Managed Care, Autonomy, and Decision-Making at The End-of-Life

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ARTICLE

MANAGED CARE, AUTONOMY, AND DECISIONMAKING AT THE END OF LIFE

Alan Meisel*

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I. INTRODUCTION

Americans hardly need to be reminded that our health care system is in the midst of tremendous change, perhaps the greatest change in the shortest amount of time that has ever been witnessed. The organization, structure, and financing of health care are changing so rapidly and are being buffeted by so many new forces\(^1\) that it is difficult to know where we are headed and at what rate. It might be the extreme of a complete free market, or it might be the opposite—a complete takeover by the federal government of the financing and/or delivery of health care brought on by the public's reaction to the excesses of the market. More likely, it will be somewhere in between, but just what, where, and when cannot now be predicted with a reasonable degree of certainty.

In the midst of this change, and not totally separate from it, has come increasing public disenchantment with health care provided to patients near the end of life.\(^2\) Dying in the latter part of the twentieth century is frequently characterized by aggressive, expensive, and depersonalized care that neither patients nor their families—nor, ironically, often the people providing the care—desire.\(^3\) As a result of this situation, a number of responses have arisen including: (1) laws to encourage the use of adequate medication for pain relief;\(^4\) (2) an increasing

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3. See generally Alfred F. Conard, Elder Choice, 19 AM. J.L. & MED. 233 (1993) (discussing the effects of current medical practices on both patients and the health care system).

emphasis on teaching medical students and doctors about the treatment of pain and other symptoms associated with terminal illness;\(^5\) and (3) efforts to increase the utilization of hospice care.\(^6\)

Of the many efforts to deal with end-of-life decisions, the response this Article addresses is the increased effort to legalize physician-assisted suicide. Physician-assisted suicide is viewed as an outgrowth of—indeed, the natural concomitant of—a trend toward greater autonomy in medical care in general, and end-of-life care in particular, that has been evolving for the better part of the twentieth century.\(^7\) Although efforts to legalize physician-assisted suicide began before it was clear that managed care would become as dominant as it has, it is accurate to state, without meaning to imply any cause-and-effect relationship, that those efforts have grown in tandem with the rise of managed care.

As managed care becomes the dominant mode for the delivery of health care and as the widespread legalization of physician-assisted suicide becomes more likely, concerns about the intersection of these two trends increases.\(^8\) In the relentless effort to cut medical costs, if suicide becomes a legally accepted

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5. See David M. Frankford, *Scientism and Economism in the Regulation of Health Care*, 19 J. HEALTH POL'Y & L. 790-91 (1994) (describing a course at the Harvard Medical School designed to teach students to examine attitudes toward terminal illness and death, to understand how patients cope psychologically and physically with chronic and terminal illness, and to consider the roles of doctors in caring for dying patients, and noting that such a course is necessary to better address and ameliorate a patient's illness).

6. See Kathleen M. Boozang, *An Intimate Passing: Restoring the Role of Family and Religion in Dying*, 58 U. PITI. L. REV. 549, 608 & n.319 (1997) (commenting that there is an increasing expectation that family members become involved in hospice care, and citing state regulations that strongly encourage family members to become involved in the formulation of a hospice care plan).


8. See, e.g., David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 415-16 (1998) (pointing out that opponents of physician assisted suicide complain that managed care organizations will pressure physicians to kill their patients).
option, some fear that costs will be cut by inducing patients to seek the aid of their physicians in committing suicide.  

This Article does not intend to attempt to evaluate the advantages and disadvantages of managed care by itself or in relation to other means of organizing the delivery of health care. For present purposes, this Article will assume that managed care is here to stay in one form or another. Similarly, this Article does not intend to mount an argument for or against the legalization of physician-assisted suicide. Physician-assisted suicide is now legal in Oregon, and its practice there has begun. Furthermore, physician-assisted suicide is practiced illicitly and, therefore, clandestinely by many physicians in other states. Thus, for present purposes, this Article will also assume that physician-assisted suicide will occur both licitly and illicitly in the years to come and that it will increasingly become decriminalized.

Given these assumptions, what this Article will focus on is the collision of these trends, namely that the impetus for the legalization of physician-assisted suicide is occurring in the context of a changing structure of the health care system—characterized by a relentless movement from fee-for-service/indemnity insurance to

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9. See id. at 416 n.25 (illustrating the concern that the socio-economic climate created by managed care organizations will encourage physicians to assist patients with suicide); Susan M. Wolf, Physician-Assisted Suicide in the Context of Managed Care, 35 DUQ. L. REV. 455, 456 (1996).

10. There is increasing opposition to managed care from patients, health care professionals, and institutional health care providers as well as opposition to the effect of managed care on patients from legislators. See George Anders & Ron Winslow, Turn for the Worse: HMOs' Woes Reflect Conflicting Demands of American Public, WALL ST. J., Dec. 22, 1997, at 1 (noting that some of the managed health care industry's biggest providers are experiencing a backlash from consumers, doctors, and politicians, describing the losses sustained by many of the large maintenance organizations, and noting the fear of managed care organization executives that they may be “losing their mandate to change the health-care system”). Managed care is on the defensive. The pendulum has begun to swing in the other direction more quickly than one would have thought likely. In fact, managed care may not be here to stay; it may merely be a transitional phase on the road to some other form of organization of the health care system.

11. As of August 1998, Oregon physicians had prescribed a lethal dose of medication to terminally ill patients on 10 occasions. See 8 Deaths Linked to Oregon Suicide Law, L.A. TIMES, Aug. 19, 1998, at A5. Eight of those patients actually died from the prescribed overdose, and the other two died naturally before being able to take the medications. See id.

12. See Tracy J. Edgerton, Comment, Fundamental Rights and Physician-Assisted Suicide: Protecting Personal Autonomy, 1 J. GENDER RACE & JUST. 283, 290 (1997) (declaring that, like bans on abortion, bans on physician-assisted suicide have historically forced individuals to seek illicit means to secure access to it).

13. Over 40 bills were introduced to legalize physician-assisted suicide in at least 15 states in 1997 and 1998. See CHOICE IN DYING, THE RIGHT-TO-DIE-LAW DIGEST (1998). None were enacted.
managed care—and that for some this changing context makes the prospect of legalizing physician-assisted suicide even more odious than it would be otherwise.

The position this Article advocates, which should be placed on the table at the outset, is that the horse is already out of the barn. Physician aid-in-dying has been increasingly recognized as legally acceptable by state courts and legislatures since 1976. The current movement for the legalization of physician-assisted suicide is merely an effort to legalize a new means of physician aid-in-dying. Whatever objections can be lodged against this new “active” means of physician aid-in-dying can also be lodged against the accepted “passive” means. Physician-assisted suicide may indeed pose greater risks under managed care than under the system of fee-for-service/indemnity insurance that it is fast replacing, but the accepted means of passively hastening death do too.

In substantiating this claim, this Article first discusses the current status of the law of end-of-life decisionmaking as it has evolved out of the law of informed consent and matured in the context of passively hastening death. In Part II, this Article explores the gradual, and in more recent years, sudden transformation of the structure and financing of the health care system. Finally, in Part III, this Article ties these themes together and examines how the changing structure of the health care system might and should affect the law governing end-of-life decisionmaking.

II. AUTONOMY AND END-OF-LIFE DECISIONMAKING

The greatest revolution of twentieth century American society has been the assertion of citizen autonomy. Despite the fact that the Bill of Rights was enacted in the first few decades of our republic’s history, most of these protections lay dormant for more than a century. As a check on the power of states to
infringe individual rights, the Bill of Rights played no important role until long after the post-Civil War adoption of the fourteenth amendment.\(^\text{17}\)

Beginning slowly in the post-World War I period, when civil liberties were first asserted in a serious manner (and first squelched in an equally serious manner), and experiencing another surge in the post-World War II period, the individual began to come out from under the sway of paternalistic social institutions—not just government, but unions, schools, families, and businesses through the assertion of rights in a series of movements for employment rights,\(^\text{18}\) student rights,\(^\text{19}\) children’s,\(^\text{20}\) spousal, and elder’s rights,\(^\text{21}\) consumer rights,\(^\text{22}\) and of course the civil rights movement (first for racial, and later for gender and equality).\(^\text{23}\) Professional relationships have not been immune from this larger social trend. Individual autonomy in one of the most important professional relationships, the doctor-patient relationship, has been on the ascendance for more than four decades.\(^\text{24}\)

\(^{17}\) See Gitlow v. New York, 268 U.S. 652 (1925) (marking the first instance in which the protections of the Bill of Rights was applied to the States); Marshall J. Tinkle, Forward Into the Past: State Constitutions and Retroactive Laws, 65 TEMP. L. REV. 1253, 1257 (1992) (noting that most of the guarantees of the Bill of Rights were found to apply to the States only in the last thirty years).

\(^{18}\) See Leroy S. Merrifield et al., Labor Relations Law 36 (8th ed. 1989) (noting that “labor unions have remained strong and have won substantial wage increases and fringe benefits . . . during the post-World War II” period).

\(^{19}\) See generally Nadine Strossen, Students’ Rights and How They Are Wronged, 32 U. RICHMOND L. REV. 457, 459-61 (1998) (detailing the development of the students’ rights movement and defining its goals).


\(^{21}\) See David S. Douglas et al., Comment, Rx for the Elderly: Legal Rights (and Wrongs) Within the Health Care System, 20 HARV. C.R.-C.L. L. REV. 425, 428 (1985) (explaining the importance of recognizing the rights of the elderly to control the course of their health care).


\(^{24}\) See Jesse A. Goldner, An Overview of Legal Controls on Human Experimentation and the Regulatory Implications of Taking Professor Katz Seriously, 38 ST. LOUIS U. L.J. 63, 74-75 (1993) (tracing the change over the last few decades in the physician-patient relationship through the doctrine of informed consent).
A. The Development of the Law of Informed Consent

In both legal and ethical theory, informed consent is the primary instrument of autonomy in the doctor-patient relationship. However, as is often the case, theory is quite different from reality. Doctors frequently deride informed consent, claiming that it is impossible to achieve and calling it a myth or a fiction. In day-to-day medical practice, form—literally, the so-called informed consent form—is too often honored over substance. In legal practice, informed consent has turned out to be less a means for achieving patient autonomy than for recovering damages for injured patients when it is impossible to prove garden variety professional negligence.

The original proponents of informed consent—as well as the more thoughtful contemporary commentators—had something grander in mind than the faint shadow that is informed consent in practice, something that caught the imagination of the field of bioethics and which, it is probably not an exaggeration to say, has become the core principle of American bioethics. It is probably no coincidence that the contemporary field of bioethics originated in the 1950s, the same decade that the term “informed consent” was first used in a judicial opinion.


[26. See Sandra H. Johnson, End-of-Life Decision Making: What We Don’t Know, We Make Up; What We Do Know, We Ignore, 31 IND. L. REV. 13, 46-47 (1998) (discussing one school of thought that holds informed consent to be ill-suited to decisionmaking regarding medical intervention and that argues it is time to abandon the myth of individual patient autonomy and redesign the doctor-patient relationship).]


[28. See Ben A. Rich, The Values History: A New Standard of Care, 40 EMORY L.J. 1109, 1148-49 (1991) (discussing, in the bioethics context, the idea that the doctrine of informed consent allows for the inclusion of all relevant factors when determining an appropriate course of action and not just medical diagnosis and prognosis).]

[29. See generally ALBERT JONSEN, THE BIRTH OF BIOETHICS 3 (1998); DAVID J. ROTHMAN, STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISION MAKING 105-06 (1991) (explaining how one of the first efforts to explore medical ethics from a non-physician standpoint occurred in 1954, and noting that it looked at the topic using Protestant religious ethics rather than formal academic philosophy).]

The origins of informed consent extend back long before the phrase informed consent came into the law of the doctor-patient relationship. Despite the fact that it so often quoted, none of its luster has been lost. I am referring to Justice Cardozo's 1914 dictum that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."\(^{31}\) It took almost a half-century for this resounding, but amorphous, phrase to begin to be actualized. Although the term informed consent was introduced into the case law in 1957,\(^{32}\) it took another fifteen years for it to mature into the requirement resembling the one we know today: reasonable divulgence of information by physicians to patients enabling the making of intelligent decisions.\(^{33}\)

B. The Right to Refuse Treatment and End-of-Life Decisionmaking

The corollary of the doctor's obligation to obtain informed consent (or even simple consent) before treating a patient is the patient's right to refuse treatment.\(^{34}\) These two concepts are, in theory, opposite sides of the coin, but in practice, the latter has not always lived up to the promise of the former.

