ the now-overruled Ninth Circuit case that would have made assisted suicide a constitutionally protected choice, this is an urgent task. Most disturbing about that opinion was not the result that it reached by itself, but its willingness to brush aside any practical dangers raised by the abstract autonomy-based right that it championed. Oblivious to the shifting financial incentives of managed care, the opinion proceeds as if physicians will virtually always act as an effective counterweight to a patient's prema-

88 See IRA BYOCK, *DYING WELL: THE PROSPECT FOR GROWTH AT THE END OF LIFE* (1997).

89 See MARY ANN GLENDON, *ABORTION AND DIVORCE IN WESTERN LAW* 99-104 (1987).

90 79 F.3d 790 (9th Cir. 1996) (en banc).

ture desire to choose death.⁹¹ Oblivious to the vast disparity in the cost of a lethal injection and the cost of competent hospice care for the terminally ill,⁹² the opinion naively suggests that the real danger facing the poor is that they will be denied a lethal prescription, not that they will all too eagerly be given it.⁹³ Oblivious to widespread views that persons with disabilities have an unacceptable quality of life, it proceeds without considering the devastating pedagogical effect its words might have on society's willingness to dedicate significant resources to their assistance.⁹⁴

On the level of philosophical commitment, American society encompasses a range of views on the moral permissibility of physician-assisted suicide, ranging from those who consider it a core aspect of individual autonomy to those who view it as a betrayal of a physician's obligation to care for and not to kill the patients in her charge.⁹⁵ That debate will not be settled any time soon. Nonetheless, like the New York Task Force, we do not all need to agree about the morality of assisted suicide to recognize the dangers of legalizing it in the midst of the managed care revolution currently sweeping through all facets of our health care system. Let us first ensure that the specific tempta-

91 See *id.* at 827. (“[M]ost, if not all, doctors would not assist a terminally ill patient to hasten his death as long as there were any reasonable chance of alleviating the patient’s suffering or enabling him to live under tolerable conditions.”)

92 On February 26, 1998, the Oregon Health Services Commission, which is the group responsible for determining the scope of services covered by the Medicaid program in the state, voted 10:1 to make assisted suicide a covered service. In response to a question about the cost of providing coverage, Hersh Crawford, the head of the Oregon Office of Medical Assistance Programs, said “these are cheap prescriptions, and health care provider time will not be significant.” Brad Cain, *Oregon Officials Say Suicide Should Be a Tax-Funded Benefit*, ROCKY MOUNTAIN NEWS, Feb. 28, 1998, at 38A. There is no indication that Mr. Crawford recognized any irony in his remark. Oregon will need to cover the service entirely from state funds, since President Clinton signed a law prohibiting the use of federal funds to pay for physician-assisted suicide in April 1997. The Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105–12, 111 Stat. 23 (1997).

93 See *Compassion in Dying*, 79 F.3d at 825. (“The argument that disadvantaged persons will receive more medical services than the remainder of the population in one, and only one, area—assisted suicide—is ludicrous on its face.”)

94 For example, the en banc court writes, “[a] competent, terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent.” *Id.* at 814. Such a statement immediately places *all* those living in such a state of helplessness in the rhetorical position of justifying why they would choose *not* to die.

95 See Leon R. Kass, M.D., *Neither for Love Nor Money: Why Doctors Must Not Kill*, in MERCY OR MURDER? EUTHANASIA, MORALITY, AND PUBLIC POLICY (Kenneth R. Overberg, S.J. ed., 1993)

tions to wrongdoing inherent in managed care are well understood and effectively counteracted before we consider extending the power of physicians so far as to encompass a license to kill their patients. In light of the well-publicized abuses that have been associated with the transition to managed care, this type of legislative restraint should be something that we all can agree is collectively owed to the most vulnerable members of our community, as well as to ourselves, no matter what our stand on the morality of assisted suicide considered as an abstract issue.