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UNDUE ECONOMIC INFLUENCE ON PHYSICIAN-ASSISTED SUICIDE

Fred R. Garzino*

INTRODUCTION

Litigation leading up to the June 1997 United States Supreme Court decisions of *Washington v. Glucksberg*, ("*Compassion in Dying*")¹ and *Quill v. Vacco*,² has generated significant debate concerning their attendant moral, ethical, and medical ramifications.³ Discussion in the legal

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¹850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995), *aff'd on reh'g*, 79 F.3d 790 (en banc), *cert. granted sub nom.*, *Washington v. Glucksberg*, 117 S. Ct 37 (1996). For clarity of exposition, this case will be generically referred to under its original name as *Compassion in Dying*. The individual cases that lead up to the eventual *Glucksberg* appeal will be discussed separately.

²*Quill v. Kappell*, 870 F. Supp. 78(S.D.N.Y. 1994), *rev'd sub nom. Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *cert. granted*, 117 S.Ct. 36 (1996).

³The moral and ethical aspects of the physician-assisted suicide question continue to be extensively debated by bioethicists, theologians, legal scholars, and a host of other advocates on both sides of the equation. The flavor and key considerations of these varied points of view may be accessed in the following sources.

Sources favoring physician-assisted suicide: Timothy E. Quill, M.D., *Risk Taking By Physicians In Legally Gray Areas*, 57 ALB. L. REV. 693 (1994); C.K. Cassel and D.E. Meier, *Morals and Moralism in the Debate Over Euthanasia and Assisted Suicide*, 323 NEW ENG. J. MED. 750 (1990); Michael Lasalandra, *New England Medical Journal Chief Backs Physician-Assisted Suicide Bill*, BOSTON HERALD, Nov. 5, 1996, at 18; Maura Lerner, "*End of Life*" Care; *Medical Specialists Debate How to Give Death Its Due and the Dying Their Dignity*, STAR TRIB., Oct. 31, 1996, at 12A; John A. MacDonald, *Profound Issues Before Court: Death, Dying -- And Doctors*, HARTFORD COURANT, Nov. 12, 1996 at A1.

Sources disapproving physician-assisted suicide: Albert R. Jonsen, *Physician-Assisted Suicide*, 18 SEATTLE U.L. REV. 459 (1995); Stanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857 (1992); Peter M. McGough, M.D., *Medical Concerns About Physician-Assisted Suicide*, 18 SEATTLE U.L. REV. 521 (1995); C.S. Campbell, "*Aid-In-Dying*" and the Taking of Human Life, 18 J. MED. ETHICS 128 (1992); R.M. Sade, *Ethical Arguments Against Physician-Assisted Death*, 92 J.S.C. MED. ASSOC. 63-69 (1996); C.A. Tauer,

community has largely focused on the constitutional aspects of personal autonomy, the proper reach of states' interests, and informed consent.⁴ Much of the public debate and judicial discussions have centered on the separate role of each of these factors.⁵

As this Article will argue, however, conspicuous by its absence has been any integrated discussion of the role of the economic forces that underlie these issues and significantly affect legal judgments concerning the proper balance among them. This omission takes on increased importance as pivotal structural changes sweep through the United States' health-care

Ethical Issues of Human Embryos Research and Physician-Assisted Suicide, 274 (17) JAMA 1344 (1995); *Physician-Assisted Death*, 152 (2) CAN. MED. ASSOC. J. 248A-48B (1995); Arthur Caplan, *Balancing Right to Live With Right to Die*, THE TIMES UNION, Nov. 20, 1996, at A10; Aaron Epstein, *Suicide Opponents Receive Legal Boost From White House*, HOUSTON CHRON., Nov. 13, 1996, at 2; Alfred Sommer, *The Trouble With Rationing Health Care*, BALTIMORE SUN, Nov. 12, 1996, at 11A.

Representative of the religious view of the matter is a letter from Joseph Cardinal Bernadin, Archbishop of Chicago, as part of the Catholic Health Association's amicus curiae brief to the United States Supreme Court in *Quill v. Vacco and Washington v. Glucksberg*. James A. Serritella and James C. Geoly, *Commentary: Uneasy Lessons To Live By*, CEN. TRIB., Nov. 20, 1996, at 27. Cardinal Bernadin stated that: "There can be no such thing as a 'right to assisted suicide' because there can be no legal and moral order which tolerates the killing of innocent human life, even if the agent of death is self-administered." He went on to note that "even a person who decides to forgo treatment does not necessarily choose death. Rather, he chooses life without the burden of disproportionate medical intervention." *Id.*

Source discussing both sides of the issue: *Respect For the Dying*, BOSTON GLOBE, Nov. 14, 1996, at A26.

⁴Many states are against the decisions rendered in both of the physician-assisted suicide cases currently before the Supreme Court. About twenty states collaborated in filing two amicus curiae briefs supporting the denial of constitutional protection for assisted suicide. *Assisted Suicide: Administration to Seek Ban on Practice*, HEALTH LINE, Nov. 12, 1996. States joining in this friend-of-the-court action include Alabama, California, Colorado, Florida, Georgia, Illinois, Iowa, Louisiana, Maryland, Michigan, Mississippi, Montana, Nebraska, New Hampshire, South Carolina, South Dakota, Tennessee and Virginia. *Id.*

⁵Melinda Lee, et al., *Legalizing Assisted Suicide: Views of Physicians in Oregon*, 334 NEW ENG. J. MED., 310 (1996); Jerald G. Bewitchment et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 NEW ENG. J. MED. 303 (1996); Mark A. Hall, *Informed Consent to Rationing Decisions*, 71 MILBANK Q. 645 (1993); *Safeguarding the Health Care of Senior Citizens, 1996: Hearings Before the Subcomm. on Labor, Health and Human Services and Education, of the Senate Comm. on Appropriation*, 104th Cong., 2d Sess. (1996)(statement of John C. Nelson, M.D. for the Am. Med. Assoc.); Robert H. Jerry, II, *Health Insurance Coverage for High-Cost Health Care: Reflections on the Rainmaker*, 26 U. MEM. L. REV. 1347 (1996).

industry. A significant portion of America's health-care system is rapidly moving towards managed care in all of its various forms (*i.e.*, health maintenance organizations (HMOs), preferred provider organizations (PPOs), etc.). These organizational structures are based on the economic needs of financing and delivering care in a for-profit, cost-conscious and resource-constrained environment.⁶

The legal implications of these economic drivers, however, have not been adequately recognized or even addressed in recent court opinions on physician-assisted suicide. Neglecting the reality of economic considerations in the health-care industry and how these considerations interact and influence personal autonomy and state interests only serves to undermine well-intentioned efforts by parties on both sides who are struggling to answer the physician-assisted suicide question.

Society cannot hope to determine an appropriate solution until it first formulates the relevant dimensions of the question. While the Supreme Court's reversal of the Ninth Circuit's decision in *Compassion in Dying* and the Second Circuit's decision in *Quill* was fully anticipated, the Court's opinions were insufficient for a long-term resolution of the assisted suicide issue.⁷ By allowing the contested statutes to pass constitutional muster without fleeting mention of the economic aspects of the states' interests in assisted suicide, the Court did a disservice to the contending parties and to society itself. Unless the states' compelling interests in regulating the contending economic factors are explicitly recognized and validated, informed debate on assisted suicide in the state legislatures will not be meaningfully conducted.

⁶For ease of reference in this Article, all of these related organizational types will be collectively referred to as managed care.

⁷Jan Crawford Greenburg, *Justices Appear Skeptical About A Right To Die*, CHGO. TRIB., Jan. 9, 1997 § 1, at 1, 26. During the oral arguments before the Supreme Court on January 8, 1997, Justices were hesitant about the need to make any constitutional ruling. Many of the Justices appeared content to leave the question to the discretion of the states. The Justices suggested that the courts were ill-equipped to decide an issue that is as much about morality and ethics as it is about the law. *Id.* at 26. The general focus was on the need for or irrelevance of limiting a constitutional right to die to people who are on the threshold of death. The Justices were concerned why the Constitution would not grant others the same right. *Id.* Noticeably absent from this discussion was any exploration concerning the proper judicial response to the underlying economic drivers that appear to be shaping the overall assisted suicide issue.

Without recognition of the true underlying interests that affect health-care decisions and the financial constraints under which they are made, any public debate concerning individual autonomy or the basis for potentially rationing scarce health-care resources will be rendered almost inconsequential. Such a result is analogous to a physician's placing a misleading focus on the size, shape and color of the bandage to affix externally to a wound, while ignoring the fatal internal problems actually responsible for the patient's serious condition.

The Ninth Circuit in *Compassion in Dying* and the Second Circuit in *Quill* each based their opinions on different provisions of the Fourteenth Amendment; *Compassion in Dying* on the Due Process Clause,⁸ and *Quill* on the Equal Protection Clause.⁹ Yet these appellate courts shared common ground in their perfunctory articulation of a state's interests in the economic factors present in both cases.¹⁰ The Supreme Court gave its major attention to the analysis of the Ninth Circuit's opinion in *Compassion in Dying*, and thus, this case will serve as the basis for a discussion of state interests in physician-assisted suicide.¹¹ The Court's opinion in *Vacco v. Quill* was largely limited to an equal protection analysis of the relation between withdrawing and withholding as compared with assisted suicide.

This Article will use *Compassion in Dying* to identify and explore the legal community's neglect of any real inclusion of economic factors in deliberating the concerns presented by physician-assisted suicide. Part I will review the historical backgrounds of key legal, cultural, and economic forces that form the basis of the current assisted-suicide environment. Part II examines the arguments given by the Ninth Circuit for recognizing a right to physician assisted suicide in *Compassion in Dying*, paying particular attention to the parties' stated issues and oblique references to economic factors. Part III will discuss the economic factors underlying the growing trend towards managed-care delivery of health care services. The significance of cost-containment strategies to maintain the viability and profitability of these organizations will also be noted. It is in the interplay

⁸*Compassion in Dying v. Washington*, 79 F.3d 790, 793-94 (9th Cir. 1996) (en banc).

⁹*Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir. 1996).

¹⁰*Compassion in Dying*, 79 F.3d at 816-17, and *Quill*, 80 F.3d at 729-31.

¹¹*Id.*

of cost-containment efforts, personal-autonomy interests, and states' interests where the undiscussed, yet critical influence on the physician-assisted suicide decision should take place. Part IV will conclude with a suggestion for ending the legal community's predilection for discussing interwoven issues in isolation. An argument for integrating both legal and societal-based concerns into the judicial system will be offered.