The strength of the right to refuse treatment met its first serious test in the Jehovah's Witness blood transfusion cases that began to arise in the 1960s, and the results—often in keeping with the more paternalistic strains of the doctor-patient relationship—were not initially encouraging. For example, in three well-known cases, the courts gave serious lip service to the right to refuse treatment, but then found a way to avoid implementing the right when the consequence of refusal would be the patient's death.\(^{35}\)


\(^{32}\) See Salgo, 317 P.2d at 181.


\(^{34}\) See Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261, 270 (1990) ("The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment.").

\(^{35}\) See In re President & Directors of Georgetown College, Inc., 331 F.2d 1000, 1008-09 (D.C. Cir. 1964) (noting that an individual's liberty to control him or herself extends to the liberty to end his or her own life, but granting permission to the hospital to render unwanted treatment at least in part because the patient had voluntarily sought treatment, evidencing the patient's "actual desire to live"); United States v. George, 239 F. Supp. 752, 754 (D. Conn. 1965) (considering religious liberty but holding that a patient may not demand treatment that amounts to malpractice); John F. Kennedy Memorial Hosp. v. Heston, 279 A.2d 670, 673 (N.J. 1971) (examining the patient's freedom to choose to die but reasoning that absent a court
This was the state of the law in 1976 when the Karen Quinlan case reached the New Jersey Supreme Court.36 Ms. Quinlan (unlike the Jehovah's Witness patients) had virtually no chance for recovery; certainly, there was no reasonable medical probability that she would recover.37 When Ms. Quinlan's parents sought to terminate the medical treatment that was keeping her alive—which it was assumed would eventuate in her death—the court had little difficulty in hewing to the more autonomy-based principles, easily distinguishing the more paternalistic legal strains present in its own recent precedent in which it had upheld an order compelling the administration of a blood transfusion to a Jehovah's Witness.38 It explained the difference as follows:

We have no doubt, in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death. To this extent we may distinguish Heston ... which concerned a severely injured young woman ... whose life depended on surgery and blood transfusion; and ... most importantly a patient apparently salvageable to long life and vibrant health;—a situation not at all like the present case.39

Drawing on the federal and state constitutional rights of privacy, the court concluded that were Ms. Quinlan competent, she would have been entitled to terminate life-sustaining medical treatment and die, and that because she could not exercise this right herself, her guardian had the authority to do so for her, assuming that would be her own wish.40

37. See id. at 653-56 (describing in detail the plight of Ms. Quinlan, a 22 year old woman who, as a result of two unexplained instances of cessation in breathing, was in a permanently comatose state, and whose father sought permission from the court to cease all extraordinary medical care for his daughter).
38. See id. at 663 (distinguishing John F. Kennedy Memorial Hosp. v. Heston, 279 A.2d 670 (N.J. 1971)).
39. Id.
40. See id. at 663-64 (elaborating on the privacy right and discussing its relationship to one's choice to die).
The judicial flirtation with medical paternalism in the Jehovah’s Witnesses cases quickly receded, and courts had little difficulty following the lead set in *Quinlan* when patients had no chance of meaningful recovery even if treatment were administered. Quinlan has spawned more than one hundred similar cases litigated in appellate courts, resulting, over the course of two decades, in a consensus about end-of-life decisionmaking. The essentials of this consensus are that competent patients have the right to refuse medical treatment even if that refusal will result in the patient’s death, that families ordinarily have the authority to decline life-sustaining medical treatment on behalf of patients who no longer possess the capacity to decide for themselves, and that end-of-life decisionmaking should ordinarily take place in the clinical setting unencumbered by any requirement for judicial oversight. The consensus has expanded to include nonterminally-ill patients, and by some courts to include terminally ill patients whose wishes could not be as easily determined as Ms. Quinlan’s were. Some courts have even

41. See 1 MEISEL, supra note 4, § 1.7 (describing the development of right to die jurisprudence and legislation after Quinlan).


43. See 1 MEISEL, supra note 4, § 2.2 (discussing the legal environment surrounding the issue of forgoing life-sustaining treatment). But see Martin v. Martin (*In re Martin*), 538 N.W.2d 399, 406 (Mich. 1995) (holding that a surrogate must implement the incompetent patient’s previously expressed decisions); *In re Westchester County Med. Ctr.*, 531 N.E.2d 607, 613 (N.Y. 1988) (adopting a standard wherein it must be shown, by clear and convincing evidence, that the patient intended to decline treatment before treatment will be denied); Spahn v. Eisenberg (*In re Edna M.F.*), 563 N.W.2d 485, 486 (Wis.) (holding that a guardian may only direct the withdrawal of life-sustaining medical treatment if the incompetent ward is in a persistent vegetative state and the decision is in the best interests of the patient), cert. denied, 118 S. Ct. 372 (1997).

44. See, e.g., Thor v. Superior Court, 855 P.2d 375, 379, 390 (Cal. 1993) (In Bank) (holding that absent a countervailing state interest, a quadriplegic person is allowed to refuse treatment in the form of nutrition); Bouvia v. Superior Court, 225 Cal. Rptr. 297, 299, 307 (Cal. Ct. App. 1986) (ordering the removal of a feeding tube from a patient suffering from severe cerebral palsy and resulting quadriplegia); State v. McAfee, 385 S.E.2d 651, 651-52 (Ga. 1989) (affirming a lower court’s ruling that a non-terminally ill quadriplegic patient had the right to turn off his ventilator which he was dependent upon to breathe); McKay v. Bergstedt, 801 P.2d 617, 619-20 (Nev. 1990) (deciding that a thirty-one year old quadriplegic had the right to refuse medical treatment).

revisited the Jehovah’s Witnesses cases and concluded that the
fact that a simple treatment could restore the patient’s health to
the status quo ante did not justify the forced imposition of
treatment.\textsuperscript{46}

\textbf{C. The Changing Nature of End-of-Life Decisionmaking}

Although we have traveled far down the road of legalizing
physician aid-in-dying, the actions of courts and legislatures in so
doing has been predicated on the assumption that the physician’s
aid is “passive”—that is, it is achieved by the withholding or
withdrawing of treatment.\textsuperscript{47} We have had a strong reluctance to
legitimate the “active” hastening of death by doctors—either
physician-assisted suicide or mercy killing.\textsuperscript{48} Despite the

adult); In re Grant, 747 P.2d 445, 446 (Wash. 1987) (14-year old with Batten's
disease); In re Hamlin, 689 P.2d 1372, 1374-75 (Wash. 1984) (mentally retarded
adult); Lenz v. L.E. Phillips Career Dev. Ctr. (In re L.W.), 482 N.W.2d 60, 63 (Wis.
1992) (involving an elderly man with long history of mental illness and psychiatric
hospitalization who “may never have been competent”). But see Soper v. Storar (In re
Storar), 420 N.E.2d 64, 68, 73 (N.Y. 1981) (refusing to permit termination of life
sustaining blood transfusions from a mentally retarded adult).

46. See \textit{In re Dubreuil}, 629 So. 2d 819, 820, 827-28 (Fla. 1993) (deciding that a
separated but not divorced mother of four would not be abandoning her children by
refusing medical treatment and, therefore, the burden required to override the
patient’s right to refuse treatment was not satisfied); Public Health Trust v. Wons,
541 So. 2d 96, 97-98 (Fla. 1989) (finding that the state’s interest in the support of
children by two parents, though important, is not enough to overcome the
constitutional right to refuse treatment); Harrell v. St. Mary’s Hosp., Inc., 678 So. 2d
455, 456, 458 (Fla. Dist. Ct. App. 1996) (holding that a hospital did not have
standing to bring a petition requesting that a blood transfusion be given to a
pregnant female patient); St. Mary’s Hosp. v. Ramsey, 465 So. 2d 696, 697-698 (Fla.
Dist. Ct. App. 1985) (holding, after considering competing state interests, that a 27
year old, lucid father had the right to refuse a transfusion); Norwood Hosp. v.
Munoz, 564 N.E.2d 1017, 1018, 1024 (Mass. 1991) (stating that absent proof that a
minor child will be abandoned by an adult's death resulting from the refusal of a
blood transfusion, such treatment will not be forced upon the patient); Fosmire v.
Nicoleau, 551 N.E.2d 77, 78, 81 (N.Y. 1990) (distinguishing between the state’s
interest in protecting its citizens against third parties, and the state’s interest in
protecting citizens from injuries resulting from their own actions); In re Milton, 505
N.E.2d 255, 260 (Ohio 1987) (concluding that a competent adult who believed in
faith healing had the right to refuse medical treatment that would arguably save her
life).

47. The courts have had to use some fancy sleight-of-hand to come to the
conclusion that withdrawing treatment is “passive.” See 2 MEISEL, \textit{supra}, note 4, §
18.6 (illustrating the complexity of the distinction between acts and omissions in
physician-assisted suicide); Alan Meisel, \textit{Physician-Assisted Suicide: A Common
the problem that many times withholding treatment requires an affirmative act and not
simply an omission of treatment).

48. See David T. Burnett, Comment, Compassion in Dying v. State of
Washington: Physician-Assisted Suicide—The Struggle to Reconcile “Quality of Life”
and “Sanctity of Life,” 8 REGENT U. L. REV. 153, 179 (1997) (explaining that the
willingness of some lower courts to find that no constitutionally significant distinction between the two forms of hastening death exists, the Supreme Court disagreed, holding in 1997 that state laws making assisted suicide a crime are constitutionally permissible even when applied to terminally ill patients seeking the assistance of a licensed physician to provide them with a lethal prescription to actively end their life. However, the Court did give the states a green light to legalize physician-assisted suicide if they so choose. Thus, under the Court's reasoning, the voter initiative to legalize physician-assisted suicide for terminally ill patients approved by the Oregon electorate in 1994 and reaffirmed in 1997 is constitutionally valid. Whether other states will follow is uncertain, and whether the Court might reconsider and find that state prohibitions on physician-assisted suicide have a rational basis is an open question. The Supreme Court has been generally reluctant to expand the concept of substantive due process, and explaining how this reluctance has been carried into the realm of the physician-assisted suicide debate).

49. See, e.g., Quill v. Vacco, 80 F.3d 716, 729 (2d Cir. 1996) (comparing patients who request the removal of life support with those terminally ill patients who do not require life support but nevertheless request a hastening of their death), rev'd, 117 S. Ct. 2293 (1997); Compassion in Dying v. Washington, 79 F.3d 790, 822 (9th Cir. 1996) (en banc) (refusing to distinguish state-authorized physician life-ending conduct from physician-assisted suicide), rev'd sub nom. Washington v. Glucksberg, 117 S. Ct. 2258 (1997); Kevorkian v. Arnett, 939 F. Supp. 725, 731-32 (C.D. Cal. 1996) (noting the plaintiff's argument that the statute outlawing assisted suicide distinguished between two similarly situated terminally ill patients but refusing to apply the standard of strict scrutiny and, therefore, concluding that there need only be a rational basis for applying the statute), vacated and appeal dismissed, 136 F.3d 1360 (9th Cir. 1998).

50. See Washington v. Glucksberg, 117 S. Ct. 2258, 2275 (1997) (holding that the Washington statute making it a felony to "promote suicide" does not violate the due process clause of the Fourteenth Amendment even when applied to competent, terminally ill adults wishing "to hasten their deaths by obtaining medication prescribed by their doctors"); see also Vacco v. Quill, 117 S. Ct. 2293, 2297 (1997) (noting that the New York statutes outlawing assisted-suicide neither infringe fundamental rights nor involve suspect classifications and are, therefore, entitled to a strong presumption of validity).

51. See Glucksberg, 117 S. Ct. at 2275 (stating that the Court's holding permits the debate about physician-assisted suicide to continue); see also Lee v. Harderroad, 118 S. Ct. 328 (1997) denying cert. in Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997) (holding that plaintiffs lacked standing to challenge the constitutionality of an Oregon statute legalizing physician-assisted suicide).

Consensus among scholars is that the Court did leave it up to each state to decide for itself how to address the concerns over physician-assisted suicide. See, e.g., Benjamin C. Zipursky, Physician-Assisted Suicide: Right and Risk to Vulnerable Community, 24 FORDHAM URB. L.J. 777, 777 (1997); Susan Frelich Appleton, Assisted Suicide and Reproductive Freedom: Exploring Some Connections, 76 WASH. U. L.Q. 15, 31 (1998).

52. See Glucksberg, 117 S. Ct. at 2275 (holding only that the Washington statute banning physician-assisted suicide was valid, not that statutes to the contrary are invalid; leaving the decision to the states).
suicide are unconstitutional is even more uncertain. Nonetheless, the debate and efforts to legalize physician-assisted suicide will surely continue.

