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# Physician-Assisted Suicide in the Context of Managed Care

*Susan M. Wolf\**

The debate about whether to legalize physician-assisted suicide in the United States,<sup>1</sup> and indeed whether the federal Constitution bars state bans on the practice,<sup>2</sup> largely ignores the health care context in which the practice would occur. Increasingly, that context is managed care. Over sixty million Ameri-

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1. See, e.g., NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994); JAMES RACHELS, THE END OF LIFE (1986); Yale Kamisar, *Against Physician-Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735 (1995); Leon R. Kass, *Neither for Love nor Money: Why Doctors Must Not Kill*, PUB. INTEREST, Winter 1989, at 25; Timothy E. Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENGL. J. MED. 1380 (1992); Susan M. Wolf, *Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia*, in FEMINISM & BIOETHICS: BEYOND REPRODUCTION 282 (Susan M. Wolf ed. 1996). See generally Ezekiel J. Emanuel, *Euthanasia: Historical, Ethical, and Empiric Perspectives*, 154 ARCHIVES INTERNAL MED. 1890 (1994) (including physician-assisted suicide); Ezekiel J. Emanuel, *The History of Euthanasia Debates in the United States and Britain*, 121 ANNALS INTERNAL MED. 793 (1994).

2. See, e.g., *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), *en banc*, cert. granted, *Washington v. Glucksberg*, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 96-110); *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), cert. granted, *Vacco v. Quill*, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 95-1858); *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994); RONALD DWORIN, LIFE'S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM (1993); Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, HASTINGS CENTER REP., May-June 1993, at 35; Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey, and the Right to Die*, 44 AM. U. L. REV. 803 (1995); Sylvia A. Law, *Physician-Assisted Death: An Essay on Constitutional Rights and Remedies*, 55 MD. L. REV. 292 (1996); Susan M. Wolf, *Physician-Assisted Suicide, Abortion, and Treatment Refusal: Using Gender to Analyze the Difference*, in PHYSICIAN-ASSISTED SUICIDE: ETHICS, MEDICAL PRACTICE, AND PUBLIC POLICY (Robert Weir ed., forthcoming 1997).

cans receive care through health maintenance organizations ("HMOs").<sup>3</sup> In states heavily penetrated by HMOs, over 30% of the state population with health insurance may be enrolled in an HMO.<sup>4</sup> HMOs are only one kind of managed care organization ("MCO"); preferred provider organizations ("PPOs") and point-of-service plans are two others, both of which allow patients some access to off-plan physicians at increased cost. These three forms of MCO together account for over half of the health insurance market.<sup>5</sup> Both Medicare and Medicaid are now embracing managed care for covered individuals.<sup>6</sup> Even outside of MCOs, fee-for-service indemnity plans increasingly use some managed care techniques to control costs. Indeed, only 4% of the health insurance market remains unmanaged fee-for-service.<sup>7</sup> Between the rise of MCOs and spread of their techniques, managed care has become pervasive.

This forces consideration of how cost-containment efforts and other features of managed care would affect the use of assisted suicide<sup>8</sup> if it were legalized. An emerging literature expresses considerable anxiety at the prospect.<sup>9</sup> Sulmasy notes that

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3. See Robert Pear, *Stakes High as California Debates Ballot Issues to Rein in H.M.O.'s*, N.Y. TIMES, Oct. 3, 1996, at A1, A11 (noting that "more than 60 million Americans now in H.M.O.'s and 90 million in other forms of managed care"); see also GROUP HEALTH ASS'N OF AMERICA (GHAA), 1995 NATIONAL DIRECTORY OF HMOs 21, 26, 56 (1995) [hereinafter GHAA] (over 51 million by year-end 1994); AMERICAN MEDICAL ASSOCIATION, TRENDS IN US HEALTH CARE 92 (4th ed. 1995) [hereinafter AMA]. "19.5% of the population. . . were HMO members at year-end 1994." GHAA, *supra* at 19.

4. See AMA, *supra* note 3, at 93 (listing five states plus D.C. with over 30% HMO enrollment in 1993); see also DOROTHY A. JENSEN ET AL., REFORMING THE HEALTH CARE SYSTEM: STATE PROFILES 1994 at 31 (American Association of Retired Persons (AARP), 1994). "In 14 major metropolitan areas, more than 60% of the employed, insured, and under-65 population were enrolled in an HMO in 1994." GHAA, *supra* note 3, at 19.

5. See AMA, *supra* note 3, at 95 (53% total in 1993); HEALTH INSURANCE ASSOCIATION OF AMERICA (HIAA), SOURCE BOOK OF HEALTH INSURANCE DATA: 1994 at 26 (1995) (51% in 1993).

6. See, e.g., Diane Rowland & Kristina Hanson, *Medicaid: Moving to Managed Care*, HEALTH AFF., Fall 1996, at 150; W. Pete Welch, *Growth in HMO Share Of The Medicare Market, 1989-1994*, HEALTH AFF., Fall 1996, at 201.