BACKGROUND

Those aspects of the physician-assisted suicide question which do not directly center on personal autonomy, moral, or ethical issues may be said to be based in three areas: common law origins of the state's interest in suicide; cultural biases in health-care delivery prevalent in the United States; and the economic evolution of the organization and funding of health-care provision in this country. Examination of the historical role and contribution of each of these areas provides a needed perspective often absent from current legal discussions on the physician-assisted suicide issue.

Common Law Origins Of State Interest In Preventing Suicide

Early English common law dealing with suicide was based on the canon law of the Roman Catholic Church, dating back to the actions of the Council of Hereford in 673.¹² The penalty levied on those who committed suicide was the withholding of a Christian burial and the defilement of the body itself by putting a stake through the corpse, and placing the corpse on the open roadway.¹³ By the year 967, this ecclesiastical condemnation was expanded by King Edgar's pronouncement that, not only would the person who committed suicide be denied a Christian burial and his body be defiled, the person's material possessions would also be forfeited to his feudal lord.¹⁴

¹²Maria T. Celoz Cruz, Note and Comment: *Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?* 18 *AM. J. L. & MED.* 369, 373 (1992).

¹³WILLIAM BLACKSTONE, *COMMENTARIES ON THE LAWS OF ENGLAND* * 190.

¹⁴Celoz Cruz, *supra* note 12, at 373.

Much later, in the fourteenth century, when suicide was proclaimed to be a felony, the Royal Treasury became the sole benefactor and received the suicide's possessions.¹⁵ The state's interest in suicide was succinctly summarized by Blackstone, noting that "[a] suicide is guilty of a double offense: one spiritual, in evading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects"¹⁶

Later, this legal condemnation of suicide was extended to those who sought to assist acts of suicide by declaring such assistance to be akin to a felony.¹⁷ It is only in this century that suicide penalties in the United States have been decriminalized.¹⁸ Three reasons often cited for this decriminalization are: suicide is essentially an unpunishable crime because the person committing it does not survive the act; forfeiture of goods is an unwarranted punishment of the innocent family of the suicide; and suicide can be regarded as the act of an ill person who needs treatment rather than punishment.¹⁹

Thus, a state's traditional interest in preventing suicide has been attributed to three origins: religious belief, filling the king's coffers, and protecting the psychologically unsound from harming themselves.²⁰ Although additional state interests in opposing suicide (interests which are to be weighed against a person's right to refuse medical assistance) have not been universally recognized, recent court decisions have noted they include preserving life, protecting family members, precluding the use of arbitrary, unfair or undue influence, and protecting the integrity of the medical profession.²¹

¹⁵*Id.*

¹⁶BLACKSTONE, *supra* note 13, at *189.

¹⁷*Commonwealth v. Mink*, 123 Mass. 422, 425, 428-29 (Mass. 1977) (noting that due to the not punishable nature of the act, suicide was not a felony in the technical meaning of that term, but rather, *malum in se*).

¹⁸*CeloCruz*, *supra* note 12, at 375.

¹⁹*Id.*

²⁰*Id.* at 375-76.

²¹*Compassion in Dying v. State of Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), 49 F.3d 586, 592-93 (9th Cir. 1995), 79 F.3d 790, 816-17, (9th Cir. 1996) (en banc); *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996); *Superintendent of Belchertown State School v. Saikewicz*, 370

Cultural Biases In United States Health-Care Delivery

There is no universally recognized structure for delivering health care. Each country delivers health care in a manner that reflects its own cultural values and social preferences.²² Even a cursory comparative review of key features of the United States health-care system versus those of other countries reveals a host of social differences which translate into dissimilar medical delivery systems.²³ The cultural biases which underlie these structural differences serve to shape the questions that can be addressed by each system.

The cultural differences are readily apparent. For example, in contrast to the United States emphasis on a free-market system, the German government has, since the time of Chancellor, used a social-insurance approach to health care.²⁴ The German people believe "[t]he welfare of the people does not result automatically out of economic growth in a free-market economy. [T]he distribution has to be regulated, and the state should not limit itself to providing economic freedom."²⁵ Thus, the German health-care system of mandatory enrollment in sickness funds based on occupational status, reflects the belief that "political stability can be achieved by cementing individual loyalties to social groups."²⁵ A person's contribution to state-administered health-care premiums is

N.E.2d 417, 425 (Mass. 1977).

²²Robert J. Blendon, et al., *Data Watch: Who Has the Best Health-Care System? A Second Look*, 14 HEALTH AFFAIRS 220 (1995); Annette Fianagin, RN, MA (Editor), *Letter From Vienna--Health Care in Austria: Universal Access, National Health Insurance, and Private Health Care*, 269 JAMA 2789 (June 2, 1993); John K. Iglehart, *Health Policy Report: Germany's Health-Care System*, (pts. 1 & 2), 324 NEW ENG. J. MED. 503, 1750 (1991); Naoki Ikegami, M.D., and John C. Campbell, Ph.D., *Special Report: Medical Care in Japan*, 333 NEW ENG. J. MED. 1295 (Nov. 9, 1995); Magne Nylenna, M.D., *Letter From Oslo--Norway's Decentralized, Single-Payer Health System Faces Great Challenges*, 274 JAMA 120 (July 12, 1995); R.R. Orford, M.D., *Commentary: Reflections on the Canadian and American Health-Care Systems*, 66 MAYO CLIN. PROC. 203 (Feb. 1993); Marlise Simons, *Dutch Parliament Approves Law Permitting Euthanasia*, N.Y. TIMES, Feb. 10, 1993, A10 L; James Sterngold, *Japan's Health Care: Cradle, Grave and No Frills*, N.Y. TIMES, Dec. 28, 1992, at A1 L; Craig R. Whitney, *British Health Service, Much Beloved But Inadequate, Is Facing Changes*, N.Y. TIMES, June 9, 1991, at 16 L.

²³*Id.*

²⁴John K. Iglehart, *supra* note 22, at 505.

²⁵*Id.* at 505-06.

²⁶*Id.* at 506.

calculated as a fixed percentage of gross income--independent of the employee's health risk.²⁷ Such contributions have the intended redistributive dimension.²⁸

In Norway, as another example, access to health care is considered the statutory "right" of all citizens.²⁹ However, no such concept of a legal right to health care exists in the United States.

The legal concept of informed medical consent, similarly, has different cultural bases in the United States and Japan. In the United States, courts recognize a person's right to make decisions concerning his or her body by emphasizing a physician's duty to disclose pertinent information to a patient.³⁰ This is at marked variance with the approach taken in Japan where the doctrine of informed consent has yet to be accepted.³¹ Personal autonomy is regarded as egocentric and thus out of keeping with the Japanese cultural tradition.³² The Japanese believe "each human being is dependent on others in the family, and [on the] social, economic and political communities."³³ In this cultural setting, informing a patient's family about a medical condition, but not the patient herself, is considered socially, and therefore, medically acceptable conduct by a physician.³⁴

The question of physician-assisted suicide emerging in the United States, therefore, cannot necessarily be resolved by adopting solutions employed in other nations. Country-to-country differences are further strained if an attempt is made to overlay them onto equally divergent legal systems. Although lessons can be learned in a trans-cultural analysis, any comprehensive resolution to the physician-assisted suicide question will be unique to the United States and its own particular cultural environment.

²⁷*Id.*

²⁸*Id.*

²⁹Magne Nylenna, *supra* note 22, at 123.

³⁰*Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir. 1972).

³¹George J. Annas and Frances H. Miller, *The Empire of Death: How Culture and Economics Affect Informed Consent in the U.S., the U.K., and Japan*, 20 AM. J. L. AND MED. 357, 372 (1994). Informed consent is a broad area, but one whose implications for physician-assisted suicide can only be briefly noted within the limited scope of this article.

³²*Id.* at 374.

³³*Id.*

³⁴*Id.* at 373-74.

Perhaps the most unique feature of United States health care is the economic basis on which it is built.

The Economic Evolution of Health-Care Organizational Structures and Funding Mechanisms

The interplay of health-care delivery and funding has evolved in significant ways since the founding of the Republic. This section will first discuss how the path to the present situation was created by a change from personal payments for medical services to a growing reliance on insurance for reimbursing health-care providers. Next, the indemnity format of that insurance is reviewed, particularly with respect to how it laid the foundation for later cost containment problems. After the indemnity format review, the discussion will examine how these cost containment problems lead to a search for newer funding mechanisms and incentives in providing care. This section will conclude with a discussion of how managed-care organizations have begun to address the problems of upward spiraling health-care costs.

The Use Of Health Insurance Grew Rapidly

Paying for health care in the United States remained the personal responsibility of individual patients until the early decades of the twentieth century.³⁵ Insurance was rare for individuals, and only a very few firms, such as Montgomery Ward, made health insurance available as an employment fringe benefit.³⁶ Employer offerings of health insurance first became commonplace during World War II as a means of attracting workers and overcoming the effects of tight labor markets and strict, government-imposed wage controls.³⁷

³⁵GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST*, 19 (1996).

³⁶*Id.*

³⁷Milton S. Friedman, *Dr. Friedman's Rx for Health Care*, BARRON'S, Jan. 24, 1994, at 59.

Since then, health-care insurance in the United States has developed haphazardly, largely free from central control by the government.³⁸ By the end of the 1940s, the total outlay for health-care services amounted to only four percent of the gross national product.³⁹ Additionally, as a result of the excellent medical care received during the war, returning veterans and Americans who stayed at home had increased expectations about their health care. Consequently, when the postwar economy rapidly accelerated, private health-care insurance was something unions demanded and to which corporate America readily acquiesced.⁴⁰

Indemnity Insurance Planted The Seeds Of The Health-Care Cost Containment Problem

Until recently, the majority of health-care insurance was purchased mainly by employers, in various versions, as an indemnity. Medical services were supplied in response to demand by physicians on behalf of their patients, with insurance carriers reimbursing hospitals, physicians, and other medical providers for each visit or procedure performed.⁴¹ Under this arrangement, referred to as "fee-for-service," medical providers were free to set their own fees.⁴² Patients enjoyed an unlimited choice of providers and paid only an annual deductible amount plus a fixed portion of their medical bills in the form of a co-insurance payment.⁴³

Charges for medical care went essentially unchallenged by corporate paymasters due to a national attitude of deference to physician judgment.⁴⁴ Despite rising premium costs, employers saw health insurance as both prudent and affordable.⁴⁵

³⁸Anders, *supra* note 35, at 19.