III. THE CHANGING STRUCTURE OF HEALTH CARE DELIVERY

A. Historical Perspective

The American medical system, from the early part of the twentieth century until roughly 1970, was structured around two important and complementary concepts: fee-for-service medicine and indemnity insurance. In fee-for-service medicine, as the name suggests, the doctor provides a service to a patient, and charges the patient a fee. Historically, many people could not pay doctors’ fees, especially when they needed treatment most: when a major health catastrophe struck with significant associated cost. To address this problem, rudimentary mechanisms for the financing of the costs of individuals’ health care gradually began to develop in the first few decades of the twentieth century. These included individual health insurance, employer-provided group health insurance, prepayment plans for hospital care, and health care cooperatives. Hospitals, like many other institutions, suffered a severe financial crisis during the Depression. This created a strong incentive for hospitals

53. In the last footnote in each case, the majority opinion somewhat grudgingly left the door open to reconsideration. See id. at 2275 n.24 (noting that although the Court rejected the court of appeals’ specific holding that the Washington statute was unconstitutional as applied to a particular class, it did not “foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenged”); see also Vacco, 117 S. Ct. at 2302 n.13 (relating that some applications of the New York statute could in some situation intolerably intrude on a patient’s freedom). See generally Robert A. Burt, The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care, 337 NEW ENG. J. MED. 1234, 1234-35 (1997) (arguing that there are five votes for a constitutional right to palliative care, and if this right were thwarted, these five Justices might find state bans on assisted suicide unconstitutional).

54. See PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 383 (1982) (discussing the “health care crisis” of the 1970s, and noting that fee-for-service medical costs were higher than prepaid health care by 20-40%).

55. See id. at 63.

56. See id. at 260 (explaining that in 1929, the average middle class family that was financially secure was not secure against the costs of medical care, especially illnesses requiring hospitalization).

57. See id. at 294 (describing the methods private companies developed to insure against employee illness and injury).

58. See id. at 209, 290-334.

59. See id. at 295-96 (noting that during the time that private health insurance plans began to emerge, the Depression began to expose the financial insecurity of the nations voluntary hospitals through falling receipts and rising deficits).
(and later, physicians) to encourage and support the development of insurance to enhance the prospects that they would get paid for the treatment they rendered. These insurance plans were traditional indemnity insurance plans. After patients paid their bills, they submitted the bills to their insurance company, which indemnified them for their medical expenses.

Indemnity insurance is not the only way of providing people with a means for paying for health care they otherwise could not afford. Prepaid plans between employee associations and physician groups also came into being. In these plans, an employer would contract with a physician or a group of physicians to provide medical care to their employees for a fixed amount, prepaid in advance, depending on the number of employees. These evolved into comprehensive, prepaid health care plans and were first called “health maintenance organizations” (“HMOs”) in 1970. By 1971, some thirty HMOs were in operation. The Nixon administration, envisioning HMOs as a means of improving health because of their emphasis on preventive care and controlling costs because of their financing mechanism, sought to create 1,700 HMOs by 1976. Congress passed the HMO Act of 1973 to encourage the growth of HMOs and to establish standards for “federally qualified” plans.

B. The Contemporary Situation

Today, HMOs have metamorphosed into a variety of new health structures, generically referred to as managed care. No two managed care plans are alike; the variability is immense.

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60. See id. at 299 (citing a 1932 study which pointed out that patients were more likely to pay their doctors after their insurance paid the hospital bills).
61. See id. at 291-92 (defining the concept of an indemnity plan).
62. See, e.g., id. at 301 (citing the case of the Los Angeles Department of Water which, in 1929, contracted with two doctors to provide medical care to their workers and the workers’ families).
63. See id. at 301-06 (discussing the mechanics of prepaid plans and giving historical examples of their operation).
64. See id. at 395.
65. See id. at 396.
66. See id. (noting that HMOs were proposed to reverse the illogical incentive of encouraging doctors and hospitals to benefit from sickness rather than health).
68. See STARR, supra note 54, at 400-01 (discussing the goals and requirements of the legislation).
69. See Wolf, supra note 9, at 455 (stating that HMOs are just one of the three forms of MCOs that together make up more than half of the market of health insurance).
70. See John P. Little, Note, Managed Care Contracts of Adhesion: Terminating...
However, there are important common features, some of which help distinguish managed care from the combination of fee-for-service medicine and indemnity insurance that it is rapidly supplanting.

The most important feature of managed care is the mechanism by which doctors are paid for the services they render to patients—referred to as "capitation." Under capitation, doctors receive a fixed amount per patient (usually per month)—that is, a per capita payment. This per capita payment comes from the insurance company or managed care company out of the premiums paid to it by the patient, or more likely, by the patient's employer or union through a group health plan. This payment is received regardless of whether they treat the patient or not, whether the patient is sick or well.

If a patient is very sick, the amount received by the doctor for that patient that month will not cover the costs of treatment that month, and it will not be nearly as much as the doctor would have received under a fee-for-service/indemnity insurance plan. On the other hand, if a patient is well and does not require treatment, the doctor receives income on behalf of this patient that would not have been received at all under a fee-for-service/indemnity insurance plan. In the end, the situation is all supposed to even out, with the payments made on behalf of healthy patients subsidizing the cost of treating sick patients, and with enough excess of the former over the latter to ensure that the doctor winds up making a decent living.

71. See Wolf, supra note 9, at 461 (stating that capitation is the foremost incentive imposed by MCOs on physicians to contain costs).
72. See André Hampton, Resurrection of the Prohibition on the Corporate Practice of Medicine: Teaching Old Dogma New Tricks, 66 U. Cin. L. Rev. 489, 505 (1998) ("Under capitation reimbursement . . . the physician receives a flat monthly payment per each patient assigned to the physician's care.").
73. See Wolf, supra note 9, at 461 (stating that employers can contract with an MCO to provide health care for its employees, or individuals can contract directly with the MCO to subscribe to its health plan, and the MCO, in turn, contracts with the physicians to actually provide the service).
74. See Mark O. Hiepler & Brian C. Dunn, Irreconcilable Differences: Why the Doctor-Patient Relationship is Disintegrating at the Hands of Health Maintenance Organizations and Wall Street, 25 Pepp. L. Rev. 597, 606 (1998) (noting that doctors receive a fixed fee per month regardless of the health of the patients or the services provided).
75. See id. (explaining that under capitation the financial incentive is geared toward the doctor not seeing the patient because if a patient does come in and the costs associated with care exceeds the capitation amount, the doctor loses profits).
76. See id.
77. See id. at 606-07 (noting that the risk is on the doctor if all patients get sick.
1. Incentives in the Fee-for-Service/Indemnity Insurance System. The capitation system of paying doctors has significantly altered the incentives from those existing under a fee-for-service compensation mechanism financed by indemnity insurance. Under a fee-for-service system, the financial incentives were skewed in favor of the doctor treating the patient. Doctors made money when patients were sick, and they made more when patients were sicker. The worst thing that could happen to a doctor from a financial perspective would be to have patients who never got sick or injured. Although doctors may not have wished sickness on patients, they counted on it, and because sickness is inevitable, doctors would be financially rewarded by it—and more handsomely rewarded if their patients needed more medical care rather than less.

This incentive system had important implications for patients as well as for physicians. When patients were in need of treatment, the financial incentives of fee-for-service/indemnity insurance medicine were generally aligned with patients' interests in getting the medical treatment they needed. The financial incentives for doctors were also consistent with their long-standing professional duty to heal. It was really quite a simple and sensible arrangement: sick patients got the treatment their doctors thought they needed.

There were, of course, problems with, as well as benefits to, the fee-for-service/indemnity insurance system. First, this system not only creates incentives to provide necessary treatment, but it also creates incentives to provide more treatment than may be

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78. See James W. Childs, Jr., Comment, You May Be Willing, But Are You Able?: A Critical Analysis of "Any Willing Provider" Legislation, 27 CUMB. L. REV. 199, 201-02 (1997) (stating that under a fee-for-service system neither the patient nor doctor is directly responsible for the cost of the prescribed care; therefore, "good healthcare" became "more healthcare").

79. See id. at 201-02 (discussing how under a fee-for-service plan doctors are paid for each service actually rendered to the patient, and that the insurers pay for almost all the service the doctor either performed or prescribed).

80. See generally Hampton, supra note 72, at 503 (stating that the fee-for-service method of payment kept the financial incentives of the doctors in line with consumption of medical resources because the more care the doctor extended toward the patient, the more the doctor was paid).

81. See id. at 509 (stating that under a fee-for-service system the physicians' interest was aligned with that of the patient because it cost doctors and patients nothing for the doctor to recommend and carry out additional tests or procedures).

82. See id.

83. See Robert I. Field, New Ethical Relationships Under Health Care's New Structure: The Need For A New Paradigm, 43 VILL. L. REV. 467, 468 (1998) (noting that traditional medical practice dictated that physicians provide patients services based only on their professional judgment and the patient's medical needs).
necessary for the patient’s well-being. Treatment is not an unalloyed good, and more treatment is not necessarily better than less. Treatment can cause injuries worse than the disease or even kill. This fee-for-service system, therefore, creates an incentive for doctors to provide unnecessary treatment even when acting in complete good faith.

Second, the fee-for-service system became ever more costly as new technology increased the costs of treatment, and as doctors and patients became more addicted to those treatments. Indemnity insurance was like an open spigot, assuring a continued flow of cash to fund the treatment. Indeed, it is this financial consequence that has been the most powerful incentive in the movement toward managed care. But in the final analysis, the fiscal incentives created by fee-for-service medicine and indemnity insurance were generally aligned with the patient’s interest in getting treatment for illness.

2. Incentives Under Managed Care. Under managed care, all of this changed—some for the better and some for the worse. One of the important positive changes brought about by managed care, at least in theory, is that fiscal incentives now favor preventive medicine. For if an ounce of prevention is worth a pound of cure, it will benefit doctors to keep patients healthy today by expending a small amount of resources in order to eliminate the need for spending a larger amount on curative therapy in the future.

84. See Barry R. Furrow, Regulating The Managed Care Revolution: Private Accreditation and a New System Ethos, 43 VILL. L. REV. 361, 382-83 (1998) (discussing the differences in treatment between MCOs and fee-for-service plans, and suggesting that unnecessary procedures lead to harmful results).

85. See id.

86. See James F. Henry, Comment, Liability of Managed Care Organizations After Dukes v. U.S. Healthcare: An Elemental Analysis, 27 CUMB. L. REV. 681, 682 (1997) (noting that patient demand for health care under a fee-for-service system provided an incentive to develop new technologies which, in turn, increased the cost of health care).

87. See Childs, supra note 78, at 201-02 (stating that insurance companies would pay for almost any service or treatment option the doctor felt was necessary, which many feel caused increased health care costs).

88. See Little, supra note 70, at 1404-05 (stating that “[t]he need to control America’s rising health care costs greatly influenced the development and expansion of ‘managed care’

89. See Hampton, supra note 72, at 509 (explaining how the financial structure of the fee-for-service system “arguably aligned the physician’s interest with that of the patient” because there was no financial disincentive for additional procedures).

90. See Kimberly A. Jones & Tricia M. Smith, Health Care Reform: An Analysis of Potential Models, 3 KAN. J.L. & PUB. POL’Y 63, 65 (1993) (noting that the new emphasis on the cost-effectiveness of medical treatment has shifted the focus from “high-technology acute care to disease prevention and individual responsibility”).

91. See id. at 71 (discussing how West Virginia’s focus on preventative care in
Another positive change intended to be brought about by managed care is a lower rate of increase of total societal health care costs and possibly even a decline in the absolute level of health care costs. It is said that this would permit employers who provide health insurance to their employees to be more competitive in the global marketplace because foreign employers either do not provide health insurance or do so in a system in which health care costs are significantly less than in the United States. Employers' savings will ultimately redound to the benefit of the entire society, and more directly to the employees who might experience an increase in wages if fringe-benefit costs could be lowered.

However, less spending on health care, if achieved through managed care, can have a negative effect as well. The presumptive financial incentive in the fee-for-service/indemnity insurance system favors treatment; in a capitated managed care system, it is the other way around. Because doctors are receiving a fixed amount per month per patient, the financial

the prenatal context proves that the “cost of prevention is insignificant when compared to the $1 million it can cost to treat one premature infant”). Although true in theory, there are many obstacles in practice. First, in the short run, any managed care company can assume that someone who is enrolled in its plan today will not necessarily be enrolled in its plan tomorrow. Thus, spending on preventive medicine today might save money tomorrow, but the savings might inure to the benefit of a different managed care company if the patient changes plans, a not unlikely possibility. Second, even if future cost savings would inure to the benefit of the same managed care company, providing preventive care is not always as cost effective in practice as it is made out to be in theory. Illness and injury requiring expensive medical treatment are often brought about by conduct that cannot be prevented by medical treatment. Further, at least for the entity paying medical bills, early death may be cheaper than later death from a prolonged period of debilitating illness requiring a great deal of expensive treatment.

