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Is Managed Care Good for What Ails You - Ruminations on Race, Age and Class

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IS MANAGED CARE GOOD FOR WHAT AILS YOU? RUMINATIONS ON RACE, AGE AND CLASS

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"It's because you are so young,—
You do not understand.
But we are old
As the jungle trees
That bloomed forever,
Old as the forgotten rivers
That flowed into the earth . . . ."[1]

I. INTRODUCTION

MY father made me write this Article. Last year he asked me for help in deciding whether to remain in a fee for service (FFS) health plan or switch to a managed care plan.[2] He handed me a stack of papers that

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This article is dedicated to my father, Gradie McClellan, who at the age of 83 continues to teach me about compassion, pride and dignity through his words, but, more importantly, through his conduct.

1. *Being Old, in* THE COLLECTED POEMS OF LANGSTON HUGHES 109 (Arnold Rampersad ed., 1994) [hereinafter *Being Old*].

2. *See* Jonathon B. Oberlander, *Managed Care and Medicare Reform*, 22 J. HEALTH POL. POL'Y & L. 595, 606 (1997) (reviewing arguments and evidence regarding ability of managed care plans to provide quality care to elderly at financial savings over fee for service (FFS) plans, and concluding that serious concerns exist regarding provision of care to chronically ill patients and future performance of managed care plans); Joseph White, *Which 'Managed Care' For Medicare?*, 16 HEALTH AFF. 73, 79-80 (1997) (discussing movement of Medicare to managed care). In recent years, the federal government adopted a strategy of encouraging Medicare recipients to enroll in managed care programs as a means of reducing the cost of providing care to the elderly. *See* Oberlander, *supra*, at 606.

Sadly and ironically, by the Fall of 1998, health maintenance organizations (HMOs) announced plans to pull out of the managed care Medicare market because it did not prove profitable. *See* Mike Allen, *Fear Greets Cut in H.M.O. for the Elderly*, N.Y. TIMES, Oct. 5, 1998, at B5 (noting that costs and losses forced HMO to cancel coverage). Federal officials reported that more than 250,000 elderly people were being dropped by HMOs in a dozen states. *See id.* (describing cancellation of Medicare coverage benefits by Oxford Health Plans). Poor people were hit even harder than the elderly by HMOs abandoning or reducing coverage in Medicaid managed care programs. *See* Peter T. Kilborn, *Largest H.M.O.'s Cutting the Poor and*

had been sent to him by Medicare that presented him with the choice.[3] My father is eighty-three years old. He is African-American, male and retired, after having spent most of his life working fifteen hours a day, six days a week, on two jobs—one as a steelworker and another as a barber. He migrated in 1942 from South Carolina to Pittsburgh in search of a better life, where a black man could earn a decent living. Like others in his generation, he quickly learned that the streets of Pittsburgh were not paved with gold and racism did not disappear at the Mason-Dixon line. Now, he and my mother live on a fixed income, consisting of a small pension and social security.

Similar to other retired persons in my father's age group, health care looms large in their lives. The most significant trips he and my mother now make are visits to an array of doctors. The trips to the doctor are preceded by detailed preparation regarding the route of travel and the matters to be reported to the doctor after they arrive. Usually my sister or brother transport them to the various doctors' offices and participate in the discussions, when they are allowed to do so by the doctors.

For my parents, the choice of whether to enroll in a managed care plan has immediate consequences as to which doctors they are able to see.[4] At this stage in his life, my father has formed some rather firm opinions about doctors. He does not trust young doctors because they are inexperienced and always in a rush. He does not trust white doctors because

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the Elderly, N.Y. TIMES, July 6, 1998, at A6 [hereinafter Kilborn, *Largest H.M.O.'s*] (describing effect as "most pronounced in Medicaid programs").

3. *See* Milt Freudenheim, *So Far, 'Medicare Plus Choice' is Minus Most of the Options*, N.Y. TIMES, Oct. 4, 1998, at C10 (comparing Medicare Plus Choice program with traditional FFS Medicare program). In 1997, the government revised the program as part of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (codified as amended in scattered sections of 2 U.S.C., 8 U.S.C., 26 U.S.C., 38 U.S.C., 40 U.S.C., 42 U.S.C. and 47 U.S.C.), creating a program called Medicare Plus Choice, inviting private insurers, hospitals and doctors to offer a variety of new types of coverage. *See* Freudenheim, *supra*, at C10. The government mailed bulletins or handbooks to millions of the elderly enrolled in Medicare to inform them of the new options. *See id.* The mailings produced considerable confusion among Medicare recipients. *See id.*

4. *See* Barry R. Furrow, *Regulating the Managed Care Revolution: Private Accreditation and a New System Ethos*, 43 VILL. L. REV. 361, 362 (1998) [hereinafter Furrow, *Regulating Managed Care*] (noting that managed care has slowed down rate of increase of health care costs "by extracting a discount from physicians, who often reduced their fees from forty percent to seventy percent to be part of managed care networks, and by reducing hospitalization rates and lengths of stay"). One of the key strategies that Managed Care Organizations ("MCOs") employ to keep costs down is to authorize medical care by doctors who have agreed to abide by MCO rules governing the provision of services in accordance with financial terms of the MCO plan.

These cost containment strategies have raised the salaries of some medical specialists and lowered the salaries of others. *See* George Anders, *Managed Care Rewards Internists, Pediatricians*, WALL ST. J., Oct. 22, 1996, at B1 (describing growing trend of siphoning off specialist salaries and redirecting salaries to primary care physicians).

they do not really care whether black people live or die. He has many personal experiences, as well as stories told to him from the time he was a young boy, for those who want to dismiss his distrust based on skin color as racist.[5] He does not trust foreign doctors because he cannot understand them and they cannot understand him. Indeed, he had been victimized by a foreign doctor who exceeded the scope of the consent my father gave for limited surgery. After my father complained about the violation of consent, the doctor asserted that "there must have been a misunderstanding." He does not trust young black doctors because too many of them have forgotten where they came from and only care about making money. The only doctors he really trusts are African-American doctors around his age, but there are few of them still practicing.[6] So he does the best he can with the doctors available, but stays on the alert. He is highly suspicious of the motivations of every doctor and skeptical of all of their diagnoses and advice. Yet, he depends on them to keep his now fragile body functioning.

I glanced through the papers Medicare had sent my father requesting that he elect a health care plan. Two fundamental differences stood out between the FFS and managed care plan. First, under the managed care plan, he could get most of the prescriptions he and my mother required for a nominal cost.[7] Under the FFS plan, they were spending about $250 a month for prescriptions.[8]

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5. He was one of the early patients to undergo pedicle screw surgery, a procedure where an orthopedic surgeon uses a screw as a spinal fixation device. The problem was that the device had not been approved by the FDA for such a use and the patients were not told in many instances that the procedure was experimental. My father was one who was not told that the procedure was experimental. Fortunately, while he has suffered problems from the surgery, it did not disable him. Thousands of patients, however, claimed to suffer serious physical and emotional injuries and brought legal actions that eventually precipitated a $100 million dollar settlement for approximately 3200 patients. *See In re* Orthopedic Bone Screw Prods. Liab. Litig. v. AcroMed Corp., MDL No. 1014, 1997 WL 164237, at *1 (E.D. Pa. Mar. 26, 1997) (discussing settlement agreement); *see also AcroMed Settlement Ok'd, Creates a $100 Million Fund; Judge Dismisses Objections* 12 No. 5 MEALEY'S LITIG. REP. INS., Dec. 2, 1997, at 11 (same).

6. *See* Note, *The Impact of Managed Care on Doctors Who Serve Poor and Minority Patients*, 108 HARV. L. REV. 1625, 1625 (1995) (noting that transformation from FFS to managed care poses special threat to minority physicians who have traditionally served minority and poor communities in disproportionate numbers). Given the increasing specialization in medicine, the heavy reliance on technology and growing dominance of managed care companies, it seems unlikely that the kind of doctor my father would trust will appear in significant numbers in the coming decades.

7. *See* Peter J. Jurgeleit, *Physician Employment Under Managed Care: Toward a Retaliatory Discharge Cause of Action for HMO-Affiliated Physicians*, 73 IND. L.J. 255, 255-56 n.4 (1997) (discussing nominal copayment in managed care scheme).

8. *See* Elyse Tanouye, *Drug Dependency U.S. Has Developed an Expensive Habit; Now, How to Pay for It?*, WALL ST. J., Nov. 16, 1998, at A1 ("Retail pharmacies will rack up an estimated $102.5 billion in sales of prescription drugs by year end, up 85% in just half a decade. Drug sales in the [United States] are rising 16.6% this year, more than four times the increase in health-care spending overall."). Studies

The second difference, choice of doctors, weighed in favor of the FFS plan. Under the FFS plan, my parents enjoyed a wide choice of physicians and hospitals, both geographically and in terms of the number of medical specialists.[9] In contrast, the managed care plan required them to select from a list of providers in the several managed care plans that were competing for their business as Medicare Managed Care Organizations (MCOS). My parents each see several specialists on a regular basis and no list contained all of their treating doctors, and some of the lists contained none. In short, if they accepted the managed care plan, they would have to start a new venture into the world of health care providers.

I reported these fundamental differences to my father who replied that he already knew about those differences. He and my sister, neither of whom are lawyers, had figured that much out. But it seemed to him that there was an awful lot of paper sent to them regarding this decision to come down to a choice as basic as paying for prescriptions and switching doctors.[10] They felt troubled by the decision and worried that they may have missed some other important differences in the plans. They thought it would be best to get my legal advice before making a decision, rather than coming to me later when something bad had happened. If, however, prescriptions and choice of doctor were the main differences, he said he

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of the cost of prescription drugs make it clear that the costs are likely to continue to escalate at a staggering pace.

9. *See* Peter T. Kilborn, *Reality of the H.M.O. System Doesn't Live Up to the Dream*, N.Y. TIMES, Oct. 5, 1998, at A1 [hereinafter Kilborn, *Reality*] (noting that managed care has "lost its luster" as answer to America's health care needs). Fee for service plans made available to subscribers by their employers have traditionally offered a freedom of choice of health care providers, but today that choice comes at an increasingly high price, sometimes so high as to make it a choice only in theory. *See id.* (observing that because FFS option sometimes costs employees as much as $6000 per year, less than 20% of employees can afford it).