³⁹*Id.* Gross national product is the label given to the total amount of all goods and services produced by the United States economy in any given year.

⁴⁰*Id.* at 20.

⁴¹Christopher Biddle & Maureen Lopes, *Managed Care Plans No. 1 Among Employers*, 42 N.J. BUS. 20 (1996).

⁴²*Id.*

⁴³*Id.*

⁴⁴Anders, *supra* note 35, at 23.

⁴⁵*Id.* at 20.

Rising Health Insurance Costs Mandated A Need For New Incentives In Delivering Care

The attitude of employers, who paid the bulk of health insurance premiums, changed dramatically, however, as this payment and practice system took hold. Joseph Califano, a director on the Chrysler Corporation board, voiced the frustrations of corporate executives when he complained that "by agreeing to first-dollar coverage, Chrysler increasingly insulated its employees from any sense of what health care cost."⁴⁶ The net effect of this, he noted, was that "Chrysler opened its treasury door to physicians and hospitals."⁴⁷

Insured workers' health-care costs began to rapidly spiral. From 1980 to 1994, health-care inflation increased annually at an average rate of 7.7 percent, compared to only a 4.3 percent increase for the consumer price index in the same period.⁴⁸ It was as though the mere existence of the benefit was generating its own demand.⁴⁹

With medical inflation rampant by the 1980s, the health-care community began to lose its "aura of untouchability."⁵⁰ Researchers began to document irrefutable instances of medical excess and inappropriate procedures.⁵¹ After decades of trying to contain the growth of health-care cost increases, employers concluded nothing worked, and "all incentives worked in the direction toward overtreatment."⁵² Insurers and employers came to realize that to effectively control costs, incentives to the medical community had to be changed. The way to do this was to intervene

⁴⁶JOSEPH A. CALIFANO JR., *AMERICA'S HEALTH CARE REVOLUTION*, 14 (1986).

⁴⁷*Id.*

⁴⁸NATIONAL CENTER FOR HEALTH STATISTICS, *HEALTH, UNITED STATES 1994 CHART BOOK*, at 32, Fig. 18.

⁴⁹Anders, *supra* note 35, at 20-21. In 1946, a day in the hospital cost \$9.39. By 1985 it rose to over \$600, before accounting for medical tests and physician fees.

⁵⁰*Id.* at 23.

⁵¹*Id.* at 23-24. For example, in Stowe, Vermont, pediatricians performed tonsillectomies on over two-thirds of all children. This proved to be three times the rate performed in surrounding towns. Researchers found that the sole reason for this difference was simply the preference that Stowe physicians had for surgery.

Similarly, researchers at the Rand Corporation found that fourteen percent of all expensive, coronary bypass surgeries, and sixteen percent of hysterectomies were not medically required.

⁵²*Id.* at 25.

before physicians saw a patient.⁵³ This novel intervention is now known as managed care.⁵⁴

Managed Care Offers A Solution To Rising Costs

All forms of managed-care providers (HMO, IPA, PPO, etc.)⁵⁵ share one essential characteristic. They receive capitated payment, a fixed amount of money per year for each person who becomes a member of their group.⁵⁶ This capitated payment feature means once a person is enrolled in a managed-care group, management's focus is on controlling health-care costs rather than increasing revenues.⁵⁷ If the total expenses of caring for

⁵³*Id.*

⁵⁴*Id.* Note, however, that although the recent growth of managed-care organizations was in response to increasing costs of health-care insurance, the earliest managed-care organizations developed for different purposes. Such pioneering organizations as Kaiser Permanente (established in the 1940's to serve the health needs of employees of the Kaiser shipyards) were rather socialist in their approach. *Id.* at 27.

⁵⁵These sets of initials stand for the prominent methods of providing medical services in a prepaid manner via entities that combine both the delivery of services with some form of financing mechanism. They are defined as follows in VERGIL N. SLEE, M.D., *HEALTH CARE TERMS*, (1986).

A Health Maintenance Organization (HMO) is any organization, either for profit or nonprofit, that accepts responsibility for the provision and delivery of a predetermined set of comprehensive health maintenance and treatment services to a group of voluntarily enrolled people at a preset, fixed, and periodic capitation payment. HMO's consist of three components: the health plan, which provides organization and management; the providers (physicians, hospitals, laboratories, etc.); and the patients (subscribers or enrollees). *Id.* at 60.

An Independent Physician Association (IPA) is a type of provider organization composed of physicians where the physicians maintain their own practices, but agree to also furnish medical services to patients who have signed up for a prepayment plan of medical services. *Id.* at 67.

A Preferred Provider Organization (PPO) is a form of health insurance in which certain physicians are designated by a third party payer (the insurance plan) as providers of medical services to be preferred by plan members because they are cost-effective. When a beneficiary elects to receive care from these physicians, the charges are paid in full—there is no additional charge to the plan member. The plan member may elect to obtain care from other physicians who are not affiliated with the plan (*i.e.* are not preferred). If the plan member selects this option, however, a financial penalty consisting of charges not covered by the plan are levied against the plan member. *Id.* at 111.

⁵⁶Anders, *supra* note 35, at 26.

⁵⁷Strictly speaking, providing specific health-care services is not the only way in which managed-care groups experience costs. They also pay for the expenses associated with the enrollment process itself. This necessarily entails employing large marketing staffs and allocating significant dollar amounts for the advertising and promotional activities required to

a given patient are below the fixed annual premium, then the managed-care group will keep the difference as its profit for providing cost-effective care.⁵⁸

Naturally, managed-care groups with larger percentages of younger and healthier members do not incur much expense in keeping this already healthy *cadre* of members healthy. In fact, managed-care groups strive to maximize revenues by enrolling greater numbers of younger and healthier members.⁵⁹ But the other side of the equation is where the problem for managed-care firms resides.⁶⁰ If the cost of providing medical services to any given patient exceeds the annual premium, then the managed-care organization loses money on that patient.⁶¹ As a result, managed-care groups are economically motivated to enroll younger, healthier people and to be cost conscious when providing medical care.⁶²

The growth of managed-care organizations continues at a rapid pace. A study conducted by three managed-care trade organizations forecast enrollments will increase by 48.5 percent from 1996 to 2002.⁶³ The reason behind this tremendous rate of increase is that managed-care organizations have been successful in achieving their prime objective of reining in the rate of growth of health-care costs.⁶⁴

This history of health-care insurance and the current supremacy of the managed-care approach exerts a pivotal influence on the timing and conduct of the physician-assisted suicide issue.

attract and maintain membership rolls. In its simplest conceptual form, the economics of managed-care organizations are more easily thought of using enrollment related activities to generate revenues, and cost-cutting regimes to limit expenses and produce the overall goal of making profits and increasing shareholder value.

⁵⁸ROBERT G. SHOULDICE & KATHERINE H. SHOULDICE, *MEDICAL GROUP PRACTICE AND HEALTH MAINTENANCE ORGANIZATIONS*, 123-29 (1978).

⁵⁹Anders, *supra* note 35, at 26, 41.

⁶⁰SHOULDICE AND SHOULDICE, *supra* note 58, at 123-29.

⁶¹*Id.*

⁶²Anders, *supra* note 35, at 26, 41.

⁶³Mary Jane Fisher, *Anti-Managed Care Law Could Cost Billions: Study*, NAT'L UNDERWRITER LIFE & HEALTH-FINANCIAL SERV. ED., July 3, 1995, at 49.

⁶⁴*Id.*

LEADING PHYSICIAN-ASSISTED SUICIDE CASE

As noted in the Introduction, although the appellate courts in *Compassion in Dying* and *Quill* each based their opinions on different provisions of the Fourteenth Amendment, they both shared common ground in giving scant attention to a state's interests in the economic factors present in physician-assisted suicide cases.⁶⁵

Compassion in Dying posed two related questions: whether a person who is terminally-ill has a constitutionally protected liberty interest in hastening his or her own death; and whether the state of Washington could constitutionally restrict the exercise of this liberty interest by banning a form of medical assistance that is requested by terminally-ill people who wish to die.⁶⁶

The issues arose out of a Washington statute which provided: "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another to attempt suicide."⁶⁷ These issues were finally resolved by the United States Court of Appeals for the Ninth Circuit, sitting *en banc*, after having been reviewed by the district court and a three member panel of the Ninth Circuit.⁶⁸ This procedural history is important because of the light it sheds on the choice of factors each court identified as germane to physician-assisted suicide.

The Courts Do Not Agree On A List Of The Key Relevant Factors That Influence Physician-Assisted Suicide

Surprisingly, the district and appellate courts failed to agree on a single set of relevant factors affecting physician-assisted suicide that were to be scrutinized, weighed, and balanced. The absence of common criteria for assessing the legality of physician-assisted suicide reveals an underlying confusion about exactly what should be evaluated. In such an unsettled

⁶⁵*Compassion in Dying v. Washington*, 79 F.3d 790, 793-94 (9th Cir. 1996) (en banc).

⁶⁶*Compassion in Dying*, 79 F.3d at 793.

⁶⁷RCW 9A.36.060.

⁶⁸*Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), 49 F.3d 586 (9th Cir. 1995), 79 F.3d 790 (9th Cir. 1996) (en banc).

environment, symptoms can easily be mistaken for causes. As a result, judicial analysis may not capture important factors in the legal equation. In the case of physician-assisted suicide, the omission of economic drivers which inform and to some extent control other factors has seriously eroded the practical value of the courts' opinions.

Conspicuously absent from the following discussion of factors deemed important by each of the three courts are the words "economics," "financial," "business concerns," or comparable words relating to the underlying marketplace drivers that are increasingly shaping medical treatment decisions.⁶⁹ Although economic influences can potentially be inferred from some of the language employed, failure to explicitly include such influences is tantamount to omitting them entirely. This omission makes it difficult, if not impossible, to fully address the underlying economics of the physician-assisted suicide decision.

As will be discussed in Part III, the economic dimension of the problem becomes critical when one places the physician-assisted suicide decision within the context of its real-world, managed-care environment. In determining whether a liberty interest was impeded by the statute, the en banc court enumerated five relevant factors:

- (1) the importance of various state interests;
- (2) the manner in which those interests are furthered by the state law;
- (3) the importance of the liberty interest;
- (4) the extent to which that interest is burdened by the state action; and
- (5) the consequences of upholding or overturning the statute.⁷⁰

⁶⁹Literally speaking, the *Compassion in Dying* en banc court does refer to financial burdens in its opinion. *Id.* at 826. However, monetary matters are considered solely from the perspective of potential burdens to self-interested relatives or an unnamed group of "others who have influence over them." *Id.* Yet this concern is of an entirely different and diminished magnitude than that presented by explicit recognition of the presence of the managed-care industry. Focusing only on a few relatives' interests ignores the enormous economic pressures exerted by the managed-care firms on the physicians with whom patients must ultimately and intimately interact. This article argues that failure to consider the significant economic power represented by the new managed-care environment is synonymous with neglecting to recognize a key, but silent actor, in the drama of assisted suicide.