92. See Furrow, supra note 84, at 369 (stating that although no one knows the exact impact HMOs will have on health care costs in the long run, HMOs do provide real cost savings).

93. See Christine Cassel, The Right to Health Care, the Social Contract, and Health Reform in the United States, 39 ST. LOUIS U. L.J. 53, 60 (1994) (discussing the fact that employers will not reduce profits to provide health care to their employees, instead they either have to reduce wages, increase the price for their products, or do both).

94. See Allen Buchanan, Managed Care: Rationing Without Justice, but Not Unjustly, 23 J. HEALTH POL. POL’Y & L. 617, 620 (1998) (explaining how managed care was an effort at containing costs brought about by corporate buyers of health care as they watched the amount of the gross domestic product rise toward 15% and the proportion of the profits that were going toward employee health care premiums climb).

95. See Hampton, supra note 72, at 505-06, 509 (discussing how the capitation system provides an incentive for doctors to use fewer medical resources because they receive flat fees regardless of how often they actually see patients, and if a patient’s needs happen to exceed that flat fee the doctor may be financially responsible for any services rendered).
incentive is to do less rather than more. All other things being equal, doctors will earn more by treating less. Under some capitation systems, primary care physicians can actually incur out-of-pocket expenses when treating their patients, for example, when referring a patient to a specialist. This provides an opportunity for less ethical doctors to act on their own behalf in the guise of furthering the theoretically laudable goal of keeping society's medical costs under control. It also provides an opportunity for perfectly conscientious doctors to subconsciously succumb to latent financial incentives.

In managed care, the role of the primary care physician is not only to be a doctor for patients. Doctors are also entrusted with the responsibility for efficient use of plan resources. In this regard, doctors have responsibilities to a variety of constituencies: other doctors in the plan, who may receive less compensation if the plan makes less profit; shareholders in a publicly owned plan; themselves (if compensation is based not just on capitation, but also on incentives that reward doctors for keeping costs down); employers and other patients, in keeping down premiums; and other patients, who may face tighter strictures on treatment if the plan is in financial straits.

Moreover, in managed care, the company keeps track of how "efficiently" doctors treat patients, and doctors who provide more treatment to patients rather than less may find that they are "deselected," sometimes quite arbitrarily. That is, they may

96. See id. at 505-06.
97. See Ezekiel J. Emanuel & Lee Goldman, Protecting Patient Welfare in Managed Care: Six Safeguards, 23 J. HEALTH POLY & L. 635, 636 (1998) (revealing how physician salaries or year-end bonuses under managed care are in direct proportion to the ordering of fewer medical procedures and the use of fewer medical resources).
98. See id. at 636-37 (noting how "more than 60 percent of managed care plans withhold a portion of physicians' salaries to cover expenditures that exceed target projections for use of specialists or hospitals; most plans withhold more than 11 percent of physicians' salaries and some even withhold more than 30 percent").
99. See Hampton, supra note 72, at 490 (commenting on the fact that patients are unaware of all the financial incentives that are provided by HMOs to influence physicians into eliminating services in order to keep costs down and, thus, there is a potential conflict of interest in the physician-patient relationship).
100. See Field, supra note 83, at 479 (discussing the obligations that physicians have under their HMO contracts "to control costs, to keep referrals in the system, to limit referrals, and to look out for their employer's or network's interest").
101. See id. (outlining the physicians' various responsibilities in the managed care context).
102. See id. at 473 (stating that deselection of doctors from a plan can occur when a doctor does not accept the HMO's mandated rates).
find that the managed care plan no longer wishes to retain them as a member of the panel of doctors who are able to receive capitation payments.\textsuperscript{104} To be deselected is, in effect, to be fired, with sometimes devastating financial consequences to the doctor.\textsuperscript{105}

C. Implications for Autonomy

A very important aspect of managed care plans is the limitation on patients’ freedom of choice. Under fee-for-service, patients could pretty much go to any doctor they wished, as long as they could pay the bill.\textsuperscript{106} In addition, indemnity insurance, if not guaranteeing they could pay the entire bill, certainly moved patients substantially in that direction.\textsuperscript{107}

Under managed care, by contrast, limitation on freedom of choice is one of the key elements of the plan, intended to keep health care costs down.\textsuperscript{108} Under classic managed care, patients must use a primary care physician who participates in the plan, and no other, and all referrals to specialists must be authorized by the primary care physician.\textsuperscript{109} Patients are prohibited from using other doctors unless they will pay the nonplan doctor’s entire fee out of their own pockets.\textsuperscript{110}

The reasons for this arrangement are several. First and most concretely, capitation payments go only to plan doctors.\textsuperscript{111} Second, it is important to the plan to limit the doctors who participate in order to better impose practice guidelines, utilization review, and other mechanisms to assure treatment that is relatively standardized in terms of both cost and quality.\textsuperscript{112} Finally, and

\textsuperscript{104} See Field, supra note 83, at 473.

\textsuperscript{105} See id. at 473-74 (stating that deselection has the ability to cause great financial harm to doctors, especially when there are only a small number of managed care plans controlling a large share of the market).

\textsuperscript{106} See Henry, supra note 86, at 681.

\textsuperscript{107} See id.

\textsuperscript{108} See Little supra note 70, at 1400 (commenting on how MCOs cut costs by directly or indirectly restricting access to medical care).

\textsuperscript{109} See Hiepler & Dunn, supra note 74, at 609 (discussing how the primary care physician must be a “rationer of health care resources,” deciding who should and should not be referred to specialists or prescribed additional testing).

\textsuperscript{110} “Point-of-service” managed care plans permit patients to see doctors who do not participate in the plan if the patient pays a deductible and co-insurance; however, the premiums for these plans are higher than those for managed care plans in which patients do not have plan coverage for doctors outside the plan. See, e.g., Henry, supra note 86, at 687.

\textsuperscript{111} See Little, supra note 70, at 1411-12 (noting that MCOs only pay doctors that are enrolled in their plan).

\textsuperscript{112} See Field, supra note 83, at 478 (stating that managed care does not really change health care quality in the entirety, but “standardizes quality at an average
most importantly, if patients have the freedom to go to any doctor whenever they wish, there is essentially no fiscal cap on the costs they can impose on the plan.\textsuperscript{113} This freedom is what has made the fee-for-service/indemnity insurance system as costly as it is and so unattractive to those who pay for it.\textsuperscript{114}

More than any other aspect of managed care, limitation on freedom of choice seriously undermines patient autonomy. Freedom of choice, by its terms, is an autonomy concept.\textsuperscript{115} Informed consent is the mechanism for implementing autonomy to choose among various treatments offered by a doctor, and freedom of choice is the mechanism for implementing autonomy to choose doctors.

Although informed consent is usually thought of as requiring physicians to warn patients of the risks of recommended treatments, this is a seriously reductionist view of the doctrine. In legal theory, and increasingly from litigated cases, it is clear that the central requirement of informed consent is not merely a Miranda-like warning of risks, but a duty on the part of physicians to provide patients with: (1) material information about the therapeutic options available for the amelioration of the patient’s condition; and (2) information about the material possible consequences of each option, so that patients may make an intelligent choice among options in the context of their own values, goals, wishes, desires, and fears.\textsuperscript{116}

level for all\textsuperscript{116}).

\textsuperscript{113} See Childs, supra note 78, at 203 (stating that HMOs are able to achieve substantial financial savings when they are able to contract with a closed panel of providers who, in return for a steady volume of patients, are willing to offer discounted rates).

\textsuperscript{114} Field, supra note 83, at 468-69 (noting that the use of the fee-for-service system coincided with the rise in health care insurance premiums, and that managed care came about as a response to the costliness of the fee-for-service system).

\textsuperscript{115} See Cathy J. Jones, Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy, 47 WASH. & LEE L. REV. 379, 379-80 (1990) (examining our society’s commitment to personal autonomy, and citing a patient’s right to choose types of medical treatment as an example).

\textsuperscript{116} See, e.g., Stover v. Association of Thoracic & Cardiovascular Surgeons, 635 A.2d 1047, 1051 (Pa. Super. Ct. 1993) (stating that a physician must discuss alternate prostheses and their relative merits when other prostheses represent medically recognized alternatives). Of course, a description of options alone is inadequate; patients must also be provided with information about the positive and negative material possible consequences of each of those options so that patients may make an intelligent choice after weighing the pros and cons of each option. See, e.g., Matthies v. Mastromonaco, 709 A.2d 238, 250 (N.J. Super. Ct. App. Div. 1998) (“Informed consent requires ‘the patient [or the incompetent patient’s surrogate to] have a clear understanding of the risks and benefits of the proposed treatment alternatives or non-treatment, along with a full understanding of the nature of the disease and the prognosis.’” (quoting In re Conroy, 486 A.2d 1269, 1222 (N.J. 1985)).
Thus, the cornerstone of the modern doctrine of informed consent is that patients are provided with information about their options. In the fee-for-service context, freedom of choice allowed patients to obtain the option they wished to select, including the right to go to another doctor, to whom the doctor providing them with information might or might not refer them, even if that doctor were in some distant place.117

The conflict with managed care could not be clearer. First, patients are not free—certainly not in the first instance and possibly never—to choose any doctor: patients must use doctors within the plan.118 Perhaps ultimately the patient may get to go outside the plan, but not without surmounting sometimes daunting and lengthy procedural requirements (internal grievances and appeals), including a possible lawsuit. Second, even if patients remain within the plan, they are not free to choose any therapeutic option—not even any responsible therapeutic option.119 Patients are limited to those options the plan makes available for the treatment of the patient's condition.120 For instance, when there is more than one prescription medication available for the treatment of a particular condition, the plan will often permit the doctor to prescribe only the least expensive one.121 When there are a variety of different diagnostic procedures that might be used, the plan may require the use of the least expensive one.122 If the patient's condition could be treated by a primary care physician

This allows patients to make a choice with the opportunity to consider relevant information in the context of their own values, goals, wishes, desires, and fears. See generally John H. Derrick, Annotation, Medical Malpractice: Liability for Failure of Physician to Inform Patient of Alternative Modes of Diagnosis or Treatment, 38 A.L.R.4th 900, 903-04 (1985) (summarizing the basic principle underlying informed consent along with the physician's duties in regard to disclosure).

117. Refer to note 106 supra and accompanying text (discussing how the fee-for-service system allowed the patient to chose any doctor or treatment option they wanted as long as they were able to pay for it).

118. See Little, supra note 70, at 1412 (discussing how most MCOs will only provide payment for doctors who are enrolled in their plan and then only when authorized by the primary care physician).

119. See id. at 1409 (stating how both physicians and patients now must argue with MCOs regarding permission for even basic treatment).

120. See id.

121. See Michael A. Weber, Impact on the Pharmaceutical Industry of Changes in the American Health Care System: A Physician's Perspective, 24 SETON HALL L. REV. 1290, 1293 n.1 (1994) (observing that MCOs have used "their authority to select drugs for formulary listings that are less expensive than other available alternatives").

122. See Little, supra note 70, at 1446 (discussing how MCOs do, in effect, make medical decisions because by not authorizing expensive treatment, the only way a patient may receive it is to pay for it on their own or have their physician strongly advocate for its use).
or by a specialist, the plan may require treatment by the cheapest, but possibly less expert, provider—the primary care physician. Finally, all of these choices will be dictated by cost, not by quality.

All of this might be acceptable, or at least tolerable, because of the lower health care costs that patients gain by restrictions on freedom of choice. Compounding the problem, however, is the fact that under managed care, patients may have difficulty getting information that would let them know that their options have been restricted. A feature of some managed care plans are provisions in the contract between the doctor and the plan called "gag clauses" that prohibit doctors from telling patients about options that are unavailable to the patient or that the patient's condition might be better treated by a specialist because those options are more expensive. Some plans even prohibit doctors from telling patients that these options exist and that they might receive them by paying for them out of pocket.