10. *See* Freudenheim, *supra* note 3, at C10 (comparing health care options in Medicare program). I would discover later how correct my father's instincts were regarding the complexity of the decisions he had to make. The options from which he would soon have to choose, as detailed in one newspaper article, included: Original Medicare with supplemental Medigap insurance, Medicare HMO, Medicare provider sponsored organization, Medicare private FFS plan and Medicare medical savings account. *See id.* Moreover, the question of how the health care would in fact be delivered under the various plans, as distinguished from the express provisions in the handbooks and marketing materials, remained questionable. One health care provider made the following observations about how the managed care plans affected medical care provided to the elderly:

> "Some elderly patients require 30 to 50 minutes, not the 10 minutes managed care allots . . . . They need help getting out of their wheelchair and disrobing. To care for them properly, you need time to listen to and talk with them. Since many can't hear well, you can't fire rapid questions at them. You also need time to explain the medications."

Deborah Grandinetti, *Can You Trust an HMO With Your Elderly Patients?*, MED. ECON., Apr. 14, 1997, at 94, 102 (quoting Gordon Shiff, M.D., internist at Cook County Hospital in Chicago).

still needed my advice because he and my sister disagreed about the right choice.[11]

My sister, who assisted him in balancing his expenses against fixed income, thought it best to save on prescriptions. In contrast, he thought it was more important to keep the doctors that he and my mother had, even though neither was thrilled with those particular doctors. My father finished by informing me that, notwithstanding his reservations, he was willing to consider seriously switching to managed care if I could assure him that the consequences of the choice were limited to those major factors—doctor choice and prescription payment.

Before answering, I decided to research the issues a little more. My initial research revealed that the medical studies that compare quality of care rendered under managed care to that rendered under FFS have produced mixed conclusions.[12] One medical study of Medicare managed care reached the troubling finding that for elderly persons, declines in

11. *See* Freudenheim, *supra* note 3, at C10 (describing tough choices involved when choosing health plan). In fact, as my later research would disclose, a myriad of significant issues are impacted by the choice. Included among the important factors to my father were:

> If in switching to an H.M.O. you give up an insurance policy that fills gaps in Medicare coverage, you may not be able to get that Medigap coverage back at the same price if you later decide to return to traditional Medicare.
>
> If in switching to an H.M.O. you give up traditional Medicare coverage supplemented by extras from your former employer, the employer does not have to take you back if you change your mind later.

Id.

12. *See* Furrow, *Regulating Managed Care*, *supra* note 4, at 384 (citing numerous studies and arguing that private accreditation promises to improve quality of care provided by managed care organizations). In light of many recent studies, one commentator has stated that "managed care has substantial advantages over FFS plans not only in controlling costs, but also in maintaining or even improving the quality of care for subscribers. Managed care also confronts potential weaknesses, including care for the chronically ill, for children and for the elderly." *Id.*

My view, after reviewing reports of many of the studies done to date, is that it is too soon to draw a conclusion as to which system is best overall, from a quality of care perspective. *See generally* Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?—A Survey of Recent Studies Shows Mixed Results on Managed Care Plan Performance*, 16 HEALTH AFF. 7 (1997) (reviewing 37 recently published peer review studies). Although some medical studies have concluded that managed care does a better job than FFS in diagnosing or treating particular conditions or illnesses, other studies have concluded the opposite. Still others have found the care to be the same under each system. *See* Furrow, *Regulating Managed Care*, *supra* note 4, at 377-85 (citing and summarizing numerous studies). For a further discussion of recent studies, see *infra* notes 13-19 and accompanying text.

It may be that each system performs better in serving particular populations and/or in providing care under particular conditions. In any event, the empirical evidence that now exists best supports the view that consumers should be well informed and offered a choice. Otherwise, disappointment, frustration and litigation will flourish. *See* Peter T. Kilborn, *Complaints About H.M.O.s Rise as Awareness Grows*, N.Y. TIMES, Oct. 11, 1998, at A22 [hereinafter Kilborn, *Complaints Rise*] (reporting that number of complaints about HMOs to state regulators has increased

health were more common if they were enrolled in a health maintenance organization (HMO) plan as compared to a FFS plan.[13] In addition, a study of the General Accounting Office (GAO) found that a large percentage of Medicare recipients who had voluntarily enrolled in managed care programs withdrew from managed care as soon as they were able.[14] Significantly, people who had chronic illness, like my parents, disenrolled in larger numbers than those who were in good health.[15] The GAO study did not offer definitive answers for this enrollment and disenrollment pattern.[16] What seemed clear, however, was that many Medicare recipients quickly became dissatisfied with the managed care program they enrolled in.[17]

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significantly and have shifted from who should pay for care to disputes over denials and delay of care and medication).

13. *See* John E. Ware et al., *Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems*, 276 JAMA 1039, 1045 (1996) (noting that older patients with chronic illnesses do not fare well in managed care programs).

14. *See* GENERAL ACCOUNTING OFFICE, MEDICARE: FEWER AND LOWER COST BENEFICIARIES WITH CHRONIC CONDITIONS ENROLL IN HMOS 3 (1997) (noting that enrollees with chronic illness withdrew from HMOs at rate of 10.2%, whereas enrollees with no chronic illness withdrew at rate of 4.5%). Federal regulations allow Medicare patients to disenroll from managed care or FFS plans every 30 days. *See id.* at 4 (noting that Medicare rules permit beneficiaries to select from any federally approved HMO and also to switch plan or return to FFS program on monthly basis). Given this option, a high percentage of the elderly with chronic illnesses disenrolled from HMO systems. *See id.* ("Because of freedom to change plans every 30 days, disenrollments can indicate enrollee dissatisfaction with an HMO.").

15. *See id.* at 10-11 (noting that new HMO enrollees suffering from one or more chronic illness disenrolled at rate more than twice that of new enrollees suffering from no chronic illness). Because of the option to change plans every 30 days, this disproportionate number of disenrollees tends to indicate a dissatisfaction with the service provided to the beneficiary by the plan. *See id.* at 9-10 (noting that Medicare beneficiaries who withdrew from HMOs after less than six months cited dissatisfaction with primary care physician, misunderstanding of HMO rules and inability to obtain appointments as reasons for withdrawal).

16. *See id.* at 13 (concluding that only chronically ill beneficiaries were less likely to enroll and more likely to disenroll from HMOs then healthier beneficiaries).

17. *See* Oberlander, *supra* note 2, at 613 (reviewing arguments for and against managed care for Medicare recipients and concluding that benefits of managed care realized by younger enrollees may not be applicable to Medicare recipients). One commentator who looked specifically at delivery of care to Medicare recipients under managed care and FFS from 1982 to 1995 offered the following summary:

> 1. Medicare has lost money on its HMO patients.
> 2. HMOS have enrolled relatively healthy beneficiaries.
> 3. HMOs have a mixed record on quality of care. Most studies show health outcomes in Medicare HMOs that are comparable or superior to those in FFS, but less-adequate care has been found for chronically ill elders enrolled in HMOs.

Id.

One matter that may have prompted dislike of the care rendered under the managed care programs is suggested by studies that found health care providers

Of additional concern is that these studies do not adequately assess whether race, ethnicity, culture or class influenced the peoples' choices.[18] If people like my parents have not been studied, perhaps the information offered by the studies is misleading.[19] In other words, managed care may be good for some and bad for others. Factors influencing the assessment may include class, race and age, as well as health. A realistic assessment of who my parents are may serve as a useful guidepost in identifying relevant studies that would shed some light on the benefits and limitations as set forth in the fine print of the available health care plans.

I offer this story of the dilemma of individuals faced with the Medicare choice of managed care or FFS to make two points that I regard as important in the debate over the public policy choices we are facing in the area of health care. First, the debate has been driven in recent years by a macro-analysis that marginalizes, even obliterates, concerns about particular individuals. The utilitarian view of ethics now dominates, endorsing the political view that if we are to do the best thing for the nation from a health care perspective, we must stop worrying about individuals.[20] I have not yet been persuaded as to the necessity, wisdom or morality of this approach to health care decisionmaking.

I submit that neither courts nor juries have fully accepted the notion that we should provide a lower standard of care to particular groups or individuals to promote the greatest good.[21] If the tort system is allowed to

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spending less time with patients under HMO plans than under FFS plans. Ware, the author of the seminal study on the quality of care provided under Medicare managed care, found that "the HMO visits were shorter and more likely to be with a physician the patient had never seen before. Less was done during the visits, such as prescribing a new drug. And patients had to wait longer for follow up appointments." Grandinetti, *supra* note 10, at 101-02.

18. *See generally* Barbara A. Koening & Han Gates-Williams, *Understanding Cultural Difference in Caring for Dying Patients. (Caring for Patients at the End of Life)*, 163 W.J. MED. 244 (1995) (discussing both importance and complexity of interpreting relevant cultural dimensions of particular case).

19. *See* Barbara A. Noah, *Racist Health Care?*, 48 FLA. L. REV. 357, 357 (1996) (discussing studies that find racial disparities in three separate health care contexts, including utilization of Medicare services). For a further discussion of medical studies that have identified differences among blacks and whites in the medical care offered by care givers and in the outcomes of the medical care rendered, see *infra* notes 37-41 and accompanying text. Moreover, studies have found that birthplace may impact on health risks among persons of the same race, indicating that making an accurate assessment of the significance of race in health care is even more complicated than previously thought. *See, e.g.*, Jing Fang et al., *The Association Between Birthplace and Mortality From Cardiovascular Causes Among Black and White Residents of New York City*, 335 NEW ENG. J. MED. 1545, 1545 (1996) (finding that black people have higher rates of heart disease than white people, and that black people who live in South have higher rate of heart disease than black people living in Northeast).

20. For a brief discussion of utilitarian ethics as contrasted with Kantian ethics, see J. ARRAS & N. RHODEN, BIOMEDICAL ETHICS 6-28 (3d ed. 1989).