⁷⁰*Id.* at 793.

The factors focused on in this Article are the first and fourth because they address interests which may have some relationship to economic considerations.

There Is No Settled List Of State Interests In Assisted Suicide

State interests are a critical consideration because the decision regarding whether a patient's constitutional rights have been violated "must be determined by balancing his liberty interests against the relevant state interests."⁷¹ Not surprisingly, these interests were included in the list of important factors considered by each of the three courts. The district court simply focused on the twin state interests of preventing suicide and preventing undue influence and abuse.⁷²

The three member panel of the Ninth Circuit was more particular in its list of key state interests to be weighed and balanced against the rights of the individual patient. Five factors comprised the list of state interests:

- (1) not having physicians in the role of killing their patients;
- (2) not subjecting the elderly or infirm to psychological pressure to consent to their own deaths;
- (3) protecting the poor and minorities from exploitation;
- (4) protecting handicapped from societal indifference and apathy; and
- (5) preventing the kind of abuse that has occurred in the Netherlands, where, since 1984, legal guidelines have tacitly allowed assisted suicide or euthanasia in response to a repeated request from a suffering, competent patient.⁷³

The *Compassion in Dying* court came closest to considering economic factors in items three and four when it referred to "psychological pressure" and protecting the poor and minorities from an unspecified "exploitation." As will be seen in Part III, however, these oblique

⁷¹Youngberg v. Romeo, 457 U.S. 307, 321 (1982).

⁷²Compassion in Dying v. Washington, 850 F. Supp. 1454, 1464-65 (W.D. Wash. 1994).

⁷³Compassion in Dying v. Washington, 49 F.3d 586, 592-93 (9th Cir. 1995).

inferences do not directly raise the considerable economic issues that require specific legal attention in a managed-care environment.

The *en banc* court also elaborated on the elements it believed described the state's interests. These include:

- (1) preserving life;
- (2) preventing suicide;
- (3) protecting the integrity of the medical profession;
- (4) avoiding adverse consequences if the statute was declared unconstitutional;
- (5) protecting family members; and
- (6) avoiding the involvement of third parties and their potential use of arbitrary, unfair or undue influence.⁷⁴

At best, suggestions of economic components can only be gleaned from the last two elements on the court's list.

It is apparent from both the district and circuit courts' opinions there was no agreed upon set of state interests which guided those courts when dealing with the issue of physician-assisted suicide. Certainly, the economic influences exerted by the growing managed-care sector of the health-care industry were nowhere to be found among the specific factors considered by these courts.

As discussed in the next section, this omission holds potentially dangerous consequences for people seeking to exercise their autonomy interests in this area. The related issue of rationing health-care services due to limited resources has been discussed in other contexts by legal authors.⁷⁵ But these considerations have similarly failed to integrate with the personal autonomy, liberty interests, and moral/ethical concerns as they relate to the question of physician-assisted suicide.

⁷⁴Compassion in Dying v. Washington, 79 F.3d 790, 816-17 (9th Cir. 1996) (*en banc*).

⁷⁵Paul S. Applebaum, *Must We Forgo Informed Consent to Control Health Care Costs?* 71 MILBANK Q. 669 (1993); Mark A. Hall, *Disclosing Rationing Decisions: A Reply to Paul S. Applebaum*, 72 MILBANK Q. 211 (1994); Mark A. Hall, *Informed Consent to Rationing Decisions*, 71 MILBANK Q. 645 (1993); Mark A. Hall, *Rationing Health Care At The Bedside*, 69 N.Y.U. L. REV. 693 (1994); David Mechanic, *Trust and Informed Consent to Rationing*, 72 MILBANK Q. 217 (1994).

ECONOMIC FACTORS DRIVING PHYSICIAN-ASSISTED SUICIDE

Regardless of the extent of a patient's personal autonomy interests, the exercise of those interests in decisions affecting physician-assisted suicide does not exist in isolation. Rather, the exercise of autonomy may itself be influenced by information available to the patient at the point of decision-making. Since most patients are not sophisticated consumers of medical information, they often rely on physicians to interpret the data and make treatment recommendations "in the patient's best interests."⁷⁶ This is the traditionally accepted view of the physician-patient relationship.

With the emergence of managed-care organizational structures, however, powerful forces are rapidly reshaping the practice of medicine, not simply by controlling costs, but by fundamentally altering the physician's view of the physician-patient relationship.⁷⁷ Thus, it is necessary to understand the role played by managed-care organizations in order to fully understand the context in which any exercise of a patient's personal autonomy is likely to occur.

A number of critical, interrelated economic factors must be explicitly included in any legal equation that seeks to resolve the physician-assisted suicide issue. One section discusses managed-care issues as they relate to physician-assisted suicide in the contexts of the elderly, the changing roles of physicians, and the physician-patient relationship in general. Another section then assesses state interests in protecting vulnerable groups from being unduly influenced by professionals, and the interest in protecting consumers from potential economic abuse. Finally, a section will examine the significant experience of the Netherlands with euthanasia guidelines because that experience has many implications for the monitoring and control of potential abuse in physician-assisted suicide.

⁷⁶Patients do not possess the data or, often, the analytical abilities, needed to effectively interact with physicians on a co-equal basis. The unfortunate result of this disparity in bargaining power is an undermining of the patient's theoretical capacity to allocate risks through this market mechanism. Michael B. Kelly, *The Rightful Position in "Wrongful Life" Actions*, 42 HASTINGS L.J. 505, 511.

⁷⁷Erik Larson, *The Soul of an HMO*, TIME, Jan. 22, 1996, at 45.

The Advent Of Managed Care Has Accelerated The Need To Explore The Question Of Assisted Suicide

A question rarely posited in the controversy over assisted suicide is why the issue is being debated now. What factors have coalesced to create increased attention to physician-assisted suicide? A case may be made which attempts to explain the current impetus as the result of advances in modern medical technology. But such an explanation falls far short of conclusively demonstrating why interest in assisted suicide is now capturing nationwide attention. After all, technological progress in medicine has occurred on numerous fronts throughout this century, yet none have ever sparked sustained interest in physician-assisted suicide.

What is uniquely different now is the creation and expansion of new, integrated health-care organizational structures and funding mechanisms. The significant shift to a managed-care environment provides compelling economic reasons which, in themselves, practically require the introduction of physician-assisted suicide as an acceptable treatment option.

In assessing the economic role managed care plays in health-care delivery, seven critical areas will be discussed:

- (1) managed care's singular focus on price and cost;
- (2) the overall crucial interplay of costs and quality;
- (3) the impact on the elderly;
- (4) the general implications for assisted suicide;
- (5) the adverse changes in physician-patient relationships;
- (6) the emergence of clinical outcome measurements; and
- (7) the impacts of managed-care economics on physician choices for patient care.

The Singular Focus on Price and Cost Raises Questions About Proper Incentives and Priorities

Managed-care organizations have a critical need to ensure they provide low cost medical treatment.⁷⁸ In actuality, this process is merely a means

⁷⁸Anders, *supra* note 35, at 26, 41.

of setting a price for health-care services. Judge Richard Posner of the United States Court of Appeals for the Seventh Circuit recognized this in a recent antitrust case when he noted:

the different method of pricing used by the HMO has, of course, consequences both for the practice of medicine and the allocation of risk of medical expenses. The method of pricing gives the HMO an incentive to minimize the procedures that it performs, since the marginal revenue it derives from each procedure is zero.⁷⁹

Managed-care groups' relentless pursuit of bottom-line savings, however, is beginning to diverge from some employers' objectives of providing employees with reasonably priced, quality health care. This point is illustrated by a managed-care group that was unable to extract a stiff, percent price reduction from Seattle's renowned Swedish Medical Center.⁸⁰ The managed-care firm promptly dropped the Center from its approved list of providers, substituting an arguably lower quality but cheaper facility.⁸¹ Boeing, the largest area employer, believed good care was comprised of more than cost savings and as a result, withdrew its support of the managed care plan.⁸² The managed-care group, however, refused to alter its single, cost-based focus.⁸³ Its chief executive officer unabashedly stated he felt Boeing's "major priority was not to control costs but to keep their employees happy I'm sure that when we talk with them again, their priorities will be different."⁸⁴

The Overall Interplay of Costs and Acceptable Levels of Quality Becomes Crucial

Even if managed-care firms and employers share identical priorities regarding low costs, the question of quality treatment remains. The pursuit of greater cost efficiencies has unquestionably been a successful outcome

⁷⁹Blue Cross and Blue Shield United of Wis. v. Marshfield Clinic, 65 F.3d 1406, 1409 (7th Cir. 1995).

⁸⁰Anders, *supra* note 35, at 44.

⁸¹*Id.*

⁸²*Id.*

⁸³*Id.*

⁸⁴*Id.*

of the movement towards managed care.⁸⁵ The drive to obtain such efficiencies, however, threatens to become the all-consuming goal of managed-care groups,⁸⁶ to the detriment of quality care.⁸⁷ A brief look at mortality rates for open heart surgery illustrates this point.

When coronary-artery-bypass-graft surgery (CABG)⁸⁸ became widely accepted, one west coast hospital attracted managed-care contracts by dramatically slashing its price for the procedure from \$60,000 to an all-inclusive \$23,000.⁸⁹ Competition among hospitals for managed-care contracts eventually drove prices down to about \$13,000.⁹⁰ Unfortunately, the quality of care patients received declined almost as rapidly as the cost.

Between 1991 and 1993, CABG patients at the same west coast hospital died on site or within thirty days of their operations at a rate of 10.4 percent, which was among the highest rates of high-volume heart centers in the region.⁹¹ In contrast, two other area hospitals, noted for handling unusually sick patients, posted mortality rates of only 7.9 percent and 5.6 percent respectively.⁹² One managed-care executive's comment regarding the cost versus survival rate trade-offs was that "[f]or a 2 to 3 percent difference in mortality, I'm not willing to spend an extra \$40,000 per case."⁹³

⁸⁵ANDERS, *supra* note 35, at 182.