7. See AMA, *supra* note 3, at 95 (in 1993, 43% of the health insurance market was managed fee-for-service and 4% was unmanaged; in 1988, the numbers were 42% and 29% respectively).

8. Throughout this article, "assisted suicide" shall mean physician-assisted suicide. This is the form of assisted suicide litigated in *Compassion in Dying* and *Quill*. This author does not here consider suicide assisted by a family member or other non-physician.

9. See Leonard M. Fleck, *Just Caring: Assisted Suicide and Health Care Rationing*, 72 U. DET. MERCY L. REV. 873 (discussing Sulmasy's argument and coming to different conclusions); Tony Smith, *Cheap, Managed Death*, 310 BRIT. MED. J. 744 (1995) (noting: "It must be wrong for doctors or other health professionals to have a financial incentive for their patients to die sooner rather than later."); Donald E. Spencer, *Practical Implications for Health Care Providers in a Physician-Assisted Suicide Environment*, 18 SEATTLE U. L. REV. 545, 550 (1995); Daniel P. Sulmasy, *Managed Care and Managed*

assisted suicide and euthanasia "would be. . . chillingly effective way[s] to control the costs of managed care."<sup>10</sup> Callahan similarly remarks, "[o]ne's ear does not have to be very close to the ground to hear it said that legalizing physician-assisted suicide could help hold down the costs of health care for the elderly."<sup>11</sup> Alpers and Lo more specifically worry that "it may serve the interests of a physician or a managed care plan to provide a quick and inexpensive lethal prescription rather than palliative care, which can be emotionally difficult, time consuming, and expensive."<sup>12</sup> Other individuals express concern that "pressure will. . . be put on the long dying,"<sup>13</sup> and that "[l]egalizing physician-assisted suicide, particularly in a profit-driven system of managed care, could invite abuses."<sup>14</sup> Moreover, legalizing assisted suicide could "put the most vulnerable patients at high risk of involuntary euthanasia."<sup>15</sup>

To be sure, there are other commentators more sanguine. One such commentator speculates that MCOs will not encourage assisted suicide or euthanasia because it would be bad for public relations and discourage managed care enrollment.<sup>16</sup> Another argues that currently "there is no evidence that. . . [MCOs] are hastening the deaths of their sickest, highest-cost patients to save money."<sup>17</sup> Some commentators are even hopeful that man-

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*Death*, 155 ARCHIVES INTERNAL MED. 133 (1995). The anxiety is not limited to experts. A cartoon by Don Wright in *The Palm Beach Post* depicts a physician standing by a patient's bed and saying to a nurse, "[h]er HMO coverage ran out! They recommend a physician-assisted suicide!" Reprinted in N.Y. TIMES, Apr. 14, 1996, §4 (Week in Review), at 4.

10. Sulmasy, *supra* note 9, at 135.

11. Daniel Callahan, *Controlling the Costs of Health Care for the Elderly—Fair Means and Foul*, 335 NEW ENGL. J. MED. 744, 745 (1996); see also Daniel Callahan, *Vital Distinctions, Mortal Questions: Debating Euthanasia & Health Care Costs*, 115 COMMONWEAL 397, 399 (1988). Callahan's articles are part of a literature arguing that health care rationing, whether or not in the context of managed care, carries the danger of pushing patients and physicians toward assisted suicide and euthanasia. See, e.g., George Dunea, *Thinking the Unthinkable: Rationing and Assisted Suicide*, 305 BRIT. MED. J. 720 (1992); Fleck, *supra* note 9.

12. Ann Alpers & Bernard Lo, *Physician-Assisted Suicide in Oregon: A Bold Experiment*, 274 JAMA 483, 484 (1995).

13. Diane Johnson, *Assisted Suicide: Where the Law Should Not Tread*, L.A. TIMES, May 12, 1996, at M1.

14. Bob Groves, *U.S. Shouldn't OK Assisted Suicide, Experts Say: Profit Motive Could Put Patients at Risk, They Warn*, BERGEN RECORD, May 18, 1995, at N09.

15. *Id.*

16. Gordon Slovit, *'U' Researcher Takes on Critics of Managed Care; Minnesota Citizens Concerned for Life Said Bureaucrats, not Physicians, Are Making Medical Decisions*, STAR TRIBUNE, June 28, 1996, at 10A (quoting Ezekiel Emanuel).

17. *Id.* (reporting on comments by Steven Miles). See also Steven Miles, *Does "Managed Care" Endanger Sick People by Denying Life-preserving Care such that Managed Care is a Corporate Form of Involuntary Euthanasia?* (1996) (unpublished manuscript on file with the author).

aged care can improve dying by discouraging overtreatment, making sure that providers obey patients' advance directives that refuse treatment, formulating practice guidelines along these lines, and overseeing the full range of services a patient receives.<sup>18</sup>

With no state having legalized assisted suicide and institutionalized the practice yet,<sup>19</sup> we have no data in hand to resolve the issue of how legalized assisted suicide would work in the context of managed care. Oregon's 1994 legalization of one form of assisted suicide might have yielded data and permitted managed care/nonmanaged care comparison, but the statute has been tied up in litigation and has not yet gone into effect.<sup>20</sup> A recently reported survey of internists provocatively finds that "physicians who tend to practice resource conserving medicine are significantly more likely. . .to report a willingness to provide a lethal prescription at the request of a terminally ill patient."<sup>21</sup> Such early data, however, are primarily an invitation to further research.