21. *See* Fox v. Health Net, No. 219692, 1993 WL 794305, at *1 (T.D. Cal. Jury Dec. 23, 1993) (awarding damages against HMO for failing to provide medical treatment that HMO believed to be experimental). Perhaps the most poignant

operate, retrospective reviews of health care decisions may reveal community values that differ from those held by managed care organizations driven by economic efficiency. When injured consumers bring tort actions emphasizing the need to protect individual autonomy with meaningful informed consent or an efficacious principle of equal health care rights, judges and jurors may well disagree with economics-driven health care decisions.[22]

The second point of the personal story is to lay the groundwork for the argument that the protection of human dignity requires a willingness to acknowledge different personal and group experiences, perspectives and values. Good public policy cannot be made in this area by decision makers who are "color-blind" or "class-blind."[23] We must have enough courage and sensitivity to acknowledge that race, ethnicity and class affect health and health care treatment. Differences among individuals necessitate a diversified health care system that allows consumers and providers to make some fundamental decisions about the delivery of health care. This may not be at odds with the overriding principles of systematic managed care. We will have to deal with issues of race, class, gender and culture, however, to establish health care systems that are efficient, fair and effective in delivering services to a diverse clientele.

In this Article, I will argue that we should not adopt a policy that compels all Medicare recipients to enroll in managed care plans, even though managed care may produce substantial savings in tax dollars.[24] I contend that managed care cannot provide many older people with a value that is most important to them, and one that they have earned through a lifetime of hard work—treatment with a level of respect that allows them to maintain a sense of dignity and self-worth as they negotiate the complex world of twenty-first century health care. I will also argue that the tort system represents an important tool for the protection of senior

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example of public disagreement with the utilitarian view of ethics occurred in a case in which a jury rendered an award of $89 million to the estate of a woman who sued an HMO that refused coverage to the woman, who was dying from cancer, for a bone marrow transplant on the ground that it was experimental. *See id.*

22. *See* Domenick C. DiCicco, Jr., *HMO Liability for the Medical Negligence of its Member Physicians*, 43 VILL. L. REV. 499, 504-16 (1998) (identifying various theories of liability used against MCOs, including vicarious and direct liability).

23. *See* Trina Gillo & Stephanie M. Wildman, *Obscuring the Importance of Race: The Implications of Making Comparisons Between Racism and Sexism (or Other -isms), in* CRITICAL RACE THEORY 564, 566 (Richard Delgado ed., 1995) (stating that "members of dominant groups assume that their perceptions are pertinent ones, that their problems are the ones that need to be addressed, and that in discourse they should be the speaker rather than the listener").

24. *See* Furrow, *Regulating Managed Care, supra* note 4, at 361-65 (describing methods and role played by managed care in reducing health care costs); *see also* Ken Terry, *Don't Miss Out on Medicare Managed Care*, MED. ECON., Apr. 7, 1987, at 58 (urging physicians to compete with HMOs for Medicare dollars through physician groups and provider-sponsored networks).

citizens in general, and people of color in particular, from substandard medical care.[25]

I do not contend that managed care is inherently evil and FFS is inherently good.[26] Rather, I argue that the benefits and burdens of a health plan vary significantly with the socioeconomic, cultural, racial, age and health status of individuals. Further, I argue that legislators and courts should consider race, age and other socioeconomic factors when evaluating the reasonableness and desirability of practices and policies adopted by managed care companies. Only then can we fashion a policy that both protects and enhances human dignity while allowing managed care to realize its tremendous potential to improve the availability of health care to the poor, the elderly and people of color. To assist the development of my arguments, I begin with a comparison of the risks and benefits inherent in both a FFS or managed health care plan.

II. COMMON GROUND

The conflict between cost-driven medical care and a physician's duty to put the health interests of the patient above all other concerns affects everyone who needs health care. Consequently, I do not argue that race and class are the sole or, necessarily, dominant factors that should influence the consumer's decision to choose managed care or FFS. There is readily identifiable common ground that must be covered by patients, re-

25. *See* Ellen Wertheimer, *Ockham's Scalpel: A Return to a Reasonableness Standard*, 43 VILL. L. REV. 321, 357-59 (1998) (arguing that customary tort law of negligence is necessary to make HMOs balance their financial interests with interests of consumers); *cf.* Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 442 (1997) [hereinafter Furrow, *Rethinking Liability*] (reviewing studies comparing quality of managed care health delivery and concluding that evidence does not support indicting managed care and that tort system should focus on individual managed care systems that may not be operated properly).

26. *See* Henry T. Greely, *Direct Financial Incentives in Managed Care: Unanswered Questions*, 6 HEALTH MATRIX 53, 56-57 (1996) (noting that studies conducted in 1970s and 1980s indicate that HMOs are no worse or better than FFS systems, but warning that those studies may not be indicative of current situation). Neither system may accurately claim to focus solely upon consumer protection. Both involve decisionmaking by a variety of actors whose goals may conflict, such as making a profit while providing good medical care to all patients. The most important question to consumer advocates, however, is which system is best able to ensure that the decisions made by health care providers are in the best interests of their patients. *See id.* at 69-70 (noting that public concern exists regarding possibility that direct financial incentives will result in medical decisions adverse to patient needs); *see also* Edward B. Hirshfeld & Gail H. Thomason, *Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3, 5 (1996) (arguing that to prevent overall lower quality of care, law must recognize that coverage decisions and medical decisions are, in reality, same decision). *See generally* MARC A. RODWIN, MEDICINE, MONEY & MORALS: PHYSICIANS CONFLICTS OF INTEREST 1-18 (1993) (discussing financial incentives for doctors and resulting conflict of interest that may arise because financial incentives may compromise judgment and loyalty of doctors to patients).

gardless of race, age or class.[27] Nevertheless, it is unrealistic to ignore the impact of these factors on the process of obtaining informed consent as well as on the advantages and disadvantages of a particular plan. Legislators, administrators and courts should give appropriate weight to such factors. This position is supported by first examining the common challenges that all consumers face when they enroll in managed care and then demonstrating how much more complicated these challenges are if you are black, elderly, poor or all three.

The following problem will serve to illustrate the fundamental challenges that the managed care system poses to physicians and consumers. The manner in which those challenges are handled requires responses from the courts and the legislatures in terms of the appropriate role of the tort system.

III. PROBLEM: DECISION TO FORGO A TEST OR REFERRAL[28]

A. *The Problem*

Over the course of one year, Dr. Frugal, an ophthalmologist, evaluated Mr. Fields, forty years of age, for eye problems. After performing a number of tests on Mr. Fields, Dr. Frugal concluded that Mr. Fields suffered from low-pressure glaucoma, a rare disease that causes a loss in peripheral vision due to excess pressure on the lens in the eyes. Mr. Fields was enrolled in a HMO plan that required him to get approval for any consultations or referrals from his primary physician, who had referred him to Dr. Frugal. She prescribed eye drops, the customary treatment for glaucoma.

Unfortunately, Mr. Fields did not have glaucoma; he had a slow-growing tumor that was causing him to go blind. Concerned about his continuing loss of vision over the coming year, on his own initiative and at his own expense, Mr. Fields consulted an ophthalmologist who also specialized in neurology. After he underwent a computerized tomography (CT) scan, the tumor was detected and surgery was performed.

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27. *See* Furrow, *Regulating Managed Care, supra* note 4, at 364-65 (noting that HMOs rationalize delivery of health care in ways that FFS cannot, such as utilizing market forces to reduce costs while maintaining quality of care). Managed care seeks to reduce the costs of health care through incentives, reviews and other controls of medical decisionmaking for all enrollees. *See id.* at 362 ("Managed care has achieved this slowdown [in health care cost inflation] by exacting a discount from physicians . . . and by reducing hospitalization rates and lengths of stay."). FFS plans offer more choices of providers and more medical services, regardless of age, race or class. Nevertheless, each system may produce benefits and burdens that impact on people differently, and some of those effects are sensitive to age, class and race. For a further discussion of the demographic impact of both FFS and managed care systems, see *infra* notes 38-106 and accompanying text.

28. *See* FRANK M. MCCLELLAN, MEDICAL MALPRACTICE: LAW, TACTICS AND ETHICS 64, 73-76 (1994) [hereinafter MCCLELLAN, MEDICAL MALPRACTICE] (discussing decision to forgo test or referral and analyzing it from perspective of law, economics and ethics).

It is undisputed that a substantial portion of the vision that Mr. Fields lost could have been saved if a CT scan had been ordered and evaluated by an ophthalmologist with specialized training in neurology. It is also undisputed that Dr. Frugal considered ordering a CT scan or making a referral, but decided not to because of cost considerations. Given the financial incentives built into the HMO reimbursement plan, however, Dr. Frugal undoubtedly did just what most ophthalmologists would have done in light of the patient's symptoms, the risks and the cost of the CT scan and the referral. On the other hand, Mr. Fields has an expert who will testify that ninety-five percent of the physicians treating a patient with Mr. Fields's symptoms and history would have immediately ordered a CT scan or made a referral if the patient had a non-HMO plan such as Blue Cross and Blue Shield or Medicare.

B. *Analysis of the Problem*

Whether it was appropriate to refer the patient with eye problems to an ophthalmologist who specializes in neurology and whether it was appropriate to order a CT scan depend on whose values dominate the decisionmaking process. An informed consumer would certainly opt for the referral and the CT scan if these services offer the potential of saving his or her eyesight. A physician working under a FFS plan would probably make the referral and order the test because it may help the physician diagnose a potentially serious problem and it poses almost no risk to the patient.[29] Additionally, a physician working under a FFS plan has the added incentive in that the doctor's income may benefit from the test. A managed care physician, driven by cost considerations, probably would not order the test or make the referral because the clinical picture supports a diagnosis that allows the physician to conclude that the probability of the patient benefitting from the test is low.