⁸⁶Seeking cost-saving efficiencies is so prevalent that the managed-care industry refers to it with a term borrowed from conventional insurance lexicon. Managed-care firms consider the funds that they allocate for actual patient care to be their "medical loss ratio." Thus, they directly associate patient care with financial loss rather than with a benefit or service which they are contractually obligated to provide. *Twelve Reasons Why For-Profit Managed Care Isn't Working For Physicians Or Patients*, HEALTH LETTER, (Public Citizen Health Research Group, Wash. D.C.), Dec. 1996, at 2.

⁸⁷ANDERS, *supra* note 35, at 101-03.

⁸⁸*Id.* at 96. CABG is pronounced "cabbage."

⁸⁹*Id.* at 96-98.

⁹⁰*Id.* at 98-99.

⁹¹*Id.* at 99. These figures are taken from Medicare mortality data. Medicare figures are used because some states, such as California where the statistics for this example were derived, do not collect mortality data for all heart-surgery patients. The Medicare mortality rates tend to be higher than for other such patients, yet they are considered to provide an accurate gauge of how a hospital handles sicker individuals.

⁹²ANDERS, *supra* note 35, at 100.

⁹³*Id.*

These quality/cost trade-off issues call into question the ability or desire of managed-care organizations to control health-care expenditures, yet provide effective care, as they face increasing pressure from the demographic realities of an aging population. As the percentage of elderly in the population increases, more health-care services will be required.⁹⁴ Because the economic strength of managed care lies solely in its ability to control costs, the mechanisms used to manage expenses become key considerations in confronting the specter of rising costs generated by this increasingly elderly population.⁹⁵

According to researchers Lubitz and Riley, the highest medical costs occur in the last year of life.⁹⁶ Although this conclusion is based on Medicare data,⁹⁷ it serves as a benchmark for more generalized observations. Overall, these numbers are compatible with similar data for the costs of caring for terminally-ill patients suffering from cancer, as well as patients who die following a stay in a critical care unit.⁹⁸ Analysis of data from whatever source, however, is complicated by the fact relationships between "prognosis, expenditure, and outcome are more complex than can be appreciated when a study focuses only on nonsurvivors or on subsets of patients with the poorest prognosis or the highest costs."⁹⁹

Even with these limitations, the costs associated with the terminally-ill remain significant. Focusing on the available Medicare information for the

⁹⁴PAUL J. FELDSTEIN, *HEALTH POLICY ISSUES: AN ECONOMIC PERSPECTIVE ON HEALTH REFORM*, 258-61 (1994).

⁹⁵Alfred F. Conrad, *Elder Choices*, 19 AM. J. L. & MED. 233, 240-41 (1993). The rise in per capita health-care expenditures is exacerbated by the rate of growth of the elderly versus overall population growth rates. While the total population has increased by twenty-six percent, the elderly segment (*i.e.* people aged eighty-five or older) has grown by an astonishing 126 percent.

⁹⁶James D. Lubitz & Gerald F. Riley, *Trends in Medicare Payments in the Last Year of Life*, 328 NEW ENG. J. MED. 1092, 1092 (1993).

This widespread view has recently been criticized based on differing interpretations of the data. See *End of Life Issues and Implementation of Advance Directives Under Health Care Reform: Hearing before the Senate Comm. on Finance, 103rd Congress, 2d Sess. 54* (1994) (testimony of Ezekiel J. Emanuel). Some of the difference of opinion stems from the fact that the definition of costs near time of death is a complex issue.

⁹⁷Lubitz & Riley, *supra* note 96, at 1092.

⁹⁸Ronald Bayer, et al, *The Care of the Terminally Ill: Morality and Economics*, 309 NEW ENG. J. MED. 1490, 1491, (1983).

⁹⁹*Id.* at 1492.

terminally-ill, one can conclude that although these health-care costs have not increased relative to other health-care expenses over time, their absolute size continues to account for a significant portion of health-care expenditures, about 29 percent.¹⁰⁰ The most significant component (77 percent) of these last year of life expenses was for hospital-based care,¹⁰¹ an area in which managed-care groups continue to exhibit strong interest in controlling costs. As a consequence, the elderly remain an important target group in the quest to control health-care costs.

Because death is most prevalent among the elderly, and because the elderly are an increasing portion of the population,¹⁰² this group represents the largest potential pool of patients who might be candidates for physician-assisted suicide. Furthermore, because of the large percentage of health dollars directed towards the care of those in their final year of life, the majority of whom are elderly, the economic importance of this group is significant in a managed-care environment where cost control is the primary objective.

At the same time, the elderly possess adequate medical insurance and are, therefore, a financially attractive group to managed-care organizations. Medicare legislation in 1965 made this situation possible by ensuring the availability of government-funded health coverage for anyone aged sixty-five or older.¹⁰³ Prior to that time, the elderly were basically considered uninsurable.¹⁰⁴ Today, the federal government pays an average of \$400 per month for each person enrolled in a Medicare-approved managed-care group and managed-care groups have been quick to capitalize on this additional source of funding.¹⁰⁵ By mid-1996, four million senior citizens were enrolled in Medicare managed-care groups, with new membership growth rates hovering at approximately 20 percent per year.¹⁰⁶

¹⁰⁰Lubitz & Riley, *supra* note 96, at 1092-93 (finding that 29 percent of total Medicare expenses was generated by only a small proportion of Medicare enrollees—for example, only six percent of the enrollees who died in 1978).

¹⁰¹Sally C. Stearns, et al., *Risk Indicators for Hospitalization During the Last Year of Life*, 31 HEALTH SERV. RES. 49 (1996).

¹⁰²Conrad, *supra* note 95, at 240-41.

¹⁰³Anders, *supra* note 35, at 174.

¹⁰⁴*Id.*

¹⁰⁵*Id.*

¹⁰⁶*Id.* at 176.

Even in the face of this enormous growth of annual Medicare enrollment revenues, the managed-care industry has not, unfortunately, changed its preferences for emphasizing cost savings over quality of care. Treatment can easily be denied to the elderly through the simple expedient of more stringently defining what is considered a "medical necessity."¹⁰⁷ The government hears about 3,000 disputes each year where the elderly contest these definitions and denials of treatment.¹⁰⁸ Of these, approximately 40 percent are decided in favor of the elderly, resulting in an additional managed-care firm financial obligation of \$3 million to \$8 million in services annually.¹⁰⁹

Researchers are uncovering numerous examples of "disturbing gaps" in the quality of care received by the elderly--gaps in care which only serve to boost managed-care incomes.¹¹⁰ In one study of stroke patients, managed-care Medicare patients were found to have been discharged from hospitals sooner and sicker than a control group of traditional fee-for-service Medicare patients.¹¹¹ Another group of researchers from Boston's New England Medical Center, Tufts, and Harvard Universities recently conducted a major four-year study of chronically-ill patients in Boston, Chicago, and Los Angeles.¹¹² The research concluded elderly Medicare patients and poor people who received care from HMOs experienced worse health outcomes than those treated in traditional fee-for-service settings.¹¹³ A senior scientist at the New England Medical Center summarized the results by stating: "The study clearly indicates that the chronically-ill elderly and poor patients are at a greater risk in this new era of cost containment that involves managed care."¹¹⁴

¹⁰⁷*Id.* at 174.

¹⁰⁸ANDERS, *supra* note 35, at 178.

¹⁰⁹*Id.*

¹¹⁰*Id.* at 179.

¹¹¹*Id.* The managed-care patients were released an average of two full days sooner than were members of the control group. This occurred even though at discharge the managed-care patients "had more trouble talking, seeing clearly, or moving their arms and legs." *Id.*

¹¹²Ronald Kotulak and Peter Gomer, *Managed Care: National Leap of Faith*, CHGO. TRIB., Oct. 2, 1996 § 1, at 1.

¹¹³*Id.*

¹¹⁴*Id.*

Implications Of The Managed-Care Environment On Physician-Assisted Suicide

It is within the structure of managed-care organizations that the seeds of the physician-assisted suicide controversy are sown. Managed-care groups, by their nature, focus on strictly controlling costs when providing medical care and operate under strong economic incentives. As a result, these organizations may view physician-assisted suicide as an opportunity to control the demonstratively high costs associated with patients, often the elderly, who are candidates for the physician-assisted suicide option. Any expenses saved in providing care to these patients drops directly to the industry's bottom-line profits.

If sufficiently large numbers of these patients can be persuaded by managed-care physicians to pursue or choose physician-assisted suicide and die earlier than they might otherwise, managed-care organizations will undoubtedly enhance their profits. Judge Posner has observed “[f]rom a short-term financial standpoint ... the HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible.”¹¹⁵

Unfortunately, the specter of economically driven physician-assisted suicide outlined above is not limited to some morbid, grade-B movie plot. Concrete evidence of the desire and practice of managed-care firms to actively pursue this attractive financial opportunity already exists. William Jarvis, Professor of Public Health at California's Loma Linda University, documented such cost savings from the terminally-ill as an openly admitted goal of some managed-care groups.¹¹⁶ He describes the situation of an HMO that provides inexpensive dietary supplements for AIDS patients.¹¹⁷ The managed-care firm actively pursues the use of this alternative to the costly AZT drug even though the efficacy of the dietary treatment is

¹¹⁵Blue Cross and Blue Shield United of Wis. v. Marshfield Clinic, 65 F.3d 1406, 1410 (7th Cir. 1995).

¹¹⁶HMO's Flirting With Alternative Medicine, CHGO. TRIB., Oct. 7, 1996, § 1, at 7.

¹¹⁷*Id.*

uncertain at best.¹¹⁸ The reason given by an official of the HMO is that "it's cheaper than AZT, and the patient won't be around as long ..."¹¹⁹

Such lucrative economic incentives assume increased significance in a health-care environment in which an increasing number of people are coming under the overall managed-care umbrella. Further, the significance is greatest where increasing numbers of those people are the elderly who are more likely to incur expensive terminal illnesses and, thus, become prime candidates for the cost-saving physician-assisted suicide option.

A Managed-Care Approach Adversely Changes Critical Physician-Patient Relationships

Health care and its administrative management are becoming increasingly sophisticated. At the same time, the ability of patients to understand the complex and often conflicting factors and relationships that influence the choice of care has failed to keep pace.¹²⁰ Quite simply, most patients often do not understand either the managed-care arrangements or the contractual implications that govern the patient's relationships with managed-care employees.¹²¹

Even the underlying assumptions that formerly governed the physician-patient relationship no longer hold in the new managed-care world.¹²² The ongoing, long-term relationships between physician and patient that were once the hallmark of medical service are no longer the norm. The traditional physician-patient relationship has lost its intimacy as employer-sponsored insurance plans switch people into managed-care settings where a patient's choice of physician is often limited to an

¹¹⁸*Id.*

¹¹⁹*Id.*

¹²⁰HERBERT E. KLARMAN, *THE ECONOMICS OF HEALTH*, 14 (1965).