There nonetheless are data from which to piece together the likely picture. In Part I, this article considers what is known about the role of physicians in MCOs, and what this predicts for physicians' involvement in assisted suicide. Managed care typically imposes on physicians financial and organizational incentives quite different from those in fee-for-service medicine. This has led to a raging controversy over the ethics that should guide physicians in managed care. Neither the *Compassion in Dying* nor *Quill* opinion now going to the Supreme Court shows any awareness of this controversy. Indeed, the Ninth Circuit in *Compassion in Dying* relied on antiquated assumptions about physicians' behavior in order to minimize state interests that might otherwise support a ban on assisted suicide. Thus, the court assumed that the state's "strong interest in avoiding undue influence and other forms of abuse . . . [was] ameliorated in large

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18. See Ann Fade & Karen Kaplan, *Managed Care and End of Life Decisions*, 10 TRENDS HEALTH CARE L. & ETHICS 97 (1995); Steven H. Miles et al., *End-of-Life Treatment in Managed Care: The Potential and the Peril*, 163 W. J. MED. 302 (1995); R. Sean Morrison & Diane E. Meier, *Managed Care At The End Of Life*, 10 TRENDS HEALTH CARE L. & ETHICS 91 (1995).

19. See ALAN MEISEL, 2 THE RIGHT TO DIE 478 (2d ed. 1995); *Quill*, 80 F.3d at 724. Oregon is the only state so far to legalize assisted suicide, but litigation has prevented the statute from going into effect. See *infra* note 20.

20. OR. REV. STAT. §§ 127.800-.897 (Supp. 1996, part 2); Lee v. Oregon, 869 F. Supp. 1491 (D. Or. 1994), *injunction issued*, 891 F. Supp. 1439 (1995), *appeal argued*, No. 95-35804 (9th Cir. July 9, 1996).

21. B.P. Linas et al., *Use of Medical Resources and Physician Willingness to Participate in Assisted Suicide* (1996) (abstract) (on file with the author).

measure because of the . . . involvement . . . of physicians, who have a strong bias in favor of preserving life."<sup>22</sup> The Ninth Circuit repeatedly asserted that physicians would "provide. . .[a] safeguard against abuse," resisting assisted suicide if the patient's suffering could be alleviated or the patient's situation could be made tolerable.<sup>23</sup> Based on assumptions about physicians' inclinations, "conservative nature" and ethics,<sup>24</sup> the court dismissed the idea that the state's acknowledged interests might justify a ban.

These unsupported assumptions require close scrutiny in the era of managed care. In fact, the actual incentives found in MCOs suggest the Ninth Circuit is wrong. Physicians in managed care may have strong incentives to perform assisted suicide, rather than to act as a safeguard.

In Part II, this article considers whether MCOs would further drive patients to assisted suicide through systemic neglect, that is, failing to respond to the problems that motivate patients to consider assisted suicide. Numerous studies have reported on why patients request assisted suicide, both in the United States and in the Netherlands where assisted suicide and euthanasia are legally tolerated.<sup>25</sup> Examining the role of a patient's depression, in particular, allows assessment of how well MCOs deal with this risk factor now, and thus a prediction as to whether managed care would propel patients toward assisted suicide.

Finally, in Part III, this article examines how these predictions bear on the constitutional controversy surrounding assisted suicide now bubbling through the courts, as well as the policy question of whether to legalize assisted suicide that now faces legislatures and the electorate.

This article concludes that there is ample reason to suspect that the dangers of assisted suicide are heightened in managed care contexts. Yet, there is also reason for caution here. This analysis is no effort to demonize managed care. Indeed, the arti-

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22. *Compassion in Dying*, 79 F.3d at 837.

23. *Id.* at 826-27.

24. *Id.* at 827.

25. Assisted suicide and euthanasia remain criminal in the Netherlands, but generally are not prosecuted when they fall within guidelines articulated by the courts, codified by the Royal Dutch Medical Association, and subsequently rearticulated in legislation. For explanation of the legal status of the practices in the Netherlands, see, e.g., MARGARET PABST BATTIN, *A Dozen Caveats Concerning the Discussion of Euthanasia in the Netherlands*, in *THE LEAST WORST DEATH: ESSAYS IN BIOETHICS ON THE END OF LIFE* 130-31 (1994). On the most recent statute, see G. K. Kimmsa, *Infanticide and the Vulnerable Newborn: The Dutch Debate*, 2 *CAMBRIDGE Q. HEALTHCARE ETHICS* 259 (1993). In addition, the Northern Territory of Australia has legalized euthanasia and assisted suicide. On the first euthanasia performed under that new law, see *Australian Man First in World to Die with Legal Euthanasia*, N.Y. TIMES, Sept. 26, 1996, at A5.

cle assumes below that many physicians will resist the built-in incentives. It would be a mistake, however, to ignore the incentives that already exist in managed care and the evidence of where managed care falls short. The question is whether assisted suicide should be added to that mix.