IV. SAFEGUARDS FOR END-OF-LIFE DECISIONMAKING

The road to the legalization of withholding and withdrawing life-sustaining medical treatment has been relatively smooth, although there have been some bumps along the way. There has been the occasional physician, hospital, or prosecutor who has raised obstacles to forgoing life-sustaining treatment in particular cases, and there have been state legislatures that were successfully lobbied for years by organized religious interests not to enact advance directive statutes or surrogate decisionmaking statutes. On balance, however, the opposition to physicians providing "passive" aid-in-dying to terminally ill patients has been marginal.

123. See id. at 1412 (stating how some MCOs require the primary care physician to perform specialized medical treatments that they are not necessarily trained to provide).
124. See Hyman, supra note 8, at 414 (explaining that MCOs are able to offer lower costs associated with premiums, deductibles, and the like because of the restrictions on choice).
125. See Little, supra note 70, at 1415 (stating that "gag clauses prevent physicians from discussing treatment options, utilization policies and financial incentives with patients").
126. See Hyman, supra note 8, at 416.
127. See Meisel, supra note 47, at 822 (discussing how the 1976 case of In re Quinlan was the "first step in the legalization of physician aid in dying").
Entirely the opposite has been the case with respect to "active" aid-in-dying. The organized medical profession, state courts, state legislatures, Congress and other organized interests have affirmed and reaffirmed their uncompromising opposition. In seeking to obtain legitimacy, there are at least three advantages that passive aid-in-dying has that active aid-in-dying has not. First, and perhaps most important, has been a rhetorical advantage. From the beginning, passive aid-in-dying has been cloaked in the language of "natural death." A hallmark of the Quinlan opinion is the "high-tech" characterization of the medical efforts to keep Ms. Quinlan alive and the termination of these efforts as allowing natural death to occur. Second, this characterization of forgoing life-sustaining treatment as letting nature take its course, along with some other rhetorical devices, provided an easy way to define the withholding and withdrawing of life-sustaining medical treatment as being outside the ambit of criminal homicide statutes. Third, the creation of a carve-out in the criminal law for these medical practices, whether substantively warranted or not, meant that efforts to achieve legitimacy for withholding and withdrawing life-sustaining medical treatment could proceed incrementally. Thus, public attention to these efforts was kept at a low level—at least relative to what was later to ensue when efforts began to legitimize actively hastening death.

By contrast, efforts to legalize physician-assisted suicide have met widespread resistance. If nothing else, the rhetoric alone created an immense hurdle. The word "suicide" turned many against the concept—indeed, put a halt to rational discourse—regardless of the underlying merits. That the

129. See Dan W. Brock, Voluntary Active Euthanasia, HASTINGS CTR. REP., Mar.-Apr. 1992, at 10, 12-13 (discussing the difference between "letting nature take its course" and active aid-in-dying).


131. See generally Meisel, supra note 47, at 826-43 (challenging the traditional distinction between act and omission).

132. See id. at 824 (referring to the political purpose of avoiding the attachment of the label "killing" to passively hastening death).


134. See Meisel, supra note 47, at 825 (noting the negative connotations associated with the term suicide).
conduct in question could so easily be viewed as falling within
the ambit of the criminal law had a similar effect. Thus,
societal acceptance of actively hastening death—and especially
acceptance by legal institutions—had a strong presumption
against it from the outset, quite contrary to what occurred with
passively hastening death, in which any presumptions against it
were swept away before they could even take root. Nonetheless,
the opposition to the legalization of actively hastening death has
come primarily from institutional quarters.

Public opinion polls of citizens and health care professionals have demonstrated far
greater support for its legalization than might be inferred from
the positions of institutional representatives of citizens and
health care professionals—most notably, legislatures and
professional societies.

A. The Objections to Physician-Assisted Suicide

The basis for substantive opposition to the legalization of
physician-assisted suicide arises from a variety of sources. Some
is based on moral or religious grounds: that it is wrong to kill
oneself and to assist another in doing so. Some opposition to it
is prudential. Some believe that even though physician-assisted
suicide might be warranted in some individual cases, it is bad
public policy because it can easily be abused. Others argue that
even if acceptable in itself, its legalization would inevitably lead
to other practices, such as voluntary or involuntary mercy killing,
which would be abhorrent.

135. See id. at 825-26 (explaining the concern that physician-assisted suicide
might constitute some form of criminal homicide).

136. Refer to note 133 supra and accompanying text (discussing institutional
opposition to assisted suicide).

137. See, e.g., Melinda A. Lee et al., Legalizing Assisted Suicide-Views of
Physicians in Oregon, 334 NEW ENG. J. MED. 310, 311-12 (1996) (analyzing the
attitudes of Oregon physicians regarding assisted suicide).

138. See Charles J. Dougherty, The Common Good, Terminal Illness, and
Euthanasia, 9 ISSUES L. & MED. 151, 158-59 (1993) (discussing the moral arguments
against assisted-suicide and euthanasia).

139. See, e.g., Compassion in Dying v. Washington, 79 F.3d 790, 853 (9th Cir.
1996) (en banc) (Beezer, J., dissenting) (arguing that the legalization of physician-
assisted suicide could disrupt the established legal order of wills, trust, life
insurance, annuities, pensions, and other estate planning tools), rev'd sub nom.

140. See, e.g., id. at 852-53 (Beezer, J., dissenting) (discussing possible abuses
and noting the large number of abuses in the Netherlands, despite supposed
procedural safeguards).

141. See Ezekiel J. Emanuel, The Future of Euthanasia and Physician Assisted
Suicide: Beyond Rights Talk to Informed Public Policy, 82 MINN. L. REV. 983, 1001-
02 (1998) (discussing the impossibility of separating physician-assisted suicide from
euthanasia).
In addition to the foregoing, other opponents believe that although physician-assisted suicide might otherwise be acceptable, now is the wrong time to be debating legalization because of the structural changes in our health care system.\footnote{142} Even if physician-assisted suicide could be accommodated within fee-for-service medicine, the combination of physician-assisted suicide and managed care is a lethal prescription.\footnote{143} The observations of a few commentators help to illustrate.\footnote{144} Ann Alpers and Bernard Lo of the University of California at San Francisco note that “it may serve the interests of a physician or a managed care plan to provide a quick and inexpensive lethal prescription rather than palliative care, which can be emotionally difficult, time consuming, and expensive.”\footnote{145} Susan Wolf of the University of Minnesota states that “[f]or a physician faced with a patient considering assisted suicide, the incentives MCOs use would reward the physician for encouraging the act.”\footnote{146} Similarly, Daniel Callahan of the Hastings Center says that “[o]ne’s ear does not have to be very close to the ground to hear it said that legalizing physician-assisted suicide could help hold down the costs of health care for the elderly.”\footnote{147} Finally, a more extreme version is that “[i]t will only be a matter of time... before courts will sanction putting people to death, not because they are desperately ill and want to die, but because they are deemed to pose an unjustifiable burden on society.”\footnote{148}

\footnote{142}{See Wolf, supra note 9, at 462-63 (noting the potential conflict of interest facing physicians in the managed care setting); Ira Byock, Dying: After the Court Ruling, WALL ST. J., June 27, 1997, at A14 (arguing against legalization of physician-assisted suicide “[i]n these budget-weary, cynical times”).

\footnote{143}{See Wolf, supra note 9, at 473 (discussing the likelihood that MCOs will profit from encouraging patients to commit suicide).

\footnote{144}{These commentators do not object to physician-assisted suicide solely because of timing. I merely cite the argument that each makes on this particular basis.


\footnote{146}{Wolf, supra note 9, at 465.

\footnote{147}{Daniel Callahan, Controlling the Costs of Health Care for the Elderly—Fair Means and Foul, 335 NEW ENG. J. MED. 744, 745 (1996).

\footnote{148}{Compassion in Dying v. Washington, 79 F.3d 790, 830 (9th Cir. 1996) (en banc) (rejecting this argument), rev’d sub nom. Washington v. Glucksberg, 117 S. Ct. 2268 (1997); see also Brock, supra note 129, at 17 (discussing the possibility that euthanasia will weaken society’s commitment to provide health care to dying patients); Nancy W. Dickey, Euthanasia: A Concept Whose Time Has Come?, 8 ISSUES L. & MED. 521, 529 (1983) (opining that if euthanasia is couched in socially acceptable terms such as “mercy” and “compassion” it may become more acceptable); Yale Kamisar, Against Assisted Suicide—Even a Very Limited Form, 72 U. DET. MERCY L. REV. 735, 757 (1995) (discussing the dangers of allowing physician-assisted suicide).}
As Callahan suggests, it does not take much imagination to understand why we should worry about the legalization of physician-assisted suicide in the context of managed care. Managed care companies are bent on paring costs in order to make their plans more attractive to employers who purchase them. In addition, as for-profit managed care companies increasingly dominate the market for health insurance plans, an additional impetus to controlling costs is the clamor of shareholders (especially institutional shareholders) seeking to maximize the value of the company. In such a situation, it is argued, physicians will be pressured—and even if they are not, they may feel pressured—to keep the cost of providing care lower. One way to do so would be to suggest, induce, pressure, or coerce terminally ill patients to choose this means of hastening death.

What takes more imagination, perhaps, is to figure out why the threat is more apparent than real. First, physician-assisted suicide, if subject to abuse—and of course it is, as is virtually everything that humans do—is no more subject to abuse than the "passive" brand of physician-assisted dying that has been legally acceptable since the Quinlan case. Second, we should be capable of devising procedural protections against abuse at least as good as those used when the passive hastening of death is practiced.

Whatever concerns we have about physician-assisted suicide—whether in the context of managed care or otherwise—we should also have about the termination of life support. The two practices are merely different ways of achieving the same end: hastening death. Indeed, there are

149. See Barry R. Furrow, Managed Care Organizations and Patient Injury: Rethinking Liability, 31 GA. L. REV. 419, 421 (1997) (discussing the proliferation of managed care organizations due to their promise of lower health care costs).

150. See Wolf, supra note 9, at 455-56 (noting the high percentage of Americans enrolled in some type of managed care).

151. See Council on Ethical and Judicial Affairs, AMA, Ethical Issues in Managed Care, 273 JAMA 330, 331 (1995) (noting that for-profit MCOs attempt to avoid unnecessary spending in order to report favorable information to their shareholders).

152. See id. (noting that managed care can create competing interests between patient care and a physician's income).

153. Where physician-assisted suicide is legal, physicians may actually be required to mention it to patients who are terminally under the doctrine of informed consent. Refer to note 116 supra and accompanying text.

154. Refer to notes 36-40 supra and accompanying text (discussing the Quinlan decision).

155. Professor Wolf makes the argument that physician-assisted suicide poses serious dangers in the context of managed care. See Wolf, supra note 9, at 456-57
(discussing the proliferation of managed care and the potential impact of cost containment efforts on legalized assisted suicide). In doing so, she seems to dismiss concerns about, and minimizes the dangers of, withholding and withdrawing life-sustaining medical treatment in the same context. Professor Wolf claims that "there are substantial differences between the problems surrounding assisted suicide and those surrounding termination of treatment, especially in the context of managed care." *Id.* at 473. Chief among these differences is that "[s]ystems and physicians driven by cost containment are likely to find assisted suicide much more tempting than termination of treatment..." *Id.*

The first reason for this assertion is that:

Patients may raise the possibility of suicide and assisted suicide early in the disease process. Indeed, it may be prompted by the initial announcement to the patient of a frightening diagnosis. Thus physician incentives and systemic biases may begin to play a part in encouraging assisted suicide early. Indeed, if a patient concludes that the best way out is assisted suicide, the patient must act while still competent and able to commit suicide. *Id.* at 474. While plausible, this claim is entirely speculative. If true, it might be that the proper solution is for doctors to learn how to better communicate a terminal diagnosis to patients, something that they are notoriously poor at doing.

Second, Professor Wolf contends that when a decision about forgoing treatment is to be made, patients are likely to have lost decisionmaking capacity and physicians are more likely to be dealing with the patient's family. *See id.* at 475. "Since the surrogate is not the one suffering from disease, depression, pain, or the like," a decision that the surrogate makes to terminate treatment is less likely to be the product of the physician's input than is a decision by a competent patient to commit suicide. *Id.* (noting that a surrogate is more likely to hold his own against a physician). If true, we might be trading one set of dangers for another, as is implicit in some of Professor Wolf's remarks but which she overlooks. Professor Wolf states:

Even though both the physician and the surrogate should ordinarily honor past choices by the patient, commentators routinely note that the ultimate choice may be different from what the patient contemplated. Moreover, indications are that many patients may want their surrogate to consider their past choices only as general guidance. Thus, the surrogate may have considerable latitude. *Id.* (footnotes omitted). Thus, although the doctor might not pressure the surrogate about forgoing life-sustaining treatment, the decision ultimately reached may not represent the patient's wishes. If we are concerned about fidelity to the patient's wishes, this is just as problematic as doctors pressuring competent patients to commit suicide.