¹²¹Mechanic, *supra* note 75, at 219.

¹²²Hall, *supra* note 75, at 704 n.32. The author cites numerous sources which oppose making physicians function as rationers of health-care resources—for any reason. Chief among these sources are the American Medical Association's position that "the treating physician must remain a patient advocate and therefore should not make allocation decisions." *Id.*

approved list of providers.¹²³ Patients in managed-care settings also complain of an inability to see the same physician over their course of care. As a consequence of these two factors, the historic physician-patient relationship is not as strong or supportive of patients' needs as it once may have been.

Among the implications of this deterioration in physician-patient relations is that the physician is no longer unequivocally seen as the patient's advocate in always pursuing what is medically best for the patient.¹²⁴ Some consumer advocates are concerned that by definition, the capitation arrangements of managed-care providers set up a conflict between the competing interests of physicians and patients.¹²⁵ There is a perception among some physicians that because of the fixed-income characteristics of the managed-care arrangement, when a patient walks through the door, he or she is a liability, not an asset.¹²⁶

Of even greater concern is the fact the economic considerations responsible for the financial success of managed-care organizations can poison the very core of the physician-patient relationship.¹²⁷ The level of trust between the two parties is corrupted when physicians are required to incorporate economic factors into their medical advice.¹²³ Simple arithmetic demonstrates that when considering which treatment to provide in managed-care delivery, with a limit on the capitated income available

¹²³United States v. Mercy Health Serv., 902 F. Supp. 968, 973 (N.D. Ia. 1995) (noting that managed-care plan members may have the choice of visiting only the approved list of providers for minimal prices, or seeing any provider of their choosing if they pay higher prices).

¹²⁴Victor R. Fuchs, *The "Rationing" of Medical Care*, 311 NEW ENG. J. MED. 1572, 1573 (1984). Victor Fuchs, a noted economist and ardent supporter of health-care rationing, has warned that "the commitment of the individual physician to the individual patient is one of the most valuable features of American medical care . . ."—one that should not be disturbed. *Id.*

¹²⁵Larson, *supra* note 77, at 47.

¹²⁶*Id.*

¹²⁷Jerome Kassirer, *Managed Care and the Morality of the Marketplace*, 333 NEW ENG. J. MED. 50-51 (1995).

¹²⁸James T.C. Li, M.D., Ph.D., *The Patient Physician Relationship: Covenant or Contract?*, 71 MAYO CLIN. PRO., 917, 918 (1996). The author places significant responsibility for the decline in physician-patient relations on the physicians. Dr. Li notes that physicians should be faulted for submitting to the external pressures of managed care and for betraying the trust granted to them by their patients. He further notes parallels with physician acquiescence to the allures and demands of medicine under Nazi Germany when physicians also failed to put the needs of their patients above other, non-medical considerations. *Id.*

from each patient, the cost of a particular treatment must be weighed against less expensive alternatives. This situation was candidly noted in the *New England Journal of Medicine*:

On the one hand, physicians are expected to provide a wide range of services, recommend the best treatments and improve patients' quality of life. On the other hand, to keep expenses to a minimum, they must limit the use of services, increase efficiency, shorten the time spent with each patient and use specialists sparingly; ... increasingly the struggle will be more concrete and stark; [P]hysicians will be forced to choose between the best interests of their patients and their own economic survival.¹²⁹

This explicit weighing of economic factors is an integral part of the contractual arrangement between the managed-care group and the physician.¹³⁰ Providers are handcuffed in their ability to resist the managed-care group's determinations of which treatments will be reimbursed because providers who resist will either end up paying some expenses themselves or be frozen out of further participation in the managed-care network.¹³¹

This cost-reducing requirement is so critical to the managed-care approach that HMO's in New Jersey, for example, are actively opposing proposed legislation that would require them to disclose to consumers any financial incentives offered to physicians to hold down medical costs.¹³²

Emergence Of Clinical Outcome Measurements

Efforts to identify and quantify measures of quality of care, which have languished for decades due to a lack of compelling need, are now actively pursued by the managed-care industry and others under the label of "outcomes measurement."¹³³ Initially, the belief was that managed-care

¹²⁹Kassirer, *supra* note 127, at 50.

¹³⁰Larson, *supra* note 77, at 47.

¹³¹Anders, *supra* note 35, at 142.

¹³²Matthew P. Schwartz, *New Jersey Proposes A Slew of New Regulations for HMO's*, NATIONAL UNDERWRITER LIFE & HEALTH-FINANCIAL SERVICES EDITION, Nov. 27, 1995, at 1.

¹³³Anders, *supra* note 35, at 40-42.

groups would disseminate information on clinical outcomes, thereby enabling patients to make smarter choices concerning health care.¹³⁴ But the reality turned out to be little more than marketing programs for the managed-care groups.¹³⁵ The outcomes measured by managed-care firms were dominated by figures on how well managed care did at checking cholesterol and doing routine cancer screenings, everything except tracking their success in delivering effective care to seriously ill people.¹³⁶

Perhaps it is no accident that such efforts are being undertaken in earnest at this time. Managed-care groups now need such standardized data in order to compile statistics that will help them determine cost effectiveness of various clinical protocols. A focus on outcomes data alone may also serve to deflect public attention from the economic incentives offered to medical personnel for decreasing the use of specific, expensive procedures.¹³⁷ This occurs when physicians give advice to patients about different possible paths of treatment. A spokesperson for the New Jersey HMO Association hinted at this deflection policy when he declared "outcomes data in terms of somebody being ill is more important than providing information on how physicians are compensated."¹³⁸ But is this necessarily true from the consumer perspective? Is outcome data alone all that is needed for consumers to make informed choices regarding medical treatment? Should economic information be ignored because there is no role for it to play?

Impacts Of Managed-Care Economics On Physician Choices For Patient Care Do Not Always Favor The Patient

As physicians become more attuned to factoring economic considerations into their clinical protocols, they may be unaware of the degree to which such financial considerations influence their decisions.¹³⁹ In the managed-

¹³⁴*Id.* at 237.

¹³⁵*Id.* at 41.

¹³⁶*Id.*

¹³⁷Wendy K. Mariner, *Outcomes Assessment in Health Care Reform: Promise and Limitations*, 20 AM. J. L. & MED. 37, 47-48 (1994).

¹³⁸Schwartz, *supra* note 132, at 2.

¹³⁹Applebaum, *supra* note 75, at 674.

care environment, medical necessity may become vulnerable to reinterpretation on the basis of the economic pressures under which managed-care operates.¹⁴⁰ Three aspects of these issues must be noted: patients cannot exercise true autonomy of treatment choice; recent examples reveal how physicians often influence patients' medical choices; and physicians may no longer function as effective patient advocates.

Patients Cannot Exercise Autonomy In Choosing Treatments

This situation obviously presents problems for patients as well. From a simple, informed consent point of view, considerable doubt is raised as to whether patients will understand the impact of such economic considerations on their treatment.¹⁴¹ If the practice guidelines established by managed-care organizations are not known or fully comprehended by patients, the economic influence exerted on physicians to modify medical choices will similarly go undetected by the patient.¹⁴² This is a critical point because patients most often defer to the medical judgment of their physicians.¹⁴³

Although the patient may mechanically give final approval to perform a procedure, in reality, it is the physician who structures the decision through the selection of options presented to the patient and in the manner in which such options are described.¹⁴⁴ The patient has no independent means of verifying either the range of medical possibilities or the desirability of undergoing any given procedure.¹⁴⁵ It is solely through the gatekeeper of medical knowledge, the physician, that the patient comes in contact with the decision regarding what should be done. If the economic pressures under which that information is provided are not clearly known

¹⁴⁰*Id.* at 671.

¹⁴¹*Id.* at 672.

¹⁴²*Id.*

¹⁴³HERMON M. SOMERS & ANNE R. SOMERS, *DOCTORS, PATIENTS, AND HEALTH INSURANCE*, 468-69 (1961).

¹⁴⁴Klarman, *supra* note 120, at 15.

¹⁴⁵Mechanic, *supra* note 75, at 219.

by the patient, then it is questionable whether informed consent or a personal autonomy interest can be freely exercised.¹⁴⁶

Examples Reveal How Physicians Often Influence Patients' Medical Choices

A recent example of how physicians often influence patients' medical choices is found in the area of obstetrics. In the 1960's and continuing through the early 1980's, alternative birthing approaches were used with increasing frequency.¹⁴⁷ The impetus for natural birthing and related alternatives largely came from the mothers.¹⁴⁸ However, since that time a dramatic pullback occurred in approaches to birthing.¹⁴⁹ This change came about through the exertion of physician rather than patient preferences.¹⁵⁰ As hospitals hired more physicians who specialized in anesthetizing women against labor pain, more women began to seek out this service.¹⁵¹ A similar decision-influencing process may be at work in other medical decisions.

Perhaps an even more dramatic example of managed-care economics seeking to channel medical decisions into financially advantageous paths is a case involving an HMO's initial refusal to allow a patient facing a life-threatening breast cancer to have needed transplants.¹⁵² While waiting to see the HMO's medical director about the matter, the patient accidentally overheard him on the phone, angrily denouncing the fact her attending physician had informed her about the expensive transplant program at another, non-HMO hospital.¹⁵³ Another cancer patient required an expensive bone marrow transplant in order to live.¹⁵⁴ Later, when she eventually saw an HMO specialist on the matter, she left from the

¹⁴⁶*Id.* at 220.

¹⁴⁷Cindy Schreuder, *Underwater Births Arise As A Mainstream Option*, CHIGO. TRIB., Oct. 18, 1996, § 1, at 30.

¹⁴⁸*Id.*

¹⁴⁹*Id.*

¹⁵⁰*Id.*

¹⁵¹*Id.*

¹⁵²Larson, *supra* note 77, at 47.