A straightforward analysis of the financial incentives impinging on managed care physicians suggests that those incentives would provide motivation for performing assisted suicide. The evidence that MCOs do not deal well with depression, the primary problem leading patients to seek assisted suicide, suggests that systemic problems would move patients in the direction of assisted suicide as well. Thus, even if the courts find a constitutionally protected interest in assisted suicide, both of the above-mentioned factors substantially heighten countervailing state interests. Indeed, it is difficult to see how states could devise adequate safeguards in a system increasingly dominated by managed care. At a minimum, neither the courts' constitutional analysis nor the legislatures' determination of whether to legalize assisted suicide should proceed without considering the dangers of assisted suicide in the context of managed care.

## I. INCENTIVES FOR PHYSICIANS

MCOs combine the insurer and health care provider functions otherwise kept separate in fee-for-service systems.<sup>26</sup> These organizations thus marry the insurer's cost-consciousness with the provider's mission of patient care. This grounds the frequently articulated hope that MCOs can be a significant engine of health care cost containment.<sup>27</sup>

In their effort to care for a given population and achieve cost containment, MCOs can be organized in a variety of ways.<sup>28</sup> They also can operate in most states on a for-profit or nonprofit basis.<sup>29</sup> Among the advantages of for-profit MCO status is the

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26. See, e.g., ROBERT G. SHOULDICE, INTRODUCTION TO MANAGED CARE 12-13 (rev. ed. 1991); Marc A. Rodwin, *Managed Care and Consumer Protection: What Are the Issues?*, 26 SETON HALL L. REV. 1007, 1009 n.1 (1996).

27. See, e.g., Michele M. Garvin, *Health Maintenance Organizations*, HEALTH CARE CORPORATE LAW: MANAGED CARE 1-4 (Mark A. Hall & William S. Brewbaker III eds. 1996). MCOs are thus a common feature of health care reform proposals. See, e.g., *id.*; John K. Iglehart, *The Struggle Between Managed Care and Fee-for-Service Practice*, 331 NEW ENGL. J. MED. 63 (1994).

28. Typologies abound. See, e.g., SHOULDICE, *supra* note 26, at 91-132; Robert E. Hurley & Deborah A. Freund, *A Typology of Medicaid Managed Care*, 26 MED. CARE 764 (1988); Jonathan P. Weiner & Gregory de Lissvooy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL. POL'Y & L. 74 (1993).

29. See Garvin, *supra* note 27, at 1-32. Minnesota is one state that requires MCOs to be nonprofit. See MINN. STAT. §62D.02(4)(a) (1996).

ability to offer physicians and others ownership interests. As noted by Garvin, "[p]hysician ownership provides the physician with a financial incentive to manage care and control costs and also generates physician loyalty to the HMO."<sup>30</sup>

How care will actually be provided and costs actually controlled is determined by a number of arrangements. When an employer contracts with a MCO to offer care to employees, and when an individual subscribes to the MCO's health plan, a set of contracts and relationships will determine what treatments will be covered. The individual's and employer's contracts with the MCO and the MCO's contracts with physicians and other providers all bear on the coverage, against a background of state and federal requirements. Those arrangements bear not only on coverage, however, but also on what treatments a physician will even offer to patients, which treatment the physician will enthusiastically endorse, the physician's practice style, and the doctor-patient relationship formed.

This result flows from the range of incentives MCOs impose on physicians to contain costs.<sup>31</sup> The foremost incentive is capitation, paying physicians or physician groups a set fee per patient per year so that excess costs are borne by that physician or group.<sup>32</sup> Capitation places the financial risk of what the MCO may regard as overtreatment on the physicians treating the patient. Capitation is meant to create an incentive for physicians to consider treatment costs and to curb their practice styles in order to minimize costs beyond those that the MCO will fund.

Capitation is coupled with gatekeeping.<sup>33</sup> Each patient must choose a primary care physician. It is then the responsibility of the primary care physician to determine when to refer the patient to other physicians for more specialized care. The patient's only access to specialists and subspecialists is through this gatekeeper. With the gatekeeper bearing the brunt of capitation, there is an incentive not to refer patients to specialists.

Other MCO techniques are intended to create further incentives in the same direction. Physicians may receive bonuses for keeping patient hospitalizations or referrals to specialists below

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30. Garvin, *supra* note 27, at 1-33.

31. For a list of incentives, see Alan L. Hillman et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 *New Engl. J. Med.* 86, 88 (1989).