Further, Professor Wolf's argument overlooks two other important facts. First, doctors can exert significant influence over decisions surrogates make simply by the manner in which they give information about the patient's diagnosis and prognosis, the quantity of the information, and the nature of the information. Second, making a decision to forgo life-sustaining treatment is stressful for surrogates. They are prone to anxiety, fatigue, and other things that make them susceptible to being pressured. Indeed, their decisions may even be affected by the trump card in discussions of physician-assisted suicide—"depression."

Finally, Professor Wolf states that "[p]atients and physicians make such decisions every day... Decisions about whether to forgo life-sustaining treatment are an integral part of caring for terminally ill patients... Physicians must honor patients' refusal of any unwanted bodily invasion. The usual rules and ethics governing doctor-patient relationships apply." *Id.* at 475-76. Would that medical practice comported with legal theory. The sad fact is that doctors often do not provide patients (or surrogates) with adequate information or make adequate efforts to assure that what information is provided is understood. They sometimes treat
features of physician-assisted suicide that may make it less subject to abuse than passively hastening death. In physician-assisted suicide, the last actor in bringing about the patient’s death is the patient, thus preserving autonomy to the very end and indeed requiring the exercise of that autonomy for death to occur. In physician-assisted suicide, because the patient is the last actor, the patient must be conscious. Proposals to legalize physician-assisted suicide, as well as the Oregon statute that does so, require that the patient not merely be conscious but in possession of decisionmaking capacity. By contrast, in the actual practice of passively hastening death, as permitted by law, patients need neither be conscious nor in possession of decisionmaking capacity. A decision to withhold or withdraw life-sustaining medical treatment may be made by others on the basis of wishes expressed by the patient at some past time—possibly some distant past time. In most jurisdictions, such a decision may be made by close family


There is, Professor Wolf claims, no tradition to guide doctors in decisionmaking about assisting suicide. See Wolf, supra note 9, at 476 (noting that physician-assisted suicide “clearly represents a departure from the past ethics of the doctor-patient relationship”). This is true, but it is the same situation that prevailed when abortion was first legalized. The argument that abortion should not be legalized because, being so contrary to the traditional doctor-patient relationship, doctors would inevitably abuse their new power, was, to my knowledge, never an issue. Doctors were forced to learn how to communicate with patients about abortion in order to provide them with adequate information without attempting to unduly influence their choice. Certainly, no one is suggesting that we ought to prohibit abortions because, under managed care, doctors will be more likely to suggest abortion because it is cheaper than a pregnancy.

156. See OR. REV. STAT. 127.815 § 3.01(1) (Supp. 1998) (mandating that the physician must make the initial determination that the patient is capable of making an informed decision).

157. See id. 127.805 § 2.01 (allowing only adults who are capable to make use of the statute).

158. See generally 1 MEISEL, supra note 4, ch. 7.

159. See In re Jobes, 529 A.2d 434, 444 (N.J. 1987) (explaining that the surrogate decisionmaker should consider the patient’s prior statements concerning medical issues).
members even in the absence of any express evidence that the patient had previously made such a decision.\textsuperscript{160} Instead, family members, under the aegis of the substituted judgment standard, may decide on the basis of their knowledge of the patient—although the patient did not actually make a decision to forgo life-sustaining treatment in advance of losing decisionmaking capacity, he or she would if it were now possible to do so.\textsuperscript{161} The application of this principle to individuals who never possessed decisionmaking capacity—such as infants\textsuperscript{162} and the mentally retarded\textsuperscript{163}—are examples of the extremes to which courts have gone to permit the passive hastening of death. Further, in some jurisdictions, if a patient’s probable wishes cannot be determined, surrogates are authorized to terminate life-sustaining treatment on the basis of their view that it is not in the patient’s best interests for treatment to be administered.\textsuperscript{164}

The concerns expressed about the dangers of legalizing physician-assisted suicide\textsuperscript{165} are no more serious, and possibly

\textsuperscript{160} See, e.g., \textit{In re Fiori}, 673 A.2d 905, 911 (Pa. 1996) (noting that the decision to withdraw medical treatment can be made “[e]ven where the individual has not expressed thoughts concerning life-sustaining treatment”).

\textsuperscript{161} See \textit{In re Quinlan}, 355 A.2d 647, 664 (N.J. 1976) (“The only practical way to prevent destruction of the right [of a patient to choose to forgo life-sustaining treatment] is to permit the guardian and family of [the patient] to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances.”); \textit{Fiori}, 673 A.2d at 911 (“Even where the individual has not expressed thoughts concerning life-sustaining treatment, the patient’s preferences can still be ascertained by referring to all of the aspects of his or her personality.”).

\textsuperscript{162} See, e.g., \textit{In re Barry}, 445 So. 2d 365, 371 (Fla. Dist. Ct. App. 1984) (holding that parents should make the decision in such circumstances).

\textsuperscript{163} See, e.g., Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 431 (Mass. 1977) (“In short, the decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decisionmaking process of the competent person.”).

\textsuperscript{164} See, e.g., \textit{Jobes}, 529 A.2d at 444, 447 (discussing the surrogate’s role in determining what course of medical treatment the patient would choose, and noting that when health-care professionals do not believe there is proper protection of the patient’s interest, a guardian should be appointed). See generally 1 MEISEL, supra note 4, §§ 7.11-7.25.

\textsuperscript{165} In this discussion, I am relying on some of those concerns set forth in \textit{Compassion in Dying v. Washington}, 79 F.3d 790, 816-32 (9th Cir. 1996) (en banc), rev’d sub nom. \textit{Washington v. Glucksberg}, 117 S. Ct. 2258 (1997) (including: (1) that life will not be preserved; (2) that suicides generally will not be prevented; (3) that more third parties will become involved in suicides and that arbitrary, undue, or unfair influence will effect more suicides; (4) that family members of a suicidal person will not be protected; (5) that the integrity of the medical profession will be under scrutiny; and (6) that allowing physician-assisted suicide could easily lead to widespread abuse on the form of socially selective euthanasia), not as a
less serious, than the potential for abuse in passively hastening death. Moreover, the supposed dangers of legalizing physician-assisted suicide are equally applicable to the already accepted practice of passively hastening death. For instance, it is said that patients will be pressured into “requesting” physician-assisted suicide, and that some categorically vulnerable groups—the elderly, the poor, minorities, women—will be more subject to pressure than others. This argument overlooks the fact that all patients—those near the end of life and those who enjoy reasonable prospects for recovery, those who are critically ill and those who are mildly ill, those who are contemplating forgoing life-sustaining treatment and those who are contemplating suicide—are susceptible to pressure by physicians, other health care professionals, family, friends, and by circumstance. It also overlooks the fact that near the end of life, doctors can pressure patients into withholding or withdrawing treatment by telling them that it is useless, painful, expensive, or all of these things. Further, even if patients are not actually pressured by others, they may perceive themselves as being pressured.

It is also said that terminally ill patients will seek the assistance of a doctor in committing suicide because of a lack of access to health care in general, and palliative care in particular. However, the same circumstances might cause patients to request that life support be withheld or withdrawn, or might cause them to more readily accede to someone else’s suggestion to do so. It is said that physicians will become hardened to the plight of the terminally ill by the existence of the

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comprehensive catalog of objections but as a representative sample. The case, now overruled, is not cited as legal authority but merely as a repository of argument. The literature on physician-assisted suicide is so vast that it is probably no exaggeration to say that every objection that could be made has been made.

166. See, e.g., Compassion in Dying, 79 F.3d at 825 (referring to the argument that Washington’s statute criminalizing physician-assisted suicide is necessary to protect the disadvantaged from becoming the victims of assisted suicide); id. at 852, (Bezzer, J., dissenting) (stating that “a right to assisted suicide might spawn pressure on the elderly and infirm—but still happily alive—to ‘die and get out of the way”).

167. See id. at 826-27 (recognizing the variety of pressures, from a host of sources, upon persons in need of medical care).

168. See Meisel, supra note 47, at 854-55 (discussing the pressure that physicians may apply regarding life-sustaining treatment).

169. See Compassion in Dying, 79 F.3d at 828 (recognizing merit in the argument that there exists in this country a lack of universal access to medical care); see also Patrick M. Curran, Jr., Note, Regulating Death: Oregon’s Death with Dignity Act and the Legalization of Physician-Assisted Suicide, 86 GEO. L.J. 725, 737-39 (1998) (discussing the role played by the failure to adequately manage pain in the context of physician-assisted suicide).
simple expedient of ending the patient's life. Rather than working carefully with the patient, attempting to end or ameliorate pain and suffering, arrange for palliative care, or refer to specialists who can do these things, doctors might encourage, or at least not discourage, suicide. Again, however, there is no reason to suppose that some doctors cannot, will not, and do not already do the same by encouraging the termination of life support, or by not discouraging it.

One additional argument against the legalization of physician-assisted suicide warrants specific attention. Professor Wolf contends that apart from whatever other dangers there are in legalizing physician-assisted suicide, legalization in the context of managed care raises special concerns. Her argument is based on two key assumptions: first, that the primary factor motivating terminally ill individuals to seek to commit suicide is depression, and that managed care organizations "have an inferior track record in responding to depression;" and second, that "the general characteristics of MCOs . . . provide incentives for physicians and patients to embrace assisted suicide . . . ." Although her concern is genuine and her arguments appealing, there are some serious problems.

Assuming for argument's sake that Professor Wolf's first assumption is correct—that depression is the primary factor motivating terminally ill individuals to seek to commit suicide—she does not tell us what primary factor motivates terminally ill individuals to request that life-sustaining treatment be withheld or withdrawn. Perhaps it, too, is depression.

170. See Compassion in Dying, 79 F.3d at 826-27.
171. See id. (suggesting that if or when physician-assisted death becomes a viable option for doctors, doctors will achieve a "hardened" attitude toward death, perhaps foregoing discussions of alternative treatments when asked about assisted suicide, or in general will treat old and infirm patients with a lack of attention and patience).
172. See generally Wolf, supra note 9, at 460 (discussing the unique problems that managed care creates regarding assisted suicide).
173. Id. at 466.
174. Id.
175. It would also be nice to know how good traditional, non-managed care health plans are in dealing with depression. Regardless of that, another problem is that her claim lumps together all managed care plans. See id. at 456 (discussing health maintenance organizations ("HMOs"), prepaid-provider organizations ("PPOs"), and point-of-service plans, and referring to them collectively as MCOs). In fact, there are many differences in managed care plans in terms of the incentives they provide physicians to conserve resources that presumably affect (and certainly are intended to affect) the degree to which resources are actually conserved, and the degree to which resources are conserved to the detriment of patients. Similarly, there are differences among indemnity plans, most having some utilization review procedures, which are also intended to encourage physicians to conserve resources.
In elaborating her second assumption, Professor Wolf states that "physicians who tend to practice resource conserving medicine," that is, physicians treating patients in managed care plans, "are significantly more likely . . . to report a willingness to provide a lethal prescription at the request of a terminally ill patient." The phrase "more likely" is assumedly a comparison

See Mark A. Hall & Gerard F. Anderson, Health Insurers' Assessment of Medical Necessity, 140 U. PENN. L. REV. 1637, 1652-54 (1992) (commenting on the proliferation of different forms of utilization review, now embraced by most indemnity insurers, and identifying that the function of review is generally to require physicians to obtain permission from the insurer before admitting a patient to a hospital or submitting a patient to certain medical procedures).

Another difficulty is that Professor Wolf's argument assumes that if terminally ill patients who seek assisted suicide are adequately treated for depression, they will no longer persist in their wish. See Wolf, supra note 9, at 472. Professor Wolf's assumption is implicit in her assertion that there is sound reason to "fear that MCO patients will be differentially driven to assisted suicide by systemic neglect, since depression is the primary reason patients seek assisted suicide." Id. Arguably, that is only true if one defines the "cure" for depression in the terminally ill as a relinquishment of the wish to end one's life. This, of course, leads right into the issue of the correct definition of depression, and its entanglement with other psychological states surrounding terminal illness. However, that is a topic far beyond the scope of the present inquiry.