¹⁵³*Id.*

¹⁵⁴*Id.*

encounter distrusting the advice she had been given.¹⁵⁵ Her family noted the physician declined to even describe what was involved in a bone marrow transplant or to give the family a tour of the medical facility where it could be performed.¹⁵⁶ Her husband was convinced the physician "was told to send us away, making it as discouraging as possible."¹⁵⁷

Physicians May No Longer Function As Effective Advocates For Their Patients

The fact that patients largely follow the lead of medical professionals and agree to whatever treatment is recommended brings the discussion squarely back to the conflict between physicians and patients that resulted from the managed-care structure. The issue of patient trust in physician recommendations takes on new importance when physicians are employees who are contractually obligated to implement the treatment priorities established by their managed-care employers.¹⁵⁸ In their new roles as employees, physicians are no longer in a position to always act as effective advocates for the patients' needs.¹⁵⁹ Were physicians to routinely conceal medical treatment options from which patients may benefit because such options did not conform to the economic preferences of their managed-care employers, then the very core of the physician-patient relationship would be jeopardized.¹⁶⁰

These same concerns become more pronounced in the context of a rapidly growing managed-care environment. Non-managed care options are increasingly disappearing from the choice of insured medical plans

¹⁵⁵*Id.*

¹⁵⁶*Id.*

¹⁵⁷Larson, *supra* note 77, at 47.

¹⁵⁸*Safeguarding the Health Care of Senior Citizens, 1996: Hearings Before the Subcomm. on Labor, Health and Human Services and Education, of the Senate Comm. on Appropriation, 104th Cong., 2d Sess. (1996) (statement of John C. Nelson, M.D. for the Am. Med. Assoc.). See Li, supra note 130, at 917-18 (discussing the role that physicians have played in enabling the physician-patient relationship to deteriorate).*

¹⁵⁹Li, *supra* note 130, at 917-18.

¹⁶⁰Applebaum, *supra* note 75, at 675.

provided by employers.¹⁶¹ In some states, even Medicaid recipients are being moved into the managed-care structure.¹⁶²

Managed-care organizations, physicians, and patients are not, as some may assume, the only players. There remains a significant role to be filled by the state in pursuing its interests to promote the health and welfare of its citizens.

The State Possesses Clear Interests In Physician-Assisted Suicide

The extensive economic influences exerted by managed care discussed earlier are not the only forces affecting the assisted suicide question. The state has a significant countervailing role to play. It does so primarily in three ways: in its capacity as regulator of professionals who can exert undue economic influence with respect to vulnerable population segments; in its capacity of protecting consumer interests; and in its traditional role of preventing suicide and preserving life.

The State Has An Interest In Regulating Professionals Who Can Exert Undue Economic Influence On Vulnerable Populations

States have an unequivocal interest in the regulation of medical professionals to ensure the interests of the lay public are protected in situations where the public is vulnerable.¹⁶³ When other professions have demonstrated similar problems with conflicts of interest between the financial interests of professionals and the people they serve, the states have not hesitated to intervene and assert their role of furthering the welfare of the public.

For example, in *Ohralik v. Ohio State Bar Ass'n*, the United States Supreme Court held the potential for "undue influence, intimidation,

¹⁶¹*Id.* at 673. Options for health insurance are dwindling as current plans merge and many employers offer their workers only a single choice plan. *Id.* This trend is further supported by the fact that approximately seventy-five percent of the non-entitlement, insured patient population is covered under some form of managed care. See *United States v. Mercy Health Serv.*, 902 F. Supp. 968, 973 (N.D. Ia. 1995).

¹⁶²Schwartz, *supra* note 132, at 2.

¹⁶³*Ohralik v. Ohio State Bar Ass'n*, 436 U.S. 447, 467 (1978).

overreaching, and other forms of 'vexatious conduct' was so likely to occur when lawyers solicited clients in person, that such solicitation could be constitutionally prohibited by the state."¹⁶⁴ Ohralik was a lawyer who approached two young accident victims, one while she lay in traction in the hospital, in order to pursue their legal interests in the accident.¹⁶⁵ He tried to unduly influence them by stressing the contingency-fee arrangement, thereby making his offer appear to be without cost and irresistible.¹⁶⁶ The court explained that in vulnerable situations a distressed or unsophisticated lay person,

"may place his trust in a lawyer ... simply in response to persuasion under circumstances conducive to uninformed acquiescence ... [T]he very plight of that person ... makes him more vulnerable to influence ... [U]nder such circumstances, it is not unreasonable for the State to presume that in-person solicitation by lawyers more often than not will be injurious to the person solicited."¹⁶⁷

The Court made it clear a preventative rule like that in *Ohralik* was justified only in situations which were "inherently conducive to overreaching and other forms of misconduct."¹⁶⁸ Because of a person's "susceptibility and vulnerability, that individual becomes positioned such that it is likely he or she will place unwarranted trust in a professional, possessing superior knowledge, and motivated by pecuniary considerations."¹⁶⁹ Such undue influence was also determined to exist in *National Funeral Services, Inc. v. Rockefeller*.¹⁷⁰ In that case a funeral home salesperson intrusively solicited a family member for funeral services when the person was emotionally vulnerable.¹⁷¹

¹⁶⁴*Id.* at 462, 470.

¹⁶⁵*Id.* at 450-52.

¹⁶⁶*Id.*

¹⁶⁷*Id.* at 465-466.

¹⁶⁸*Ohralik*, 436 U.S. at 464.

¹⁶⁹*Desnick v. The Dep't of Professional Regulation*, 665 N.E.2d 1346, 1358 (Ill. 1996).

¹⁷⁰*National Funeral Servs., Inc. v. Rockefeller*, 870 F.2d 136 (4th Cir.), *cert. denied*, 493 U.S. 966 (1989).

¹⁷¹*Id.*

The context in which physician-assisted suicide occurs is similar to both *Ohralik* and *National Funeral Services*. Like the lawyer's undue influence on the accident victim in *Ohralik*, in physician-assisted suicide the undue economic influence exerted by the physician on behalf of the managed-care group comes at a time when the terminally-ill patient is in a stressful, vulnerable state, both physically and mentally. Similar to the lawyer's irresistible financial offer, the managed-care promise of a quick, pain-free death, one that spares loved ones additional financial burdens, could appear "irresistible" to a person in need of pain management and emotional support. Also, like the accident victim in *Ohralik*, terminally-ill patients are prone to "uninformed acquiescence" with the wishes of the person attempting to unduly influence them for that person's own economic gain. Also, similar to the cases noted above, at such critical times, the state has a substantial interest in protecting the individual from being unduly influenced. As one court phrased it, "because the public is susceptible to advertising or promises of medical relief, there exists a potential for abuse which the State has a compelling interest to guard against."¹⁷²

By contrast, the medical setting of physician-assisted suicide is decidedly unlike that of the Certified Public Accountant (CPA) in *Edenfield v. Fane*.¹⁷³ In *Fane*, the United States Supreme Court ruled against the Florida Board of Accountancy, which asserted interests in protecting consumers from fraud by CPAs.¹⁷⁴ *Fane* is distinguishable from the earlier state-interest cases and from physician-assisted suicide because the typical CPA client is less susceptible to manipulation than the innocent young accident victim in *Ohralik* or the vulnerable, terminally-ill patient who has been introduced to the idea of pursuing physician-assisted suicide.

Prospective CPA clients have existing, ongoing relations with accountants and, therefore, possess an independent basis for evaluating what the CPA might say to influence the client.¹⁷⁵ The CPA's offer is made for a long-term engagement, something decidedly different from a terminally-ill patient's prognosis. The CPA also looks for referrals and

¹⁷²*Desnick*, 665 N.E.2d at 1355.

¹⁷³*Edenfield v. Fane*, 507 U.S. 761 (1993).

¹⁷⁴*Id.*

¹⁷⁵*Id.* at 775.

repeat business.¹⁷⁶ These relational aspects are, of course, missing from the accident victim's interaction with the lawyer, as well as from the terminally-ill patient's relationship with the physician.

In summary, the characteristics of medical professionals in potentially exerting undue influence on the terminally-ill patient are highly comparable to those in other professions such as law and funeral services and their interaction with vulnerable clients. The mere fact some professions, such as public accounting, do not share these characteristics is no reason to treat all professionals alike and exempt them from continuing state scrutiny regarding how they influence their clients.

The Supreme Court reinforced this proposition when it proclaimed: "We have given consistent recognition to the State's important interests in maintaining standards of ethical conduct in the licensed professions."¹⁷⁷ Thus, the State has a decided interest in how licensed medical professionals influence the choices made by terminally-ill patients. This is particularly true when the competing interests being balanced are those of a consumer's life or death versus a medical provider's economic benefit.

The State Has Additional Interests In Guarding Patients' Rights Through Its Consumer Protection Capacity

In addition to the state interest in licensed medical professionals' conduct as agents of managed-care groups, other related state interests also play into the physician-assisted suicide context. States have an ongoing interest in protecting their citizens from undue economic influence when citizens act as consumers.¹⁷⁸ Here, the consumer is a purchaser of a particular medical service -- assisted suicide. Given that the nature of advice sought is largely unknowable to the consumer, yet can potentially exert a

¹⁷⁶*Id.* at 776.

¹⁷⁷*Id.* at 770. The Court proceeded on to list the most prominent of those cases: *Ohralik v. Ohio State Bar Assn.*, 436 U.S. 447, 460; *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 766 (1976); *National Society of Professional Engineers v. United States*, 435 U.S. 679, 696 (1978).

¹⁷⁸*Zauderer v. Office of Disciplinary Counsel of the Supreme Court of Ohio*, 471 U.S. 626 (1985) (noting, in part, the state's interest in preventing deception of consumers); *Bates v. State Bar of Ariz.*, 433 U.S. 350, 366 (1977) (describing a state's right to restrict practices that have the potential to exert undue influence over consumers).

significant impact on the buyer, a state has a responsibility to ensure the interests of the individual are appropriately safeguarded.

The State Also Possesses Traditional Interests Related To Preventing Suicide and Preserving Life

The state also possesses other more traditional interests which were the only ones explicitly acknowledged by the courts in *Compassion in Dying*. However, as previously noted, the various courts in that case could not agree on the scope of the traditional state interests. They include preventing suicide, preventing undue influence and abuse, preserving life, protecting the integrity of the medical profession, not subjecting the elderly or infirm to psychological pressure to consent to their own deaths, protecting all handicapped persons from societal indifference and apathy, avoiding the involvement of third parties, and preventing abuse similar to what has occurred in the Netherlands.¹⁷⁹ The situation in the Netherlands may have a direct bearing on potential methods of administering physician-assisted suicide and will be discussed separately below.