Indeed, if managed care is successful in making physicians think twice before ordering tests and making referrals, a decision to forgo the costs in situations where a FFS doctor would incur them comports with the basic goals of the managed care system. It may be difficult for a physician or practice group to rationalize, on ethical grounds, providing one standard of care to FFS patients and another to managed care patients if both are

29. *See* Helling v. Carey, 519 P.2d 981, 982-83 (Wash. 1974) (examining malpractice action against ophthalmologist). In *Helling*, the court found that an ophthalmologist, who treated a patient who was losing her vision for several years, was negligent for failing to perform a pressure test to detect glaucoma. *See id.* The court reached this conclusion despite the fact that the patients age—she was only 32—made the possibility of glaucoma highly unlikely. *See id.* The court's reasoning was based on the fact that the test posed a minimal risk to the patient, offered a tremendous potential benefit and cost very little. *See id.* at 983 ("The test is a simple pressure test, relatively inexpensive. There is no judgment factor involved and there is no doubt that by giving the test the evidence of glaucoma can be detected .... Under the facts of this case reasonable prudence required the timely giving of the pressure test.").

cared for in the same practice. Instead, it may be much easier to rationalize changing the treatment standards for all patients to match the standard provided for managed care patients.

A tort case may thus present some intriguing questions regarding what is the acceptable standard of medical care. Should medical standards differ, depending on the insurance plan?[30] In light of the managed care system's goal of eliminating tests and referrals when they are not generally cost effective, an argument could be made that it is reasonable for a managed care doctor to make medical decisions based primarily on the cost of the treatment. If the standard of care differs under managed care and FFS, the question arises whether consumers are entitled to an informed consent at the time they enroll. Can the marketers of the plans be relied upon to provide the information in a meaningful way to all consumers, regardless of age, class or race? If a consumer sues for negligence or absence of informed consent, should the courts and juries be allowed to consider the claims? If the courts are allowed to entertain the claims, should courts and juries be allowed to consider race, age and class and impose different standards on managed care organizations in light of those characteristics?

In a recent decision upholding the viability of a claim against a managed care company for potential breach of a fiduciary duty as a result of its financial incentive scheme, the United States Court of Appeals for the Seventh Circuit observed:

> The shift to profit-driven care is at a gallop. For nurses and physicians, the space for good work in a bad system rapidly narrows. For the public, who are mostly healthy and use little care, awareness of the degradation of medicine builds slowly; it is mainly those who are expensively ill who encounter the dark side of market-driven health care.[31]

The restricted access to specialists and expensive testing may find justification when one looks at the overall efficiency of the health care system. If the managed care system is presented to consumers as an option rather than a mandate, however, the justification for forgoing the test or referral must rest ethically, at least in part, on the informed consent of the consumer who elects to enroll. I suspect that few elderly consumers, particularly those who are working class or members of racial and ethnic mi-

30. *See* Wickline v. State, 239 Cal. Rptr. 810, 820 (Ct. App. 1986) (holding state insurer not liable for medical decision to discharge surgery patient from hospital after high-risk surgery where decision resulted in need to amputate patient's leg), *appeal dismissed*, 741 P.2d 613 (Cal. 1987). *Wickline* has been interpreted to rest in part on the public insurance coverage that applied to plaintiff's medical care. *See* Wilson v. Blue Cross, 271 Cal. Rptr. 876, 879 (Ct. App. 1990) (stating that "[t]he *Wickline* court correctly concluded that the public policy as expressed in the Welfare and Institutions Code and Title 22 of the California Administrative Code constituted an exception to the usual standard of tort liability").

31. Hedrich v. Pegram, 154 F.3d 362, 375 (7th Cir. 1998).

norities, consent to the restricted access to specialists and tests when they enroll in the managed care program. Nor do they consent to a lower standard of medical care.[32]

Let us assume that a person like my father enrolled in the managed care program and analyze the issues in that context.[33] Recall that my father was not sure that the gain of free prescriptions and the lower cost of office visits was worth it to him. The choice was a lot more complicated because of the many specialists he and my mother needed to see periodically, the cost of transportation to get to the doctors and, most importantly, the difficulty today of finding a doctor he can trust. For people like my father, finding a doctor that you can trust is an arduous challenge. He had managed to find a few doctors that he did not trust too much, but with whom he was willing to continue with rather than risk getting worse doctors in a managed care program. The dominant financial consideration flowed from the prescriptions my parents purchase monthly. In effect, the papers Medicare sent to my father asked him whether he would agree to give up the doctors in exchange for saving a meaningful chunk of money he and my mother were spending on prescription drugs.

The goal of the government in offering the elderly an option of a managed care health plan is to save tax dollars. Savings are expected to be

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32. *See* Kilborn, *Largest H.M.O.'s, supra* note 2, at A1 (noting possible impact of Medicare on poor and elderly). Some have argued that Medicaid managed care has provided poor people with better medical care than was provided to them under FFS through overcrowded and impersonal clinics. *See, e.g.*, Claire Kohrman et al., *Medicaid Enrollees in HMOs: A Comparative Analysis of Perinatal Outcomes for Mothers and Newborns in a Large Chicago HMO* (1990) (study conducted by Center for Health Administration Studies, University of Chicago) (finding that payment made by FFS or HMO had relatively little impact on perinatal outcomes). As with the elderly enrolled in Medicare, it is too soon to assess confidently the impact that managed care for the poor will have on the quality of medical care provided to the poor. *See id.* Empirical studies are just beginning to appear. *See id.*; *see also* Colleen Foley, *The Doctor Will See You Now: Medicaid Managed Care and Indigent Children*, 21 SETON HALL LEGIS. J. 93, 95 (1997) (presenting analysis of potential of using managed care to improve standard of medical care provided to poor); Janet P. Perloff, *Medicaid Managed Care and Urban Poor People: Implications for Social Work*, 21 HEALTH & SOC. WORK 189, 193 (1996) (noting that Medicaid managed care has enrolled mainly children and adults receiving welfare, and that elderly and disabled Medicaid recipients have been excluded from managed care, historically because of challenges posed by their complex health care needs). Two significant differences exist between Medicare enrollees and Medicaid enrollees in managed care. *See id.* First, the medical care senior citizens received under FFS Medicare was much better than poor people received under FFS Medicaid, apparently due in part to the higher level of reimbursement allowed under Medicare. *See id.* Second, the quantity and quality of medical services needed by senior citizens, many of whom have chronic illnesses, is vastly different than that needed by the younger and healthier Medicaid population, where the emphasis on preventive care reaps huge dividends. *See id.*

33. In fact, my father elected not to enroll in managed care because he decided that he was too old to form new relationships with doctors, so long as the choice belonged to him. Nevertheless, he regularly revisits the issue as he pays for his monthly prescriptions.

generated by a medical care system with a gatekeeper who would identify and eliminate unnecessary referrals, tests and hospitalizations. The goals are laudable. The implied warranty accompanying the offer to those enrolled in Medicare is that they will receive adequate care through the managed care system, have more money to spend and also save taxpayers money—a win-win situation.

The costs of the FFS system are fairly well identified and documented. So are the savings offered by the managed care plan. But what about the costs of the managed care plan in terms of the quality of care, the dignity and spirit of the health care providers and the dignity and spirit of the patients? These are the questions that are unanswered and the questions on which my father wanted me to offer some thought and guidance. My sister certainly made a valid point, not only in terms of finance, but also in terms of dignity, when she suggested that a gain of $250 per month to my parents was significant. Living on a fixed income places a person with limited assets at peril when even small changes take place in their life, as demonstrated by the recent action of my father's former employer who made a unilateral decision to withhold more money from the pensions of retired workers to defray the increased health care costs. In addition to increasing health care costs, the company was faced with more retirees living longer than the company had anticipated when the retirement plan was designed with his union, so they passed the unexpected costs on to the retirees.[34]

My father recognized that he faces a future where his benefits are likely to continue to diminish. This made the decision of whether to enroll in a managed care plan that covered the prescription costs even more important and stressful. To enroll made sense financially, but not in accordance with his need for some control over his health-care decisionmaking. To him, managed care threatened his autonomy in a way that he was unprepared to tolerate.[35]

Had my father elected to enroll in Medicare managed care and encountered the medical decisionmaking described in the glaucoma problem above, he would have been shocked and angered and he would most likely have gone blind.[36] A retrospective assessment of his decision to en-

34. One attempt by an employer to reduce health care benefits of retirees precipitated a class action challenge. *See* Fuller v. Fruehauf Trailer Corp., 168 F.R.D. 588 (E.D. Mich. 1966) (certifying class action on behalf of employees who alleged that employer violated ERISA by failing to honor its promise to provide post-retirement medical benefits at employer's expense).

35. Faced with a constant erosion of autonomy and increasing dependence on others to make each day meaningful, it is readily understandable why having a choice to select your doctor and to participate in your health care decisionmaking may become an important facet of an individual's personal dignity.

36. *See* Wickline v. State, 239 Cal. Rptr. 810, 815 (Ct. App. 1986) (noting problem when patient was discharged earlier than surgeon thought appropriate because insurer denied request for extension of hospital stay), *appeal dismissed*, 741 P.2d 613 (Cal. 1987). If health care providers make decisions influenced heavily by costs and efficiency considerations, they shift a tremendous burden to consum-

roll would have revealed that neither he nor his family understood that by enrolling in a managed care Medicare program he would be agreeing to accept a different (*i.e.*, lower) standard of medical care. Their concerns related to whether saving money on doctors visits and prescriptions was worth the problems attendant to establishing new doctor-patient relationships. Having enrolled in the program, however, the burden would now lie with him to negotiate the system and challenge decisions that appeared to change the kind of medical care he expected to receive. Alternatively, if he was dissatisfied at some point in the future, he could disenroll from managed care and return to the FFS system. Whether the savings generated by the managed care system are worth the restrictions is a question that should be answered in light of the reality of the situation. Determining how different senior citizens should answer the question requires a critical look at how age, race and class may influence the health care delivery system, whether delivery is through a FFS or a managed care model.

IV. RACE AND HEALTH CARE

"*Elderly African-Americans remain three times more likely to be poor than elderly whites, and poverty rates for elderly Hispanics still fluctuate greatly with the business cycle, because many do not receive Social Security and are thus dependent on employment, often at part-time, low wages.*"[37]

As I observed in the introduction, I believe my father represents a substantial group of seniors who stand at great risk of being victims of malpractice. The risk is greater for them than for many other groups because of the impact of intersecting factors: age, race and class. Although it is not always possible to determine which of those characteristics has the most influence in particular situations, it is useful to look at the impact of age, race and class, separately and collectively. I begin with race.