32. See Thomas S. Bodenheimer & Kevin Grumbach, *Capitation or Decapitation: Keeping Your Head in Changing Times*, 276 *JAMA* 1025 (1996); Marsha R. Gold et al., *A National Survey of the Arrangements Managed Care Plans Make with Physicians*, 333 *NEW ENGL. J. MED.* 1678 (1995).

33. See Gold et al., *supra* note 32.



a certain level.<sup>34</sup> A portion of physician compensation may be withheld, with later payment of that portion conditioned on the physician's meeting the target levels.<sup>35</sup>

Physician employment contracts may further contain "gag clauses" forbidding discussion with patients of treatments off-plan or not yet approved by the MCO's utilization review office.<sup>36</sup> These "gag clauses" may also prohibit physician disclosure of the physician's arrangements with the MCO and the set of financial incentives that the MCO has placed on the physician.<sup>37</sup> Even when there is no governing "gag clause," MCO emphasis on cost-containment has led to a debate about whether physicians should withhold from patients information about treatment options not covered by the health plan.<sup>38</sup>

All of these financial incentives and restrictions<sup>39</sup> are also backed up by the health plan's authority to approve or disapprove coverage for treatment. Plans pervasively require utilization review in order to examine treatment prospectively, concurrently, or retrospectively and determine whether the MCO will pay for the treatment.<sup>40</sup> This creates a mechanism for blocking treatment coverage, even if the physician recommends the treatment. It also forces physicians to decide when to go to bat for the patient and advocate reversal of coverage denial.<sup>41</sup>

Physicians in MCOs thus face profound conflicts of interest.<sup>42</sup> Should those physicians serve the individual patient's needs, or

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34. See *id.*

35. See Bodenheimer & Grumbach, *supra* note 32, at 1027; Gold et al., *supra* note 32.

36. See Steffie Woolhandler & David Himmelstein, *Extreme Risk—The New Corporate Proposition for Physicians*, 333 NEW ENGL. J. MED. 1706 (1995); Robert Pear, *The Tricky Business of Keeping Doctors Quiet*, N.Y. TIMES, Sept. 22, 1996, § 4 (Week in Review), at 7. Sixteen states have thus far banned or limited "gag clauses," with federal action also being considered by Congress. See Robert Pear, *Laws Won't Let H.M.O.'s Tell Doctors What to Say*, N.Y. TIMES, Sept. 17, 1996, at A12.

37. See Pear, *The Tricky Business of Keeping Doctors Quiet*, *supra* note 36. The AMA advocates health plan disclosure of "[a]ny incentives to limit care." See Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*, 273 JAMA 330, 335 (1995) [hereinafter AMA Report]; see also Douglas F. Levinson, *Toward Full Disclosure of Referral Restrictions and Financial Incentives by Prepaid Health Plans*, 317 NEW ENGL. J. MED. 1729 (1987).

38. Compare Mark A. Hall, *Informed Consent to Rationing Decisions*, 71 MILBANK Q. 645 (1993) with Paul S. Appelbaum, *Must We Forgo Informed Consent to Control Health Care Costs? A Response to Mark A. Hall*, 71 MILBANK Q. 669 (1993).

39. This list is not exhaustive. For others, see, e.g., Gold et al., *supra* note 32; Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENGL. J. MED. 604, 605-06 (1995).

40. See, e.g., SHOULDICE, *supra* note 26, at 67, 78-82, 178.

41. For discussion of this, see Susan M. Wolf, *Health Care Reform and the Future of Physician Ethics*, HASTINGS CENTER REP., Mar.-Apr. 1994, at 28, 35-36.

42. See generally BRADFORD H. GRAY, *THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS* (1991); MARC A. RODWIN,

join the MCO in conserving resources to serve the whole covered population? Should they seek necessary treatment for each patient even when it runs contrary to their own financial interests? In short, should the physicians abandon the traditional physician commitment to place the needs of the individual patient above all?

The seriousness of this challenge to the traditional fiduciary ethics of the doctor-patient relationship and to a relationship based on patient trust has been widely recognized.<sup>43</sup> The American Medical Association ("AMA") urges physicians to continue placing patient needs above everything else and to reject arrangements that encourage substandard care.<sup>44</sup> The AMA also argues that some financial incentives imposed on physicians in MCOs are unethical.<sup>45</sup> Yet, controversy abounds in this arena. There are no settled answers as to how physicians should act in MCOs and what incentives MCOs may impose upon physicians. The debate about physician ethics is matched by debate over

MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST (1993); Alan L. Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?*, 317 *NEW ENGL. J. MED.* 1743 (1987).