176. Wolf, supra note 9, at 458 (alteration in original) (quoting B.P. Linas et al., Use of Medical Resources and Physician Willingness to Participate in Assisted Suicide (1996) (abstract on file with Professor Wolf)). This study appears to have been published by Daniel P. Sulmasy et al., Physician Resource Use and Willingness to Participate in Assisted Suicide, 158 ARCH. INT. MED. 974 (1998). In the published version, the language that Professor Wolf quotes appears to have been replaced by the weaker statement that "[t]his study has identified a significant, strong, linear association between the tendency of general internists to choose resource-conserving treatment options and their willingness to assist a terminally ill patient with suicide, as assessed by their responses to hypothetical cases." Id. at 977. This article continues:

It would be a mistake to conclude automatically from this study that physicians view [physician-assisted suicide] as a cost-containment mechanism. Demonstrating an association between a resource-conserving practice style and willingness to participate in [physician-assisted suicide] does not establish a causal relationship. While it cannot be ruled out that [physician-assisted suicide] may be viewed by these physicians, explicitly or implicitly, as a means of conserving resources, other explanations are also plausible. It is possible, for instance, that some physicians are more resource intensive because they are averse to risk, and might therefore be less likely than their resource-conserving colleagues to participate in [physician-assisted suicide]. It is also possible that physicians who are more resource conserving might simply be more likely to view it as irrational to insist that patients who choose to end their lives should be prohibited from doing so when such acts will, in fact, conserve scarce medical resources. This view of rationality and justice, however, does not meet with universal approval.

Id. at 977-78. This explicit qualification of the study renders very weak the reed on which Professor Wolf bases her argument.

In addition, many physicians treat patients who are in a variety of health care plans, including some managed care patients and some fee-for-
with physicians treating patients who are not in managed care plans. Another element necessary to know is whether physicians treating terminally ill patients in managed care plans are more likely to provide a lethal prescription than they are to honor a patient's wish to withhold or withdraw life-sustaining medical treatment. Even if such physicians are more likely to do so, this is not proof positive that managed care and physician-assisted suicide is a lethal mix. Finally, we also need to know whether those terminally ill patients seeking assisted suicide subjectively perceive more deleterious physical and emotional consequences of their illness than do those terminally ill patients who seek to have life-sustaining treatment withheld or withdrawn.

B. Protecting Against Abuse in Both Actively and Passively Hastening Death

It is simple to say that because physician-assisted suicide might be subject to abuse, it should not be permitted. This is, of course, none other than a slippery slope argument. In *Compassion in Dying*, the Ninth Circuit affirmed a lower court holding that due process requires the legalization of physician-assisted suicide. The majority en banc opinion observed that opposition based on this ground is a "nihilistic argument [that] can be offered against any constitutionally-protected right or

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178. *See id.* at 793-94 ("[I]nsofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the Fourteenth Amendment.").
interest.... [T]he [Supreme] Court has never refused to recognize a substantive due process liberty right or interest merely because there were difficulties in determining when and how to limit its exercise or because others might someday attempt to use it improperly." In other words, we do not always prohibit practices that are subject to abuse; regulation is another option.

We do need protections against the abuse of physician-assisted suicide just as we have needed and continue to need protections against the abuse of passively hastening death. This is true whether we have a fee-for-service health care system, a managed care system, or some other kind of system.

C. What Kinds of Protections?

Since 1976, when physicians were first expressly authorized by Quinlan to aid patients in dying by withholding or withdrawing life-sustaining medical treatment, a web of safeguards has been constructed, primarily by state appellate courts in similar sorts of cases, to protect against erroneous or abusive decisions to forgo life-sustaining treatment. Although the particulars of these safeguards may or may not be what is needed to protect patients from erroneous or abusive decisions to end their lives through physician-assisted suicide, the manner in which these safeguards were developed, as well as the nature of the safeguards themselves, provides a starting place for thinking about protections for physician-assisted suicide.

179. Id. at 830-31.
180. See id. at 833 (discussing the potential for regulation in this area). The Ninth Circuit declared:

   In Cruzan, the Court recognized that the states had a legitimate role to play in regulating the process of refusing or terminating life-sustaining medical treatment even if they could not prohibit the making of decisions that met applicable state standards.... The... states [can] adopt appropriate regulations to further their legitimate interests.

Id.

181. See In re Quinlan, 355 A.2d 647, 669-70 (N.J. 1976) (summarizing that the states' power to protect life does not include the power to prevent individuals from terminating medical treatment pursuant to their right to privacy).
182. See, e.g., In re Jobes, 529 A.2d 434, 440-44, 447-48 (N.J. 1987) (identifying a variety of cases similar to Quinlan and recognizing such important factors as a consensus among medical experts that a patient has achieved a persistent vegetative state, that evidence of such state be "clear and convincing," that each case be considered solely upon its own facts, that there be some evidence of the patient's subjective views of near-end-of-life medical treatments, or that the judgement of a family member or guardian be substituted to establish what the patient his-or herself would have wanted, and lastly, that the withdrawal-of-treatment decision be further reviewed by a hospital prognosis committee to ensure abuse is not occurring). See generally, 1 MEISEL, supra note 4, ch. 5.
1. Withholding and Withdrawing Life-Sustaining Medical Treatment. The kinds of protections we employ should be determined by the goals we seek to achieve. The overarching goal in end-of-life decisionmaking when passively hastening death has been at issue is fidelity to patients' wishes. This is true whether the patient possesses or has lost decisionmaking capacity.

Both substantive and procedural devices have been used to assure that this goal is achieved. First, courts require that for life-sustaining medical treatment to be withheld or withdrawn from competent patients, those patients must give informed consent, and alternatively, that surrogates must do the same for patients who have lost decisionmaking capacity. No special safeguards have been thought to be necessary to protect patients from pressure from doctors or family members to request the forgoing of treatment, on the assumption that doctors and families will each seek to do what is best for the patient, and that, in any event, each will serve as a check on the other.

In the case of patients who have lost decisionmaking capacity, an additional substantive safeguard exists to assure fidelity to patients’ wishes. This safeguard is the requirement that, in making a decision about forgoing life-sustaining treatment, the surrogate is required to implement the patient's wishes to the extent that they are known. In the absence of

183. See, e.g., Jobes, 529 A.2d at 443 (identifying the “subjective intent test” to establish the patient's medical preferences, and affirming that the test must be satisfied by “clear and convincing” evidence); In re Conroy, 486 A.2d 1209, 1233 (N.J. 1985) (“We emphasize that in making decisions whether to administer life-sustaining treatment..., the primary focus should be the patients' desires...”).

184. See, e.g., In re Farrell, 529 A.2d 404, 413-14 (N.J. 1987) (“[S]ociety must ensure that a patient who has decided to forego life-sustaining treatment is competent; is informed about his or her prognosis, the medical alternatives available, and the risk involved; and has not been coerced.”).

185. See, e.g., Jobes, 529 A.2d at 444 (describing the “substituted judgment approach” developed through the Quinlan case and its progeny and opining that the “approach is intended to ensure that the surrogate decisionmaker effectuates as much as possible the decision that the incompetent patient would make if he or she were competent”).

186. Courts operate on the assumption, not always correct, that decisionmaking will occur in a context (i.e., a hospital or nursing home) in which there will be a number of health care professionals in addition to a doctor who will be available to act as a safeguard to the patient's interests should there be collusion between the doctor and patient. See, e.g., Farrell, 529 A.2d at 414-15 (“These issues are more easily resolved when the patient is in a hospital, nursing home, or other institution, because in those settings the patient is observed by more people.”).

187. See, e.g., Mack v. Mack, 618 A.2d 744, 758 (Md. 1993) (noting that “[t]he patient's philosophical, religious and moral views, life goals, values about the purpose of life and the way it should be lived, and attitudes toward sickness, medical procedures, suffering and death” should be explored. . . . These guidelines ‘should aid in ascertaining [the patient’s] desires” (citations omitted) (third alteration in
adequate knowledge of the patient’s wishes (and what is adequate differs among different courts), most courts have required that treatment be continued, although a few allow treatment to be forgone if it can be shown that its administration is no longer in the patient’s best interests.

In addition to substantive safeguards, courts have also prescribed some procedural safeguards to assure fidelity to patients’ wishes in end-of-life decisionmaking. Courts have not required routine recourse to the judicial process for the oversight of decisions to withhold or withdraw life-sustaining medical treatment, again on the assumption that health care professionals and patients’ family members will serve as an adequate check on each other. Instead, courts have kept their doors open for the special case in which some person close to that process believes that such oversight is necessitated by the facts of that particular case.

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188. See, e.g., id. at 760-61 (opining that the legislature of Maryland could not have intended courts to authorize the termination of treatment based on what a reasonable person deemed the patient’s “best interest” when the actual medical preferences of the vegetative patient could not be ascertained); Martin v. Martin (In re Martin), 588 N.W.2d 399, 413 (Mich. 1995) (concluding, after a thorough factual analysis, that the evidence presented regarding a patient’s pre-injury decision to decline life-sustaining medical treatment was not sufficiently clear and convincing to support withdrawal of that treatment).

189. See, e.g., Lenz v. L.E. Phillips Career Dev. Ctr. (In re L.W.), 482 N.W.2d 60, 71-72, 75-76 (Wis. 1992) (“[W]here it is in the best interest of the ward to withhold or withdraw treatment, the guardian has not only the authority to but a duty to consent to the withholding or withdraw of treatment.”).

190. See, e.g., id. at 72-73 (establishing that, in the context of discontinuing treatment of an incompetent whose wishes on the subject are unascertainable, the analysis begins with a presumption that continued life is in the best interests of the ward, and that any attempt to overcome this presumption demands that the guardian assess the facts of the ward’s situation “from the stand point of the patient, and should not substitute his or her own view of the ‘quality of life’ of the ward”).

191. See, e.g., In re Fiori, 673 A.2d 905, 913 (Pa. 1996) (holding that there is no need for court involvement when there is no disagreement among the “interested parties” regarding the course of treatment, and citing numerous cases in accord. One exception to this judicial consensus is Massachusetts, which originally required routine judicial review. See Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 433-34 (Mass. 1977) (specifically rejecting the New Jersey approach, as defined in the Quinlan case, of entrusting medical treatment decisions to a legal guardian, family members, physicians, and facility ethics committees, and holding that the courts are the proper forms for such determinations). However, subsequent Massachusetts decisions appear to backtrack, and in all likelihood, abandon this requirement. See In re Spring, 406 N.E.2d 115, 122 (Mass. 1980) (opining that judicial scrutiny of medical decisions should occur when good faith or due care is brought into question); In re Dinnerstein, 380 N.E.2d 134, 139 (Mass. App. Ct. 1978) (appearing to limit the Saikewicz holding requiring judicial review to cases in which an individual was offered a truly “life-saving or life-prolonging treatment alternative”).

192. Refer to note 186 supra and accompanying text.

193. See, e.g., Fiori, 673 A.2d at 913 (citing In re Rasmussen, 741 P.2d 674, 691
Some courts have devised additional protections when necessitated by systemic features of medical decisionmaking. The New Jersey Supreme Court has been in the forefront in this regard. In the *Quinlan* case, the court required hospital ethics committee review of decisions to forgo life-sustaining treatment when the patient lacked decisionmaking capacity and was being treated in a hospital.\(^{194}\) Recognizing that patients in long-term care facilities may be more vulnerable than those in hospitals,\(^{195}\) and that ethics committees do not exist and are not as likely to be created in nursing homes,\(^{196}\) the New Jersey Supreme Court has required notification of a specific administrative official when treatment is proposed to be withheld or withdrawn from an elderly nursing home patient.\(^{197}\) If a particular nursing home patient is not subject to protection by the administrative agency because he or she does not meet the statutory requirements necessary to invoke the agency's jurisdiction, the New Jersey Supreme Court requires that "at least two independent physicians knowledgeable in neurology," supplemented by the certification of the patient's attending physician (if there is one), confirm a diagnosis of persistent vegetative state.\(^{198}\) In a situation involving a patient treated at home, the court has recognized that because such patients lack the safeguards inherent in being treated in a hospital where a multitude of caregivers provide some protections against abusive decisions, some other safeguard is needed.\(^{199}\) In such cases, New Jersey requires that two physicians (other than the patient's attending physician) confirm the patient's competence, and that the patient has been "fully informed about his or her prognosis, the medical alternatives available, the risks involved, and the likely outcome if medical


\(^{195}\) See *In re Conroy*, 486 A.2d 1209, 1237-41 (N.J. 1985) (discussing the particular vulnerability of patients in nursing homes and detailing the circumstances that lead to such vulnerability).

\(^{196}\) See id. at 1238.

\(^{197}\) See *Jobes*, 529 A.2d 434, 448 (N.J. 1987).

\(^{198}\) See *In re Jobes*, 529 A.2d 404, 408, 414-15 (N.J. 1987) (suggesting that the needed element of informed consent may be lacking in the home environment from the lack or infrequency of physician or other caregiver presence).
treatment is disconnected. Other courts have devised similar, though not quite so extensive, safeguards.