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ers to monitor and assess their health and to seek professional health care aggressively when concerns arise. *See id.* In *Wickline*, a surgeon discharged the plaintiff from the hospital earlier than he wanted because the government insurer denied his request for an eight-day extension of hospital stay and granted only four days. *See id.* at 813. After the plaintiff went home:

> Wickline testified that in the first few days after she arrived home she started feeling pain in her right leg and the leg started to lose color. In the next few days the pain got worse and the right leg took on a whitish, statue-like marble appearance. Wickline assumed she was experiencing normal recovery symptoms and did not communicate with any of her physicians. Finally, when "the pain got so great and the color started changing from looking like a statue to getting a grayish color," her husband called Dr. Kovner. . . . Thereafter, gradually over the next few days, the plaintiff's leg "kept getting grayer and then it got bluish."

Id. at 816. By the time they realized that this was not a normal post-operative course, she had developed an infection and clot in her leg and it was too late to save it. *See id.*

37. WILLIAM W. GOLDSMITH & EDWARD J. BLAKELY, SEPARATE SOCIETIES: POVERTY AND INEQUALITY IN U.S. CITIES 35 (1992).

The impact of race flows in part from past conduct of health care providers[38] and in part from current practices and attitudes of providers and insurers.[39] In the face of their present-day experiences, many elder African-Americans cannot accept the notion that discriminatory and condescending attitudes of health care providers are a thing of the past.

In a recent newspaper article, one author offered a poignant description of the impact that past discrimination still has on health care among elderly blacks:

> Many of them need medical care but adamantly refuse to get it because of the fear—fear of doctors, fear of the haunting memories of shoddy hospitals for "coloreds" they were relegated to as children, fear of being used in medical experiments as black Americans were back then.
>
> Fear keeps one woman at Hill House Center Services from getting treatment for her breast cancer. It keeps a man from seeing a doctor for his medication. It keeps another from seeking care for his prostate problems.[40]

The AIDS epidemic has brought to the surface and crystallized for public view the pervasiveness of the distrust of the medical community among large segments of the African-American community. As one commentator has reported:

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38. *See* Barbara L. Bernier, *Class, Race, and Poverty: Medical Technologies and Sociopolitical Choices*, 11 HARV. BLACKLETTER J. 115, 142 (1994) (reviewing eugenics movement and arguing that "sterilization campaigns and the campaigning to overrule Roe have racial bases"); Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191, 199 (1996) (noting cases from time of slavery to present that have prompted African-Americans to distrust health care system).

39. *See* Daniel Q. Haney, *Medical Journal Attacks AIDS Experiments in Poor Nations*, PHIL. INQUIRER, Sept. 18, 1997, at B2 (discussing New England Journal of Medicine editorial that attacked experiments in poor countries, primarily in Africa, in which AZT was withheld from pregnant women because of its expense, even though AZT is standard treatment in rich countries to prevent infected mothers from infecting their children with AIDS during childbirth); *see also* Beverly Horsburgh, *Schredgresodinger's Cat, Eugenics, and the Compulsory Sterilization of Welfare Mothers: Deconstructing an Old/New Rhetoric and Constructing the Reproductive Right to Natality for Low-Income Women of Color*, 17 CARDOZO L. REV. 531, 550 (1966) (discussing sterilization of poor mothers); Frank M. McClellan, *Informed Consent to Medical Therapy and Experimentation: The Case for Invoking Punitive Damages to Deter Impingement of Individual Autonomy*, 3 J. LEGAL MED. 81, 86 (1982) [hereinafter McClellan, *Informed Consent*] (arguing that many of these cases, including Tuskegee Syphilis Study (the "Tuskegee Study"), should prompt award of punitive damages against health care providers involved and institutions that sponsored their outrageous conduct); Charlotte Rutherford, *Reproductive Freedoms and African American Women*, 4 YALE J.L. & FEMINISM 255, 267 (1992) (noting trouble that poor African-American women have with sterilization).

40. Sharon Voas, *Aging Sick Blacks, Scared Past Abuses, Tradition Keep Them from Clinic*, PITTSBURGH POST GAZETTE, Aug. 27, 1995, at B1.

> A survey of black church members in 1990 found that an astonishing thirty-five percent believed AIDS was a form of genocide. A New York Times/WCBS-TV News poll in 1990 found that one black person in ten believes the AIDS virus was "deliberately created in a laboratory in order to infect black people" and an additional two in ten thought that might be so. A Gallup/Newsweek poll in March produced similar results.[41]

The preceding articles present perceptions, which may or may not find support in empirical or scientific studies. Nevertheless, in the area of health care delivery, the perceptions of the patient/consumer have tremendous impact on entry into the health care system and critical use of its resources. In addition, perceptions of a different standard of care provided to individuals of different races are beginning to find disquieting support in medical journals.[42]

If race impacts on the kind of care that senior African-Americans seek out or receive, the question arises as to whether it matters if the care is delivered through a FFS or managed care system. Both systems present different risks to patients of substandard care based on the way in which health care providers and drug companies are compensated and monitored.[43]

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41. Editorial, *The Aids 'Plot' Against Blacks*, N.Y. TIMES, May 12, 1992, at A22.

42. *See, e.g.*, John Z. Ayanian, *Heart Disease in Black and White*, 329 NEW ENG. J. MED. 656, 656-58 (1993) (noting differences in heart disease between blacks and whites); Clive O. Callender et al., *Organ Donation and Blacks—A Critical Frontier*, 325 NEW ENG. J. MED. 442, 442 (1991) (noting need for more black organ donors); H. Jack Geiger, *An American Dilemma?*, 335 NEW ENG. J. MED. 815, 815-16 (1996) (defining dilemma as different standard of care being provided to different races); Marian E. Gornick et al., *Effects of Race and Income on Mortality and Use of Services Among Medical Beneficiaries*, 335 NEW ENG. J. MED. 791, 791-99 (1996) (discussing medical services to low income individuals); Michael W. Jacobsen et al., *Prostate-Specific Antigen in Black Men*, 336 NEW ENG. J. MED. 133, 133-36 (1997) (noting prostate-specific problem among black men); Bertram L. Kasiske, *The Effect of Race on Access and Outcome in Transplantation*, 324 NEW ENG. J. MED. 302, 302 (1991) (discussing outcomes among different races after organ transplants); Eric D. Peterson et al., *Racial Variation in the Use of Coronary-Revascularization Procedures—Are the Differences Real? Do They Matter?*, 336 NEW ENG. J. MED. 480, 480-86 (1997) (noting differences between races in revascularization procedures); James S. Rawlings et al., *Prevalence of Low Birth Weight and Preterm Delivery in Relation to the Interval Between Pregnancies Among White and Black Women*, 332 NEW ENG. J. MED. 69, 69-74 (1995) (discussing differences between races and health of their respective babies); Kenneth C. Schoendorf et al., *Mortality Among Infants of Black as Compared with White College-Educated Parents*, 326 NEW ENG. J. MED. 1522, 1522 (1992) (noting difference in mortality rates of infants from white parents and black parents); Howard Trachtman et al., *Effect of Race on Access and Outcome in Renal Transplantation*, 325 NEW ENG. J. MED. 428, 428 (1991) (noting differences between races after transplants); Jeff Whittle et al., *Racial Differences in the Use of Invasive Cardiovascular Procedures in the Department of Veterans Affairs Medical System*, 329 NEW ENG. J. MED. 621, 621-27 (1993) (discussing differences between races in use of cardiovascular procedures).

43. *See* RODWIN, *supra* note 26, at 55-175 (discussing impact of incentives to increase or decrease services).

A FFS system presents a risk of unnecessary services because the provider only gets paid when a service is rendered.[44] Health care is a unique commodity that allows the seller of services to wield extraordinary power in telling consumers whether they need the service as well as the quantity and quality of the service needed. The danger is acute when such services pose risks to health and dignity, for example, unnecessary hysterectomies and prostatectomies. The profit incentive may indeed corrupt medical judgment, particularly if the physician views the potential source of profit as easily manipulable.

On the other hand, as in the glaucoma problem set forth above, the managed care system provides a financial incentive *not* to provide services. Under managed care plans, physicians work under a capitation arrangement where the fee paid is on a per patient basis. Consequently, a doctor gets paid the same amount whether he or she provides thirty minutes of service, thirty hours or none at all.[45] In addition, managed care plans provide a set pool of money for the services of specialists and diagnostic testing.[46] Often the plan offers the provider a financial incentive not to provide a test or service by allowing the provider to share in any portion of the pool of money that is not spent on services or tests.[47] These arrangements present a situation in which the managed care organization hopes to alter the physicians' medical judgment, consciously or unconsciously.[48]

Under the FFS or the managed care plan, the consumer must rely on the ethics of the health care providers and their own ability to fend for themselves in critically assessing the care provided. If racism combines with the profit motive to corrupt the medical judgment, the need for consumer protection measures increases. I doubt that many senior African-Americans—at least those from the working class—will have an appreciation of the many ways in which their care is affected by the financial reimbursement system, unless they have family members or younger friends with enough time and interest to follow them on a weekly basis as they traverse the health-care maze.[49]

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44. *See id.* at 55-56 (noting that in FFS system, doctors have incentive to provide unnecessary services to increase revenues).

45. *See id.* at 137 (discussing disincentive for doctors and hospitals to service patients on per patient basis).

46. *See* John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 AM. J.L. & MED. 173, 175 (1996) (discussing payments to specialists under managed care system).

47. *See id.*

48. *See* RODWIN, *supra* note 26, at 114 (concluding that MCOs alter doctors' judgment through disincentives for providing tests and services to patients).

49. *See* Susan L. Goldberg, *A Cure for What Ails? Why the Medical Advocate is Not the Answer to Problems in the Doctor-Patient Relationship*, 1 WIDENER L. SYMP. J. 325, 333-45 (1996) (arguing that medical advocate is not answer to doctor-patient relationship troubles); Maxwell Mehlman, *Medical Advocates: A Call for a New Profession*, 1 WIDENER L. SYMP. J. 299, 319-23 (1996) (discussing role of medical advocates). The possibility exists that a friend, family member or advisor could assist the Medicare enrollee in appreciating the opportunities and limitations of a managed care plan.