To be sure, physicians rendering fee-for-service care face financial incentives to provide more and more treatment. This certainly subjects the patient to the risks of over-treatment. Yet this does not present the acute conflict of interest seen in MCOs for two reasons. First, patients' interests generally lie in the direction of receiving access to treatment. If the physician recommends excessive treatment, the patient can always say no. This is an imperfect safeguard because the patient may not always be able to tell what is excessive. However, here is the second reason why fee-for-service care is different: the patient can readily grasp that figuring out when to say no is the problem. In other words, the physician's financial interest in supplying more treatment will usually be obvious to the patient. In contrast, the patient coming to a MCO physician will similarly expect the physician to place the patient's interests in gaining access to treatment first, but rarely will arrive understanding the conflicts of interest MCOs systematically erect for physicians. And MCO "gag clauses" in physician contracts, in states where they are not yet banned, will forbid physicians from discussing these conflicts. *See supra* note 36. Even where a "gag clause" is not in play, it is a tall order to expect physicians to broach their fundamental conflicts as set up by the employing organization. Most importantly, the incentives in MCOs will discourage treatment, often without the patient ever realizing that a relevant treatment has not been discussed or offered. *Cf.* AMA Report, *supra* note 37, at 333-35 (condemning incentives that discourage appropriate and inappropriate treatment alike).

43. *See, e.g.*, E. HAIVI MORREIM, *BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS* (1995); Carolyn M. Clancy & Howard Brody, *Managed Care: Jekyll or Hyde?*, 273 *JAMA* 338 (1995); AMA Report, *supra* note 37; Ezekiel J. Emanuel, *Medical Ethics in the Era of Managed Care: The Need for Institutional Structures Instead of Principles for Individual Cases*, 6 *J. CLIN. ETHICS* 335 (1995); Ezekiel J. Emanuel & Nancy Neveloff Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 *JAMA* 323 (1995); Rodwin, *Conflicts in Managed Care*, *supra* note 39; Wolf, *Health Care Reform and the Future of Physician Ethics*, *supra* note 41.

44. AMA Report, *supra* note 37, at 332-35.

45. *Id.* at 333-35.

whether MCOs as health care organizations have any ethical obligations of their own.<sup>46</sup> Both controversies rage.

What is known is that the financial incentives work. The incentives are correlated with changes in physician behavior.<sup>47</sup> Additionally, it is known that MCOs create a practice environment placing great emphasis on cost-containment.<sup>48</sup> The issue now is what is this likely to mean for the practice of physician-assisted suicide?

It may mean a great deal. The bulk of patients who currently express interest in assisted suicide have cancer or AIDS.<sup>49</sup> Both of these illnesses are expensive to treat and can extend for quite some time. It is common for patients with these and other serious diagnoses to have thoughts about suicide, assisted suicide, and euthanasia.<sup>50</sup>

Working with a patient who has cancer, AIDS, or any life-threatening condition can be challenging for a physician.<sup>51</sup> If assisted suicide were legalized, however, the challenges would be even greater.<sup>52</sup> The physician would have to determine when, if ever, to raise the possibility of assisted suicide with the patient. Should the physician wait for the patient to raise the issue or mention assisted suicide as one of a number of treatment options? And if the patient, like many, raises the issue of assisted suicide while initially staggering under the burden of a devastating diagnosis, or later when the pain relief stops work-

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46. See, e.g., AMA Report, *supra* note 37, at 334-35; Nancy S. Jecker, *Business Ethics and the Ethics of Managed Care*, 10 TRENDS HEALTH CARE L. & ETHICS 53 (1995); Wolf, *Health Care Reform and the Future of Physician Ethics*, *supra* note 41, at 37-38.

47. See Hillman et al., *supra* note 31. Cf. Bruce J. Hillman et al., *Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population*, 268 JAMA 2050 (1992) (providing that physician part-ownership of a facility affects the physician's rate of patient referral to that facility); Jean M. Mitchell & Elton Scott, *Physician Ownership of Physical Therapy Services: Effects on Charges, Utilization, Profits, and Service Characteristics*, 268 JAMA 2055 (1992).

48. See generally SHOULDICE, *supra* note 26, at 18.

49. See Anthony L. Black et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 921 (1996) (physicians reporting that among patients who were terminal, i.e., expected to live less than six months, most (73%) who requested assisted suicide or euthanasia had cancer or AIDS); cf. Paul J. van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 LANCET 669, 672 (1991) (noting that 68% of those euthanized and 54% of those who died by assisted suicide in the Netherlands had cancer).

50. See, e.g., Black et al., *supra* note 49, at 923-24; William Breitbart et al., *Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 AM. J. PSYCHIATRY 238 (1996).

51. See, e.g., ROBERT A. BURT, TAKING CARE OF STRANGERS (1979); JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).

52. See Steven H. Miles, *Physicians and Their Patients' Suicides*, 271 JAMA 1786 (1994).

ing, or perhaps when the MCO denies coverage for a treatment or hospice, what should the physician's response be?