Given the undeniably significant state interests in preventing undue economic influence on physician-assisted suicide, it is imperative all these interests be explicitly included in court decisions weighing personal autonomy interests against the state interests. Yet, to date, neither of the two decisions recognizing a right to physician-assisted suicide ever mentioned key words such as "economic" or "financial" when considering the state interests.¹⁸⁰

Lessons Concerning the Ineffectiveness of Attempting to Control Physicians' Death-Related Activities can be Learned From The Netherlands

In *Compassion in Dying*, the Ninth Circuit briefly noted any pressures on patients' physician-assisted suicide decisions could be eliminated by

¹⁷⁹*Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), 49 F.3d 586 (9th Cir. 1995), 79 F.3d 790 (9th Cir. 1996) (en banc).

¹⁸⁰*Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc), and *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996). See *supra* note 70 and accompanying text (discussing how the word "financial" is used in the en banc court's opinion).

establishing rules to ensure free choices are made.¹⁸¹ Yet, the issue cannot be dismissed as easily as this comment might imply. The Netherlands experience with euthanasia is instructive regarding the reality of leaving the problem to be handled by a list of rules.

As in the United States, cost containment is being pursued as one of the primary goals of Dutch health-care policy.¹⁸² Legal support for euthanasia has developed within this environment, yet contrary to popular belief, the Netherlands has not legalized euthanasia.¹⁸³ In fact, Dutch penal codes 293 and 294 make both euthanasia and any type of assisted suicide illegal.¹⁸⁴

Euthanasia differs from physician-assisted suicide because the act of employing some vehicle to impart death is performed by the physician rather than the patient.¹⁸⁵ In physician-assisted suicide, the physician simply provides the vehicle of death (drugs, instructions, or mechanical devices) to the patient.¹⁸⁶ The patient is then responsible for using the vehicle to commit his or her own suicide. Euthanasia constitutes a more direct intervention by someone other than the patients themselves. The ways in which legal controls work to control the practice of euthanasia provide a critical perspective and warning for those who casually assume a list of rules will easily resolve any misgivings over the granting of the comparatively lesser right to commit assisted suicide.

Although euthanasia is technically illegal in the Netherlands,¹⁸⁷ it is relatively easy for physicians to "administer death" to a patient while

¹⁸¹Compassion in Dying v. Washington, 850 F. Supp. 1454, 1465 (W.D. 1994).

¹⁸²*Restructuring Health Care*, LANCET, Jan. 28, 1989, at 209. The Netherlands is not unique in this respect. Many European countries which provide universal access to basic health-care treatment through a mixture of mandated and voluntary health insurance are experimenting with new ways to increase the level of competition in the medical marketplace. Annas & Miller, *supra* note 31, at 380.

¹⁸³Giles R. Scofield, J.D., *Exposing Some Myths About Physician-Assisted Suicide*, 18 SEATTLE U.L. REV. 473, 493 (1995).

¹⁸⁴*Euthanasia Practice in Holland*, Fact Sheet, International Anti-Euthanasia Task Force, March, 1994, available in LifeWEB: Euthanasia Roundtable.

¹⁸⁵Peter M. McGough, M.D., *Medical Concerns About Physician-Assisted Suicide*, 18 SEATTLE U.L. REV. 521, 521 (1995).

¹⁸⁶*Id.*

¹⁸⁷Scofield, *supra* note 183, at 493.

avoiding legal penalties.¹⁸⁸ This is achieved by complying with a list of guidelines established by the Rotterdam Court.¹⁸⁹ If these guidelines are followed, no criminal action is taken against the physician.¹⁹⁰

The problem with this arrangement is that it is freely ignored. A study conducted by the attorney general of the High Council of the Netherlands documented that although involuntary euthanasia is quite prevalent in Holland, the guidelines are, in fact, openly violated.¹⁹¹ The study reviewed the particulars behind 2,300 deaths by voluntary euthanasia and 400 cases of physician-assisted suicide in 1990.¹⁹² People were troubled when the finding revealed that in 1,000 cases, the patient's life was ended by euthanasia without an explicit request.¹⁹³ Additionally, 8,000 patients died

¹⁸⁸Michael Gray, *Gently into the Night*, THE NEW PHYSICIAN, Jan-Feb., 1990, at 19.

¹⁸⁹*Id.* at 21 (listing, in part, the guidelines which physicians must follow in order to escape prosecution for murder). See Marlise Simons, *Dutch Parliament Approves Law Permitting Euthanasia*, N.Y. TIMES, Feb. 10, 1993, at A10 L (providing further information regarding these guidelines). The guidelines state that only physicians are permitted to perform euthanasia, and only if:

- (1) The patient is suffering unbearably in an irreversible situation.
- (2) The patient is a sane and rational adult who has thoughtfully and persistently made the request.
- (3) The request for euthanasia must be entirely of the patient's own free will and not under pressure from others.
- (4) The patient must be well informed and must be able to consider the alternatives.
- (5) The patient must have a "lasting longing for death."
- (6) The physician must consult at least one colleague who has faced the question of euthanasia before.

Id.

¹⁹⁰*Id.*

¹⁹¹International Anti-Euthanasia Task Force, *supra* note 184. The findings are contained in the 1991 Rummelink Report. The official name of this study is: *Medical Decisions About the End of Life, I. Report of the Committee to Study the Medical Practice Concerning Euthanasia, II. The Study for the Committee on Medical Practice Concerning Euthanasia* (2 vols.), THE HAGUE, Sept. 19, 1991.

¹⁹²Simons, *supra* note 189, at A10 L.

¹⁹³*Id.* Of this number, 14 percent were fully competent patients; seventy-two percent had never given any indication that they would want to end their lives; and in eight percent of the cases, the physicians performed involuntary euthanasia "despite the fact that they believed alternative options were still possible." International Anti-Euthanasia Task Force, *supra* note 186.

because physicians deliberately provided overdoses of pain medication--not to control pain, but to hasten their deaths.¹⁹⁴

The bottom line is that most euthanasia cases in the Netherlands are involuntary deaths.¹⁹⁵ This grim fact is concealed by the practice among physicians of falsifying death certificates, claiming death resulted from "natural causes."¹⁹⁶ As one observer noted, "[i]f the family physician does not report a case of voluntary euthanasia or an assisted suicide, there is nothing to control."¹⁹⁷

This is the true condition of euthanasia in the Netherlands. It provides the clear warning that establishing a list of guidelines, however well intended, cannot be relied upon to adequately control the use of physician-assisted suicide in this country.¹⁹⁸ It remains for the courts and legislatures to develop integrated solutions to address the multi-faceted, related issues that combine under the label of physician-assisted suicide.

INCLUSION AND INTEGRATION OF ECONOMIC FACTORS IS IMPERATIVE

The debate over physician-assisted suicide has been notable not only for the deep moral and constitutional concerns involved, but also for the lack of recognition of the growing economic component of managed care. This unfortunate situation is further compounded by the fact that there is no integration of the key personal autonomy, social, moral/ethical, political, legal, and economic considerations.

¹⁹⁴International Anti-Euthanasia Task Force, *supra* note 184.

¹⁹⁵*Id.* (noting survey results showing that in forty-five percent of the cases, the families of hospitalized patients who underwent involuntary euthanasia did not know that their relatives were purposely killed).

¹⁹⁶*Id.*

¹⁹⁷Marlise Simons, *Dutch Move to Enact Law Making Euthanasia Easier*, N.Y. TIMES, Feb. 9, 1993, § 1, at A1.

¹⁹⁸It is interesting to note that a "Death With Dignity" initiative in the state of Washington (Initiative 119) was defeated due to a similar feeling of mistrust of the medical community. Observers believe that the initiative was defeated because "ultimately the fear of a painful and degrading death was overcome by fear of killing by unaccountable physicians" George J. Annas, J.D., M.P.H., *Death By Prescription: The Oregon Initiative*, 331 NEW ENG. J. MED. 1240 (1994).

Given this inconsistent and incomplete history, the physician-assisted suicide question requires careful delineation of and agreement on the identification and scope of the key factors. Such inclusion must take into account the state's compelling interest in protecting the autonomy of patients/consumers when confronted by the powerful economically driven goals of a managed-care environment. Then, once all the critical components of the issue are properly identified, they must be integrated if a true balancing of the rights of all parties is to be achieved.

Critical social decisions regarding the proper levels and distribution of health-care dollars will be demanded with accelerating frequency in a health-care world dominated by managed-care perspectives. Indeed, that is the *raison d'être* of current trends in health-care financing and delivery. Some form of rationing seems inevitable as demands for medical treatment increase both in quantity as the population grows, and in intensity of use as the elderly segment of the population creates an increased demand for limited medical resources. These decisions can best be made if the discussions leading up to them are informed by the inclusion of all relevant factors, especially the neglected economic factors which drive the health-care marketplace.

The legal community has much to contribute to this social discussion, but can effectively do so only if it integrates the various contending concepts. Those concepts include the legal implications of growing economic arrangements which, thus far, have only been applied in isolation from one another. To date, court opinions have neglected to take advantage of the clear and pressing opportunities to do so.

The Supreme Court's decisions in *Compassion in Dying* and *Quill* have merely transferred the debate over assisted-suicide back to the individual states, with the likely result of a continuing debate unlikely to be resolved satisfactorily. By allowing the issue of a state's compelling interest in the economic drivers that directly influence assisted-suicide to remain largely unarticulated, the Supreme Court renders impossible the very type of informed public debate it hopes to achieve by declining to take a stand on the issue. Although the Court's intentions in sending the issue back to the states are laudable, its approach is flawed. The inevitable legacy of the Court's failure to openly address the states' compelling

interests in the emerging managed-care economics that underpin this issue is unfortunate.

The realities of the underlying economic forces of managed care can only be ignored at the peril of all who would argue for, let alone take advantage of, physician-assisted suicide. Failure to integrate managed-care economics into the legal discussions on assisted suicide would be to deny the very personal autonomy rights which many seek to secure for patients. The reason for this is the very autonomy sought to be exercised cannot be invoked if it is only allowed to be considered in a medical environment where the primary source of assisted suicide advice comes from physicians with economic interests that could objectively be at variance with those of the patient.

Ignoring the financial underpinnings of the act of assisting suicide only serves the limited interests of managed-care organizations themselves. These organizations are the only true winners if physician-assisted suicide discussions proceed, as they are currently, in a disconnected fashion. For those who choose to hear them, warning bells are indeed ringing. Currently, however, those bells sound increasingly like managed-care cash registers in the absence of integrated discussions within the legal profession, the legislature, and society itself.