Because of the danger that the profit motive may corrupt medical judgment, there is a need for a third party with the power to review the quality of care provided in either setting.[50] The question faced by the courts and the legislators today is whether the tort system is one of the protections that should continue to function as a third party reviewer. I will return to that question after probing a little deeper into other factors that give rise to a need for consumer protection, such as disabilities associated with social and economic class.

V. CLASS AND HEALTH CARE

"'*The sad thing is that it could happen all over again. These people could just as easily be conned and taken advantage of as their fathers and grandfathers in the syphilis study.*'"[51]

The statement above came from Billy Carter, one of the attorneys who represented the survivors and descendants of the notorious Tuskegee Syphilis Study (the "Tuskegee Study"), where the United States Public Health Service sponsored an experiment to investigate what would happen to a group of black men if the syphilis they had contracted remained untreated. The unethical nature of the deception of the men about the nature of their disease and the medical attention they were receiving engendered considerable public criticism once the study was disclosed.[52]

From my perspective, however, the two most haunting aspects of the Tuskegee Study have failed to receive the attention they deserve—particularly because they continue to hang as ominous clouds over the current health care delivery system. Both aspects concern the impact that class has

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It is likely, however, that many seniors will not be lucky enough to have someone close enough to them, personally or physically, to dedicate the time necessary to assist them in deciphering the fine print of the programs. One approach to improving understanding is a patient representative or person working in a similar capacity for the FFS and managed care company who is responsible for informing senior citizens about the plans and answering their questions.

50. *See* Wickline v. State, 239 Cal. Rptr. 810, 819 (Ct. App. 1986) (discussing cost consciousness of health care), *appeal dismissed*, 741 P.2d 613 (Cal. 1987). In *Wickline*, the court stated that although "cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment." *Id.*

In *Wilson*, the court ruled that a cost containment policy did not justify immunizing insurers from decisions that caused health care providers to make bad medical decisions. *See* Wilson v. Blue Cross, 271 Cal. Rptr. 876, 878 (Ct. App. 1990) (noting that cost containment policy does not shield insurers from liability). The court held that an insurer that prompted a hospital to release an emotionally disturbed patient by mistakenly stating that the patient was not eligible for continued insurance coverage could be found jointly liable with the health care providers for the patient's suicide. *See id.*

51. JAMES H. JONES, BAD BLOOD 218-19 (1991) (quoting Billy Carter, attorney who represented many victims of Tuskegee Study).

52. *See id.* (providing examination and critical assessment of syphilis study).

on the health care delivery system.[53] First, when the Macon County Medical Society (the "Society") was asked in 1969 whether the Tuskegee Study should be discontinued, the Society endorsed the continuation of the Tuskegee Study.[54] By 1969, the membership of the Society was composed entirely of black physicians.[55] For such an endorsement by black doctors to occur in the midst of the civil rights movement suggests that we need to look for an explanation of the endorsement beyond race. Clearly racism was involved. I, however, suggest that the other explanation is class. Black professionals did not see the Tuskegee Study as a threat to their families or friends. Somehow, despite the commonality of race, the physicians were able to separate themselves from the victims and see them as "the other."[56] If this is true, we must not be seduced into believing that issues of race subordination in the managed care context will be eliminated merely by ensuring that African-Americans and other health care professionals of color are included as part of the health care system.

The second haunting aspect of the Tuskegee Study, again relating to class, is that the people who were taken advantage of in the experiment were illiterate and so were their descendants and heirs.[57] The situation finds a poignant description in *Bad Blood*:[58]

> Perhaps the most distressing thing Gray and Carter [the victims' attorneys] encountered was the lack of social and economic mobility among the heirs. "There were more people who had to execute documents by making marks than I'll ever see for the rest of my life," Carter recalled. "It didn't matter whether they had gone to Cleveland or stayed right here, so many of them were illiterate and uneducated." Many of the heirs did not even know their family members' last names, referring to them only by nicknames such as "Kid" and "Coon."[59]

Sadly, studies of the state of literacy in the United States today reveal alarming numbers of citizens unable to read or comprehend matters presented at the most basic level.[60] A study of literacy in the United States

53. *See* McClellan, *Informed Consent*, *supra* note 39, at 81 (discussing culture of professionalism and its implications from class perspective).

54. *See* JONES, *supra* note 51, at 219.

55. *See id.*

56. *See* McClellan, *Informed Consent*, *supra* note 39, at 81 (arguing that educational and cultural process of becoming professional often separates individuals, emotionally and psychologically, from groups they previously identified with in terms of class).

57. *See* JONES, *supra* note 51, at 218 (noting illiteracy of subjects and their descendants).

58. *Id.*.

59. *Id.* (quoting Billy Carter, attorney who represented many victims of Tuskegee Study).

60. *See* IRWIN S. KIRSCH ET AL., ADULT LITERACY IN AMERICA: A FIRST LOOK AT THE RESULTS OF THE NATIONAL ADULT LITERACY SURVEY xiv-xvii (1993) (noting statistical data demonstrating poor literacy skills in American adults).

reported: "Twenty-one to twenty-three percent—or some forty to forty-four million adults in this country—demonstrated skills in the lowest level of prose, document and quantitative proficiencies."[61] Persons older than sixty-five made up one-third of the group functioning at the lowest skill level.[62] The study concluded that the reason older Americans function at a lower literacy level is that they tend to have completed fewer years of schooling than younger Americans.[63] We must develop public policy governing managed care in particular, and health care delivery in general, with a realistic acknowledgment of not just the racial divide that exists in this country, but also in light of the class divide.[64]

The problem set forth in Part II of this Article is a slight variation of my own experience with health care.[65] The difference was that I received the referral and the CT scan. Although I did not have a tumor, the careful testing and monitoring that I received allowed my doctor to diagnose my glaucoma at an early stage, before I had lost much eyesight. As the doctor ordered tests, she emphasized to me that because I was a professor in the middle of my career she wanted to be sure that she got to the source of my diminishing eyesight. In these circumstances, I did not feel that race dominated the physician's decisions. I am African-American, but for a change, my race did not seem to drive the issue. Instead, it was class that dominated. My status as a professional garnered the kind of sensitivity and careful attention to detail that every patient desires and deserves. Being a professional, albeit a "dreaded" lawyer, gave me something in common with my physician that enabled her to identify with me and recognize the importance of carefully diagnosing the cause of my eye problems.

I often wonder what would have happened if I had been poor or uneducated. What standard of care would have been given? Would it have mattered whether I was a FFS or managed care patient? In dealing with the poor, whether the person is in a FFS or managed care plan, a person's economic status may have a significant impact on the kind of subtle judgments that are made.[66] Lacking financial incentive to send the patient to

61. *Id.*

62. *See id.*

63. *See id.*

64. *See* LITERACY, HEALTH, AND THE LAW—AN EXPLORATION OF THE LAW AND THE PLIGHT OF MARGINAL READERS WITHIN THE HEALTH CARE SYSTEM: ADVOCATING FOR PATIENTS AND PROVIDERS 7-56 (Wendy L. Brandes ed., 1996) (examining impact of ability to read and write on both persons navigating today's complex health care system and on health care providers).

65. For an illustration of the fundamental challenges that the managed care system poses to physicians and consumers, see *supra* notes 27-36 and accompanying text.

66. *See* RODWIN, *supra* note 26, at 97-175 (discussing financial arrangements that create conflicts of interest by providing incentives to increase or decrease services); Jose L. Gonzalez, *A Managed Care Organization's Medical Malpractice Liability for Denial of Care: The Lost World*, 35 HOUS. L. REV. 715, 723-33 (1998) (discussing demise of FFS delivery of health care and rise of cost containment mechanisms and alternative delivery systems); Christopher Newdick, *Public Health Ethics and*

specialists, or order expensive tests, the system relies on a fiduciary relationship between the doctor and patient to provide the appropriate level of health care.[67] If the fiduciary responsibility is compromised by the financial arrangement, the incentive must come from a patient actively participating in the decisionmaking process or, alternatively, the threat of a lawsuit.[68]

Poor people enter the health care system with two serious handicaps: limited financial resources and limited education.[69] Consequently, absent a special education effort, they will fail to understand how a managed care system may affect the treatment they receive as compared to a FFS system.[70] In addition, negotiating the system once they enroll will prove nearly impossible, unless they simply do what they are told.[71] The only meaningful option may be the one exercised by many of the Medicare managed care enrollees—to opt out at the earliest possible opportunity.

In light of the above considerations, class will continue to play a significant role in affecting health care decisions. Faced with divided loyalties, doctors working in a managed care system, with the constraints of utilization reviews and financial rewards for limiting services, will be forced to change their approach to diagnosing and treating certain health problems.[72] It will take time and experience with these new decisionmak-

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Clinical Freedom, 14 J. CONTEMP. HEALTH L. & POL'Y 335, 338-39 (1998) (noting increasing practice of making health care decisions based on generating optimal monetary outcome); Jo-Ellyn Sakowitz Klein, Note, *The Stark Laws: Conquering Physician Conflicts of Interest?*, 87 GEO. L.J. 499, 514-26 (1998) (assessing effectiveness of Stark laws in curbing physician conflict of interest problems).

67. *See* Robert I. Field, *New Ethical Relationships Under Health Care's New Structure: The Need for a New Paradigm*, 43 VILL. L. REV. 467, 467 (1998) (arguing that new roles and relationships of managed care system requires re-evaluation of ethical and legal rules governing conduct of participants).

68. *See* John V. Jacobi, *Patients at a Loss: Protecting Health Care Consumers Through Data Driven Quality Assurance*, 45 U. KAN. L. REV. 705, 707 (1997) (arguing that consumers lack ability to assess critically relative quality of available care, and thus will be aided by production and interpretation of relevant data); Wertheimer, *supra* note 25, at 358-59 (suggesting that most efficient method to focus attention on patient's interest is to hold HMO responsible for its decisions through tort system); *see also* David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409, 418-22 (1998) (recognizing need for governmental role as consumer protector when managed care for poor and elderly is mandated). *But see* Field, *supra* note 67, at 489-90 (arguing that under new health care system, patients must assume more responsibility for their own care, become more informed and accept financial implications of their care).