For a physician faced with a patient considering assisted suicide, the incentives MCOs use would reward the physician for encouraging the act. Those incentives would discourage and even penalize a physician for offering yet another treatment possibility to the patient, devoting substantial resources to working out a new pain relief or palliative care regimen, or fighting for the patient's access to that treatment or hospice. Even if assisted suicide were instituted with safeguards such as a required second opinion or psychiatric consult, it would still likely be less costly than those alternatives. Thus, it is not surprising to see a study find that physicians with a cost-conserving style report greater willingness to assist patients' suicides.<sup>53</sup>

Certainly, some physicians would resist the managed care incentives to encourage assisted suicide, whether out of rejection of assisted suicide or commitment to try nonfatal alternatives with the patient first. Similarly, some physicians undoubtedly resist the incentive structure of managed care and loyally advocate for their patients. Indeed, the debate on the ethics of managed care includes pleas to physicians to remember that they are professionals with ethical obligations that cannot be bargained away. Whether those professional obligations or the conflicting demands of MCOs will win out, however, is precisely the question.<sup>54</sup> In any case, one cannot build an acceptable system of patient care on the moral sainthood of the few.<sup>55</sup> One certainly could not rely on those few for adequate protections against abuse and error, if all physicians were empowered to assist suicide.

Beyond the general danger of assisted suicide being encouraged and embraced as a cost-saving measure, there is a particular danger for vulnerable subpopulations. It is well documented in studies of medical care generally that certain groups have less satisfactory doctor-patient relationships and receive inferior care.<sup>56</sup> The fact that African Americans and women are among these groups should come as no surprise, as it simply

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53. See Linas et al., *supra* note 21.

54. Analysts have been arguing for some time that physicians are being deprofessionalized. See, e.g., John B. McKinlay & John D. Stoeckle, *Corporatization and the Social Transformation of Doctoring*, 18 INT'L J. HEALTH SERV. 191 (1988).

55. Cf. Susan Wolf, *Moral Saints*, 79 J. PHIL. 419 (1982) (a philosopher arguing the actual undesirability of moral sainthood).

56. See, e.g., Council on Ethical and Judicial Affairs, American Medical Association, *Black-White Disparities in Health Care*, 263 JAMA 2344 (1990); Council on Ethical and Judicial Affairs, American Medical Association, *Gender Disparities in Clinical Decision Making*, 266 JAMA 559 (1991).

means that medicine is not exempt from broader social dynamics and the burden of history. Studies focusing on MCOs, however, add another layer of concern. A recent study, for example, documents that elderly and poor patients have worse physical health outcomes in HMOs than in fee-for-service systems.<sup>57</sup> Those patients “who were younger, relatively healthy, and relatively well-off financially” did well in HMOs, but the “elderly and poor were more than twice as likely to decline” in an HMO than fee-for-service plan.<sup>58</sup>

This raises the concern that MCOs would do more than heighten the risk of error and abuse in assisted suicide for all patients through the incentives and conflicts created. MCOs may differentially raise the risk of vulnerable groups. The elderly and poor “account for a disproportionate share of health care expenditures and are, therefore, prime targets of cost containment.”<sup>59</sup> This suggests that those individuals would also have heightened risk of being urged toward assisted suicide rather than toward the costly care they would otherwise merit.

## II. SYSTEMIC NEGLECT

Beyond the general characteristics of MCOs that would provide incentives for physicians and patients to embrace assisted suicide, there are indications that MCOs have an inferior track record in responding to depression, the leading problem moving patients to consider assisted suicide. Thus, quite apart from the question of physician incentives and conflicts, there is reason to worry that MCOs may not adequately treat an important risk factor for assisted suicide. MCOs may thus drive patients to assisted suicide through systemic neglect.

To examine this, the reasons why patients seek assisted suicide must first be considered. A number of studies have analyzed why patients in the United States request assisted suicide or say that they would want it in the future. These studies come to similar conclusions. A Massachusetts survey of cancer patients found that the “patients who had seriously considered and prepared for euthanasia or physician-assisted suicide were significantly more likely to be depressed,” while “[p]atients experiencing pain were not inclined to” either practice.<sup>60</sup> A New

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57. John E. Ware, Jr. et al., *Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems*, 276 JAMA 1039 (1996).

58. *Id.* at 1046.

59. *Id.* at 1040.

60. Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 LANCET

York study of HIV-infected patients found that those “who expressed interest in physician-assisted suicide reported significantly more depressive symptoms, had higher levels of hopelessness and endorsed more symptoms of global psychological distress.”<sup>61</sup> The researchers, however, discovered no “significant relationships between interest in physician-assisted suicide and pain or other physical variables.”<sup>62</sup>

These results are largely consistent with those from a survey of physicians in Washington State.<sup>63</sup> Focusing on physicians who had received patient requests for assisted suicide or euthanasia and on the physicians’ judgments of why the patients made these requests, the researchers found that the primary patient concerns were nonphysical. The researchers reported that, “[a]s judged by their physicians, patients were most frequently worried about losing control, being a burden, being dependent, and losing dignity. . . .”<sup>64</sup> Additionally, in descending order of importance, patients were worried about being bedridden, depression, suffering, physical discomfort other than pain, pain, and costs.<sup>65</sup>

Moreover, the studies of why patients choose assisted suicide or euthanasia in the Netherlands are generally in line with the U.S. data in showing that pain is not the primary reason. Dutch researchers studying physicians’ assessments of patients’ reasons found that pain was a reason in less than half the cases.<sup>66</sup> Indeed, “[i]n only [ten] . . . cases was pain the only reason.”<sup>67</sup>