Presumably, all of these protections have been developed in the context of fee-for-service medicine. Fee-for-service was the prevalent payment system in the period in which these protections were prescribed, and no court has mentioned the payment system involved in its discussion of the safeguards that should surround end-of-life decisionmaking. Certainly, none has ever expressly considered whether a different payment system might require different protections. And, of course, all of these decisions have developed in the context of forgoing life-sustaining treatment, not physician-assisted suicide.

2. Physician-Assisted Suicide. The approach taken thus far in providing safeguards to protect patients in the context of physician-assisted suicide has proceeded in a significantly different manner from the approach taken in withholding and withdrawing life-sustaining treatment. In the latter, the presumption that there were adequate safeguards in the clinical setting governed, and other safeguards were added only as circumstances seemed to warrant. By contrast, the debates about physician-assisted suicide have occurred in the context of that practice being criminal. Efforts to legalize physician-assisted suicide must address this fact, and also address a de facto presumption of abuse surrounding physician-assisted suicide. Thus, the onus has been on those who have sought to legalize it to propose safeguards against the very factors

200. *Id.* at 415.


203. Refer to notes 183-190 *supra* and accompanying text (determining and describing the substantive and procedural non-judicial protections employed in termination of treatment decisions).

204. Refer to note 191 *supra* and accompanying text (asserting that courts generally abstain from involvement in medical decisions absent some dispute among interested parties).


206. That physician-assisted suicide is presumed abusive is suggested by the state's argument in *Compassion in Dying*, "that 'assisted suicide': 1) requires doctors to play an active role; 2) causes deaths that would not result from the patient's [sic] underlying disease; and 3) requires doctors to provide the causal agent of patients' deaths." *Id.* at 822.
responsible for its having been made criminal in the first place, or at least for its continuing to be criminal in recent times.

For example, the efforts to legalize physician-assisted suicide by referendum in Oregon which were successful,207 in California, in Washington,208 and in Michigan209 that were not—have not taken the approach of either simply repealing the criminal prohibitions on assisted suicide or creating an exception for physician-assisted suicide. Rather, the proposals, referenda, and the Oregon statute have been hedged with substantive and procedural safeguards210 (though not all consider them adequate).211 The Oregon statute requires, for example, that assisted suicide be carried out by a licensed physician,212 that the patient be terminally ill as established by two physicians,213 that the request for assistance in committing suicide originate with the patient,214 be made in writing,215 and be reaffirmed over a period of time.216 Oregon further requires that a written request be in a particular, detailed form.217 The foregoing safeguards represent only a small portion of those enumerated in the Oregon statute and in other proposals.218

207. See OR. REV. STAT. 127.805 § 2.01 (Supp. 1998).
208. See Compassion in Dying, 79 F.3d at 810 (noting the failure of physician-assisted suicide referendums in Washington and California).
209. See Maria Puente, Fifth Trial Likely in Michigan for Kevorkian, USA TODAY, Nov. 27, 1998, at 3A (reporting on the defeat of a statewide vote “that would have legalized assisted suicide” under certain circumstances).
210. See, e.g., OR. REV. STAT. 127.805 § 2.01 (affirmatively granting adults who meet the stated criteria the right to request life-ending medication).
211. See, e.g., Ezekiel J. Emanuel & Elisabeth Daniels, Oregon’s Physician-Assisted Suicide Law: Provisions and Problems, 156 ARCH. INT. MED. 825, 825-29 (1996) (detailing the procedures and safeguards written into the Oregon law, and extensively criticizing its perceived shortcomings). The authors state, “A major problem with the Oregon Death With Dignity Act is that its safe guards are more nominal than real.” Id. at 827.
212. See OR. REV. STAT. 127.800 § 1.01(10).
213. See id. 127.805 § 2.01 (designating the two as “attending physician” and “consulting physician”).
214. See id. The Oregon Act only implicitly requires that a discussion of the option of physician-assisted suicide be raised by the patient. See id. 127.800 § 1.01(7) (giving the definition of “informed decision”); id. 127.805 § 2.01 (mandating who may initiate a written request for medication); id. 127.810 § 2.02 (stating that a written request for medication must state that the patient is not being coerced to make the request, but not preventing the physician from suggesting this to patient).
215. See id. 127.805 § 2.01, 127.810 § 2.02.
216. See id. 127.815 § 3.01(6), (7) (mandating that the doctor shall inform the patient that he or she may rescind, and offer again the opportunity to rescind at the end of the 15-day waiting period, as well as affirm, just before writing the prescription that the patient’s decision has been an informed one).
217. See id. 127.805 § 2.01, 127.810 § 2.02 (specifying the form and the formalities surrounding its execution in substantial detail).
218. See, e.g., Charles H. Baron et al., A Model State Act to Authorize and
Undoubtedly, as experience grows in the practice of legalized physician-assisted suicide, these protections will be strengthened or abandoned as circumstances warrant. The first living will statute—the California Natural Death Act,\(^\text{219}\) passed in 1976 in response to the *Quinlan* case\(^\text{220}\)—was so hedged with inflexible protective requirements that it was virtually unworkable\(^\text{221}\) and was eventually replaced with a more flexible statute.\(^\text{222}\)

What is most noteworthy about the approach taken in Oregon is that it does not require case-by-case governmental supervision of physician-assisted suicide.\(^\text{223}\) Prospective review of each request for physician-assisted suicide by a judge or official of a state administrative agency could have been required. Instead, there is significant reliance on physicians to accord necessary protections,\(^\text{224}\) just as there is in passively hastening death.\(^\text{225}\) The only significant structural difference is that the...
safeguards are statutorily prescribed for physician-assisted suicide, and judicially designed for withholding and withdrawing treatment.\textsuperscript{226} Both, in effect, are forms of "medical due process" in which the patient's attending physician is given first responsibility for protecting the patient.\textsuperscript{227} However, in Oregon, mechanisms such as waiting periods, second opinions, reports to state authorities, documentation, and counseling for suspected mental disorder exist to protect against the protector,\textsuperscript{228} similar to the way in which ethics committees, administrative review, two-physician requirements, and ultimately recourse to courts are available in New Jersey to protect patients against ill-advised forgoing of life-sustaining treatment.\textsuperscript{229}

V. END-OF-LIFE DECISIONMAKING AND MANAGED CARE

It is easy to conjure up a parade of horribles in the context of end-of-life decisionmaking: greedy families wanting their inheritance sooner rather than later; lazy or unloving families (or loving but exhausted families) who consciously or unconsciously wish to be rid of the burdens of caring for an elderly relative; a young wife whose husband has been so critically injured that there is no hope for recovery but little prospect of a rapid death, who wishes to get on with her life and sees hastening his death as a means of easing her own burdens; parents of a seriously handicapped newborn infant who see nothing but endless years of agony for themselves and the child if it survives; doctors who are exhausted from dealing with such families; doctors who have become hardened to death and see it as preferable for patients

\textsuperscript{226} Refer to notes 210-218 \textit{supra} and accompanying text (analyzing the safeguards in Oregon's Death with Dignity Act), and Part IV.C.1 \textit{supra} (identifying and assessing court-mandated protections in the context of withholding or withdrawing treatment).

\textsuperscript{227} Such a system probably passes constitutional muster. See Washington v. Harper, 494 U.S. 210, 222-23 (1990) (holding that involuntary treatment of a prisoner with antipsychotic medications ordered by a psychiatrist and approved by a prison administrative panel comports with requirements for procedural due process); Youngberg v. Romeo, 457 U.S. 307, 324-25 (1982) (holding that the judgment of a qualified professional is presumptively valid as to whether a mentally retarded institutional resident's constitutionally protected rights to reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, and minimally adequate training reasonably required by these interests have been satisfied); Parham v. J. R., 442 U.S. 584, 590-91, 620 (1979) (holding that psychiatric hospitalization of children by parents requiring approval of a physician affords adequate due process).

\textsuperscript{228} See OR. REV. STAT. §§ 127.815 to .880 (Supp. 1998).

\textsuperscript{229} Refer to notes 194-200 \textit{supra} and accompanying text (discussing the safeguards afforded to patients by New Jersey).
who may still cling to their slender reed of life; and, of course, doctors whose personal financial well-being is adversely affected when dying patients take too long to die.

There have been strong pressures and subtle pressures, financial and otherwise, in end-of-life decisionmaking from the very beginning. Under the classic fee-for-service/indemnity system, the incentives were to provide and bill for as much treatment as possible. This factor has probably led to the overtreatment of many patients near the end of life and may have been a significant factor, along with fear of legal liability and doctors' own moral scruples, in making some doctors so hesitant to forgo life-sustaining treatment that patients and families were forced to initiate litigation to have treatment halted. In this process, patients were abused by having their interests blatantly ignored.

However, there have also long been financial incentives, if not pressures, to limit treatment near the end of life. Not all patients in the end-of-life context have insurance, and they and their families have often deliberated under the cloud of a huge financial burden. After the New Jersey Supreme Court granted the Quinlans' wish to have their daughter's life support stopped, she continued to breathe and was kept alive for almost another decade. Although in fact Medicaid paid the cost of nursing home care, and the Quinlans probably knew in advance that it would, it will not always be the case that third-party payment will be available to pay all costs of providing life-sustaining medical treatment for long periods of time. Further, Medicare, Medicaid, or private insurance company bureaucrats might be tempted to influence doctors and surrogates to forgo such treatment.

230. See, e.g., Callahan, supra note 147, at 744 (assessing generally society's attitudes about end-of-life health care costs, and noting "many elderly people claim that they do not want money wasted on them at the end of their lives, much less the full panoply of high-technology care"); see also Kamisar, supra note 148, at 737-39 (observing that the poor and other groups often lack access to adequate psychological and palliative care at the end of life because of the lack of money to provide for such care).

231. See Catherine J. Jones, Teaching Bioethics in the Law School Classroom: Recent History, Rapid Advances, the Challenges of the Future, 20 AM. J. L. & MED. 417, 429 n.68 (1994) (noting that Ms. Quinlan was maintained by artificial nutrition and hydration for the nine years following her removal from the respirator).

232. See JOSEPH & JULIAN QUINLAN WITH PHYLLIS BARTELLE, KAREN ANN: THE QUINLANS TELL THEIR STORY 77, 86 (1977) (stating that the Social Services representative informed the Quinlans that Karen would likely qualify for Medicaid, and referring to the notes of a hospital social worker which reflected that notice was given to Medicaid of Karen's likely transfer from the ICU of one hospital to another facility).

233. See Kaveny, supra note 202, at 1300 (opining that a public health care purchaser working through an MCO may rationalize encouraging a suicide by
From a systemic perspective, cost saving mechanisms have been in place for more than two decades. Utilization review has long been imposed by indemnity insurers and hospitals. Prospective payment under Medicare has existed since the early 1980s, thus putting hospitals at risk for at least some of the costs of treating terminally ill and/or permanently unconscious Medicare patients. The nature and direction of financial incentives of managed care are not entirely new, although the degree to which they permeate the delivery of health care has unquestionably increased greatly in the last decade.

We do need to be concerned about physician-assisted suicide in the context of managed care. In addition, the incentives that managed care brings into the doctor-patient relationship ought to make us concerned enough to reexamine the system of protections that has developed around passively hastening death, for competent patients as well as incompetent patients. However, in translating our concern into action, we need to focus more on the needed protections than on the manner of hastening death, and we need to focus more on protections than on the type of health care system. Of course, we need to design protections that are sensitive to the nature of the health care system and the particular kinds of problems that it might pose (such as managed care incentives), and we need to take into account any special problems, if any, posed by physician-assisted suicide in contrast to termination of life support. There is only the weakest evidence, however, that we need to prevent the legalization of physician-assisted suicide simply because of the ascendance of managed care.

reviewing the life-termination as “beneficial” not only as an end to the patient’s suffering, but also to the “plan” as a cost-saving strategy).


235. See David M. Frankford, Creating and Dividing the Fruits of Collective Economic Activity: Referrals Among Health Care Providers, 89 COLUM. L. REV. 1861, 1883 n.73 (1989) (describing Medicare’s prospective payment system and noting that under the system, “the risks of overutilization of [medical] services and production inefficiencies [are] shifted from the payer to the hospital”).

236. See Wolf, supra note 9, at 455-56, 460-66 (compiling statistics on the increasing pervasiveness of managed care in recent years, and detailing the real and potential impacts of managed care’s cost-saving mechanisms upon physician conduct).

237. Refer to note 176 supra and accompanying text (discussing the current available evidence regarding the relationship between managed care and physician-assisted suicide).