69. *See* McClellan, *Informed Consent*, *supra* note 39, at 81-85 (noting Tuskegee Study as example of how poor and uneducated stand at disadvantage in avoiding disadvantageous medical procedures).

70. *See* Jacobi, *supra* note 68, at 708-22 (discussing patient concerns over quality of managed care health plans).

71. *See id.* (noting problem of fiduciary break in doctor-patient communication).

72. *Compare* Pamela H. Bucy, *Health Care Reform and Fraud by Health Care Providers*, 38 VILL. L. REV. 1003, 1008-15 (1993) (discussing potential for fraud in FFS reimbursement arrangements), *and* Field, *supra* note 67, at 470 (arguing that

ing techniques before we can fairly determine which new approaches reflect good medical practice and which reflect a corruption of medical judgment and unacceptable medical care.[73] In the interim, poor and working class people simply will not have the resources or the communications skill to fight the system effectively, unless the legal community provides them with help through some form of representation.[74] When the incentive to deliver care is diminished by an impersonal managed care system, the legal community must provide other sources of protection for the consumer.[75] A patient advocate represents an important protection.[76] The advocate, however, will lack the one weapon that commands the attention of large corporations: the ability to impose a substantial impact on the profit margin.[77] For that, the legal community must rely on the tort system or sanctions of a governmental agency.[78]

VI. AGE AND HEALTH CARE

"You are too young to understand yet. Build another skyscraper Touching the stars. We sit with our backs against a tree And watch skyscrapers tumble And stars forget . . . . We know some things, being old, You do not understand."[79]

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abuses related to over-treating and self-referrals of dubious value spawned creation of managed care plans), *with* Hyman, *supra* note 68, at 419 (stating that medical professionals could not in good conscience oppose Hippocratic Oath or any well accepted congressional enactments aimed at promoting informed consent and patient autonomy).

73. *See* Furrow, *Regulating Managed Care*, *supra* note 4, at 394-95 (describing trend of state legislation); Hyman, *supra* note 68, at 412-13 (arguing that consumers must learn that they cannot have all medical care desired because costs must be borne by someone in society). Managed care undoubtedly will produce good and bad practices from the perspective of patient care. *See* Furrow, *Regulating Managed Care*, *supra* note 4, at 377-85 (assessing benefits and risks of new managed care system). Examples may include, on the good side of the ledger, less unnecessary surgery (*e.g.*, hysterectomies) due to required second opinions and, on the bad side of the ledger, requiring women to leave hospitals within 24 hours of delivery. *See id.* (comparing success rates for managed care versus FFS patients).

74. *See* Furrow, *Regulating Managed Care*, *supra* note 4, at 391-94 (recognizing critics argument advocating need for increase in medical malpractice suits to protect smaller claims in particular); Jacobi, *supra* note 68, at 746-47 ("The medical malpractice system, therefore, addresses very few alleged cases of medical injury compared to the negligent injuries experienced, and, even for that small number, it does so poorly.").

75. *See* Jacobi, *supra* note 68, at 743-44 (arguing that medical malpractice actions are necessary to enforce quality standards against faulty physicians, especially in light of recent fiduciary breakdown between doctors and patients).

76. *See* Hyman, *supra* note 68, at 447-51 (recognizing need for patient advocate to protect consumers).

77. *See* Wertheimer, *supra* note 25, at 658-59 (arguing that tort system should serve same function in deterring unreasonable conduct on part of HMOs by way of financial incentives as it does for other members of society).

78. *See* Eleanor D. Kinney, *Resolving Consumer Grievances in a Managed Care Environment*, 6 HEALTH MATRIX 147, 159-65 (1996) (outlining legislative and judicial grievance procedures).

79. *Being Old*, *supra* note 1, at 109.

The health care system that the country ultimately adopts will reflect the nation's sense of its moral obligations to its senior citizens. To clarify this moral obligation, society should first attempt to understand better the aging process and the needs of older people, particularly after retirement. If we reject or limit what we are prepared to do for financial reasons, we should do so only after trying to see the world though the eyes of someone in his or her seventies or beyond.

Society must acknowledge that some people age faster than others. Nevertheless, the aging process has some effect on everyone. As physical and mental abilities diminish, each person must find a way to maintain as much of a sense of self-worth as possible and demand respect from others. Having some degree of control over one's day-to-day living becomes critical.

The importance of autonomy to an elderly person is often overlooked.[80] Reflection on the accumulated small and large losses brings the point home:

> At a minimum, the elderly tire more easily. They simply do not have the energy to do all that they would like or that they used to do. Faced with such problems as impaired vision and possible loss of hearing, the elderly find themselves dependent on procedures, devices, or other people. For example, if you must nap every afternoon, you have less time to engage in your hobbies or to travel. If you cannot see well, you may feel hesitant to drive at night. If your hearing has declined, going to a play may be more frustrating than fulfilling.[81]

Whether managed care or FFS is best for all or some is unlikely to be resolved within the next ten years.[82] In the meantime, the legal profession should tread lightly and sensitively.

In 1987, ethicist Daniel Callahan, Director of the Hastings Center, wrote a provocative book purporting to set limits for our country's commitments to its elders.[83] He argued that society cannot afford to pay for all of the care that each senior citizen needs.[84] Nor should society feel

80. *See, e.g.*, JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 104-64 (1984) (discussing often overlooked issue of patient autonomy).

81. LAWRENCE A. FROLIK & ALLISON PATRUCCO BARNES, ELDERLAW: CASES AND MATERIALS 31 (1992).

82. *See* Gonzalez, *supra* note 66, at 792-99 (discussing uncertainty surrounding shift from FFS to managed care); Klein, *supra* note 66, at 514-26 (discussing uncertainty of effectiveness of new Stark laws in addressing physician conflict of interest problems).

83. *See* DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY 24 (1987) (describing book as "a call for limits, for a sobriety of purpose, and for a willingness to ask once again how we might creatively and honorably accept aging and death when we become old, not always struggle to overcome them").

84. *See id.* at 115-58 (arguing that society need not provide unlimited health care to its elderly).

morally obligated to provide such care.[85] Rather, society must accept the notion of limits and begin to set them forthrightly and rationally.[86] Callahan argues that to accept the notion of limits, society must reconstruct our concept of aging and prioritize the purposes behind the use of modern medical technology.[87] Keeping everyone alive for as long as medical technology permits should not be the governing principle.[88] Instead, society should embrace the view that age is a legitimate basis for making decisions about the allocation of medical resources.[89]

Articulating this argument so clearly and frankly angered many and frightened others.[90] Few wanted to endorse publicly the proposition that Americans are unwilling to provide health care to senior citizens if in need of such assistance.[91] Consequently, the debate shifted to the proper definition of needs and the appropriate process for setting economic priorities.[92] Today, the moral debate lies obscured by the concepts and linguistics of managed care.[93]

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85. *See id.* at 82-114 (advocating limited moral obligations to senior citizens).

86. *See id.* at 116 (recognizing need for limits in elderly medical care even in presence of unlimited resources).

87. *See id.* at 25-51 (discussing need to reconstruct society's concept of aging).

88. *See id.* at 116 (recognizing need to establish boundaries for medical care for senior citizens even if endowed with unlimited resources).

89. *See id.* at 138 (arguing that age is legitimate basis for making decisions concerning allocation of medical resources). Callahan stated:

> Medical "need" can no longer work as an allocation principle; it is too elastic a concept. Age is a legitimate basis because it is a meaningful and universal category. It can be understood at the level of common sense, can be made relatively clear for policy purposes, and can ultimately be of value to the aged themselves if combined with an ideal of old age that focuses on its quality rather than its indefinite extension.

Id.

90. *See* Marshall B. Kapp, *De Facto Health-Care Rationing by Age: The Law Has No Remedy*, 19 J. LEGAL MED. 323, 333-37 (1998) (discussing ethical and economic implications of covert health care rationing based on age); George P. Smith, *Our Hearts Were Once Young and Gay: Health Care Rationing and the Elderly*, 8 U. FLA. J.L. & PUB. POL'Y 1, 17-19 (1996) (discussing equal opportunity and elderly discrimination arguments against age-based health care rationing); Andrew H. Smith & John Rother, *Other Americans and the Rationing of Health Care*, 140 U. PA. L. REV. 1847, 1852-55 (1992) (outlining justifications for age-based rationing of health care).

91. *See* Kapp, *supra* note 90, at 336 (asserting that "[b]ecause old age by itself has no predictive value in individual situations, age-based health-care rationing cannot be justified on the basis of conserving scarce resources"); Smith, *supra* note 90, at 22 (advocating that scarcity of medical resources should not disproportionately harm elderly Americans). *But see* Smith & Rother, *supra* note 90, at 1856 (arguing that "rationing of high technology, life-sustaining treatment for the elderly would not significantly curtail the growth of health care expenditures").

92. *See generally* MARTIN A. STROSBERG ET AL., RATIONING AMERICA'S MEDICAL CARE: THE OREGON PLAN AND BEYOND (1992) (describing and debating Oregon plan to ration medical care to Medicaid recipients).

93. *See id.* at 3-11 (discussing general moral and ethical complexities underlying rationing debate).

If the government chooses to compel senior citizens to enroll in managed care—as many state governments have chosen to compel poor people on Medicaid to enroll in managed care programs—the debate would gain new life.[94] Because the federal government chose to encourage an election, however, the moral issue of rationing care has been avoided in the guise of offering greater opportunity for choices.[95] This strategy allows the moral debate to take place in the arena of the poor, where, politically at least, the government has caught much less heat in compelling poor people to accept health care under a managed care system.[96]

This Article advocates the position that society has a moral obligation to ensure that the health care delivery system provides maximum protection to the dignity of our parents and grandparents, just as we have a moral obligation to implement a financial plan that will prevent the floor of the health care system from crumbling. Empowering senior citizens to make a choice as to who will provide care for them when they need it most will nourish their sense of self-worth as well as encourage health care providers to treat them with respect. Some have argued that mandating enrollment of senior citizens in managed care programs is wise, if not essential, for Medicare to survive the strains of baby boomers moving into the system.[97] Compelling senior citizens today to accept managed care, however, will result in many senior citizens spending the final years of their lives with diminished dignity and respect because the care rendered will be less personal, less sensitive and therefore less trustworthy.[98] Having the ability

94. *See* Rhona S. Fisher, *Medicaid Managed Care: The Next Generation?*, 69 ACAD. MED. 317, 317-22 (1994) (discussing problems and obstacles associated with providing medical care to poor through managed care organizations); Catherine Clabby, *Managed Care Eyed to Replace Medicaid*, NEWS & OBSERVER (NORTH CAROLINA), July 17, 1997, *available in* 1997 WL 7844488 (describing new program in North Carolina wherein HMOs would compete with state-funded network doctors, hospitals and clinics, with goal of achieving cost savings while mandating quality); *Medicaid—States Efforts to Educate and Enroll Beneficiaries in Managed Care*, GAO REPORT, Sept. 17, 1996, *available in* 1996 WL 639791 [hereinafter GAO REPORT] (reporting that as of June 1995, 11.6 million Medicare beneficiaries, or 32%, were enrolled in managed care programs).

95. *See* RODWIN, *supra* note 26, at 55-175 (discussing dangers of incentives to increase services). Greater opportunity for choices may lead to increased kickbacks, self-referrals, dispensing of unnecessary drugs, hospital purchase of physicians' medical practice, gifts from medical suppliers and payments from hospitals to recruit or bond physicians. *See id.* at 98-111.

96. For a discussion of the impact of class and wealth in determining whether to proceed with a morally reprehensible policy, see *supra* notes 52-78 and accompanying text.

97. *See* GAO REPORT, *supra* note 94 (discussing governmental efforts to educate and enroll Medicaid beneficiaries in managed care programs).

98. *See id.* (finding that older people with chronic illnesses drop out of Medicare managed care programs). Whether managed care in fact provides a lower standard of care than FFS is a question we will not know the answer to for another decade. *See* Miller & Luft, *supra* note 12, at 13-15 (reviewing 37 recently published peer review studies and providing discussion regarding quality of care provided by HMO and non-HMO plans). The answer will most likely depend on the particular

to opt out of managed care remains important not only to individuals with special needs, but also as an incentive to the providers to respect the dignity of the persons they serve or else lose those patients to more attractive health plans.

Finally, when all else fails, senior citizens who feel they have received substandard care need to retain the option of holding both the health care provider and the managed care corporation publicly accountable. It is not only unethical for a fiduciary such as a physician to make medical care decisions based on financial considerations, but it also subjects both the doctor and managed care company to tort liability should a judge or jury find the conduct unreasonable. In short, the justification for financial concerns to drive health care decisions should be limited to the macro-decisionmaking stage, where the public has an opportunity for education and debate. Once the macro-decisions have been made, a health care provider may abide by them.[99] In the absence of a clearly applicable public policy, financially driven decisions have no place in the medical decisionmaking process of individual doctors.

Our parents and grandparents deserve a health care delivery system and a legal system that rests on more than just a financial cost-benefit analysis. The fundamental thrust of tort law into the health care arena over the past thirty years has aimed toward developing, clarifying, enhancing and nourishing the principle that everyone has the right to decide what medical care they will or will not receive.[100] In addition, personal autonomy is at least as important to individual human dignity as we get older.[101]

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circumstances involved, affected by community, disease, class, age, race and culture.

99. *See* RODWIN, *supra* note 26, at 55-175 (discussing prevalence of financial incentives in assessing medical decisions). The attack on the Medicare FFS is clearly driven solely by financial concerns and not quality of care concerns. *See, e.g.*, CALLAHAN, *supra* note 83, at 116-200 (discussing limiting expenditures on elderly to preserve precious medical resources); Kapp, *supra* note 90, at 329-37 (discussing covert rationing of medical resources on basis of age). As one editorial noted forthrightly in criticizing the bottom-line approach to health care: "Republicans prefer free-market solutions. They opposed big government programs, and most especially they hate government health care run by faceless bureaucrats who combine the efficiency of the post office with the compassion of the IRS." Lars-Erik Nelson, *An Unhealthy Attack on Prez' Medicare Plan*, N.Y. DAILY NEWS, Jan. 7, 1998, at 27. As of 1996, Medicare ate up 13% of federal spending. *See Medicare: It Needs Repair, Not Expansion*, CINCINNATI ENQUIRER, Jan. 13, 1998, at A6 (noting that "as baby-boomers retire, medicare costs will attack the budget like flesh-eating bacteria").

100. *See generally* JAMES F. CHILDRESS, WHO SHOULD DECIDE? PATERNALISM IN HEALTH CARE (1982) (discussing generally issues of patient autonomy and consent); SHANNON M. JORDAN, DECISION MAKING FOR INCOMPETENT PERSONS: THE LAW AND MORALITY OF WHO SHALL DECIDE (1985) (same); KATZ, *supra* note 80 (same); JAN WOJCIK, MUTED CONSENT: A CASEBOOK IN MODERN MEDICAL ETHICS (1978) (same).

101. *See* John F. Peppin, *Physician Neutrality and Patient Autonomy in Advance Directive Decisions*, 11 ISSUES L. & MED. 13, 16-17 (1995) (discussing problem of ageism and patient autonomy). There is, of course, a competing value to auton-

This Article has demonstrated that race, culture and economic status remain important to the construction of health care delivery and legal systems that protects the rights of the elderly.[102]

Furthermore, in light of the lifetime of racial discrimination and subordination that they have endured, we owe a special duty to older African-Americans to try to see the world through their eyes before we enact laws that will directly change the way they live. African-American males from a generation born before 1920, like my father, see the world with a perspective that young people and middle-aged people in positions of power cannot readily appreciate. It is a perspective shaped by years of struggling to survive in an environment that has proven time and again hostile and brutal to people on the basis of race, class and age. At a minimum, we ought to afford them the opportunity to choose who their doctor will be and whether they want their care to be managed.

In recent years, economics have dominated the public debate over health care when the debate takes place in the legislature.[103] When the debate takes place in a courtroom, ethics, morality and justice compete with economics for public endorsement.[104] When the debate becomes abstract, people do not seem to care about what happens to individuals who get lost in the health care system.[105] People also show little concern if the lost individual is old. In this environment, the courtroom's traditional exploration of which values determine the reasonableness of conduct serves as a critical counterbalance to economics.[106]

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omy—namely, protection. The goal of protecting our elders from fraud, abuse and substandard medical care remains laudable. The desire to protect older people from predatory or negligent conduct, however, does not justify requiring receipt of medical care from a doctor who practices in a managed care company contracted by the government to manage a patient's care. *See* FROLIK & BARNES, *supra* note 81, at 29-33 (discussing competing values of autonomy and protection).

102. For a discussion of the impact of race, culture and economic status on the health care delivery system, see *supra* notes 38-78 and accompanying text.

103. *See* Edward M. Kennedy, *Medicare Needs Saving Again*, FED. DOCUMENT CLEARING HOUSE, June 3, 1997, *available in* 1997 WL 4433442 (discussing economic overtones of Republican plan in Medicare reform debates).

104. *See* Wertheimer, *supra* note 25, at 357-59 (noting justice of tort system and practical economics as competing concepts in tackling issue of HMO operation).

105. *See* TROYAN A. BRENNAN, JUST DOCTORING: MEDICAL ETHICS IN THE LIBERAL STATE 177 (1991) (discussing Americans' indifference to de facto health care rationing). One commentator noted:

> The issue of rationing has remained generally submerged in discussions of medical care in this country. We have not wanted to face it, perhaps because it is antithetical to the constant growth in health care resources upon which the industry has relied, perhaps because Americans have been unwilling to accept the notion that access to health care must be limited. In any case, just doctoring demands explicit discussion of rationing.

Kapp, *supra* note 90, at 323-24.

106. *See* CALLAHAN, *supra* note 83, at 116 (advocating non-age-based paradigm for determining allocation of health care resources); Kapp, *supra* note 90, at 323

VII. CONCLUSION

"We sit with our backs against a tree and watch skyscrapers tumble And stars forget Solomon built a temple And it must have fallen down. It isn't here now We know some things, being old, You do not understand."[107]

One of the most important developments in tort law and medical malpractice law during the past thirty years has been the shaping and reinforcing of the doctrine of informed consent.[108] Aimed at protecting individual autonomy, the doctrine mandates that health care providers impart enough information to the individual patient to allow the patient to make a meaningful choice as to which health care procedure offers the most appropriate balance of risks for him or her.[109] Mandatory managed care may destroy individual patient autonomy for the elderly, without ever addressing the issue of patient autonomy. Similarly, it fails to acknowledge the importance of the power and opportunity making choices may have for senior citizens.

As a nation and as individuals, we need to assess critically our health care financing policies as they affect older Americans, in light of the value we place on both efficiency and individual human dignity.[110] An efficient health care system that obliterates the worth and dignity of the elderly, while at the same time destroying the pride and respect of health care providers, may ultimately cost us much more than it is worth in terms of human dignity.

(noting that rationing of health care for senior citizens has flourished de facto for most of past century).

107. *Being Old, supra* note 1, at 109.

108. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772, 779-80 (D.D.C. 1972) (discussing common law history underlying doctrine of informed consent).

109. *See id.* at 780 (describing rationale behind doctrine of informed consent); *see also* KATZ, *supra* note 80, at 48-84 (providing analysis of informed consent doctrine, including its importance to doctor-patient relationship and difficulty of giving it real meaning).

110. *See generally* MITCH ALBOM, TUESDAYS WITH MORRIE (1997) (describing how professor suffering from amyotrophic lateral sclerosis (ALS), Lou Gerhig's disease, maintains dignity despite ravaging effects of disease). As previously stated, a FFS plan will not inevitably prove better than managed care in protecting human dignity for all patients. *Cf. H.M.O.'s Seen as Easing Death for the Elderly*, N.Y. TIMES, Sept. 24, 1997, at A1 (reporting results of study that found that Medicare patients in HMOs were less likely to receive prolonged, costly and ultimately futile medical care than patients in traditional Medicare coverage). Whether the above bodes well for future HMO Medicare recipients remains unclear.