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1805, 1809 (1996). These findings on the importance of depression are consistent with studies of suicidality among patients with cancer and the terminally ill. The comparison merits caution, since desire for suicide may not be the same as desire for physician-assisted suicide. Cf. Breitbart et al., *supra* note 50, at 241 (analyzing the overlap, but concluding that “interest in physician-assisted suicide and suicidal ideation [are not] identical constructs”). However, studies of the former similarly point to the importance of clinical depression. See James Henderson Brown et al., *Is It Normal for Terminally Ill Patients to Desire Death?*, 143 AM. J. PSYCHIATRY 208 (1986); Harvey Max Chochinov et al., *Desire for Death in the Terminally Ill*, 152 AM. J. PSYCHIATRY 1185 (1995); D. Saltzburg et al., *The Relationship of Pain and Depression to Suicidal Ideation in Cancer Patients*, 8 PROC. ASCO 312 (1989) (abstract).

61. Breitbart et al., *supra* note 50, at 240.

62. *Id.* at 241.

63. Black et al., *supra* note 49.

64. *Id.* at 921. A Utah study asking relatives and other survivors after a patient’s death whether the decedent would have wanted assisted suicide or euthanasia similarly found that a positive answer was associated largely with nonphysical concerns (“religion, religiosity, type of illness, and certain life situations”), rather than with “inadequate comfort measures or pain control.” Jay A. Jacobson et al., *Decedents’ Reported Preferences for Physician-Assisted Death: A Survey of Informants Listed on Death Certificates in Utah*, 6 J. CLIN. ETHICS 149, 150 (1995).

65. *Id.* at 922.

66. van der Maas et al., *supra* note 49, at 672.

67. *Id.*

A second team of Dutch researchers surveyed family physicians and obtained similar results.<sup>68</sup> The physicians reported that the patients' reasons for requesting assisted suicide or euthanasia included "[f]utile suffering" in over half the cases. When researchers asked which was the most important reason, "[f]utile suffering," humiliation, and "[u]nbearable suffering" were on top, pain was in sixth place, and "[f]ear of/avoidance of pain" was last.<sup>69</sup> A survey of nursing home physicians likewise found that the main reasons reported for patients' requests concerned fear of deterioration, fear of suffocation, suffering, and only then pain.<sup>70</sup>

Both the Dutch and U.S. studies thus indicate that depression and nonphysical factors are more important in motivating patients to request assisted suicide and euthanasia than pain and other physical symptoms.<sup>71</sup> The latter concerns, however, remain relevant. A substantial body of published work supports the inclusion of uncontrolled pain and physical symptoms on the list of reasons why patients may wish assisted suicide, even if these symptoms are not at the top of that list.<sup>72</sup>

All of this raises the question of how well MCOs handle the type of problems that apparently motivate patients to seek assisted suicide. Consolidating the list of problems researchers have identified yields three categories: depression, suffering, and pain. Comparing the performance of MCOs to fee-for-service systems in dealing with these problems is not simple; there are tre-

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68. G. van der Wal et al., *Euthanasia and Assisted Suicide. II. Do Dutch Family Doctors Act Prudently?*, 9 FAM. PRAC. 135 (1992).

69. *Id.* at 138.

70. M. T. Muller et al., *Voluntary Active Euthanasia and Physician-Assisted Suicide in Dutch Nursing Homes: Are the Requirements for Prudent Practice Properly Met?*, 42 J. AM. GERIATRICS SOC. 624, 626 (1994). The full roster of reasons named (apart from how often each was the "main" reason) was: "Unbearable suffering" (53%); "Hopeless suffering" (49%); "Fear of/avoidance of deterioration of condition" (40%); "Fear of further suffering" (28%); "Fear of suffocation" (28%); "Pain" (29%); "Not wanting to be dependent on others any longer" (24%); "Tired of life" (19%); "Fear of/prevention of pain" (6%); "Not wanting to be a burden on relatives any longer" (4%); and "Other" (18%). *Id.*

71. Unfortunately, neither set of Dutch researchers included "depression" as one of their categories, to aid cross-cultural comparison. Some of the categories reported, such as "[t]iredness of life" may be linked to depression, but one cannot tell. However, the controversial case of Dr. Chabot, a psychiatrist who assisted the suicide of a physically healthy but depressed patient, made public the question of whether depression was adequate reason for assisting suicide in the Netherlands. For commentary, see, e.g., Alan D. Ogilvie & S. G. Potts, *Assisted Suicide for Depression: The Slippery Slope in Action?*, 309 BRIT. MED. J. 492 (1994).

72. See, e.g., Walter F. Baile et al., *The Request for Assistance in Dying: The Need for Psychiatric Evaluation*, 72 CANCER 2786 (1993); Nathan I. Cherny et al., *The Treatment of Suffering When Patients Request Elective Death*, 10 J. PALLIATIVE CARE 71 (1994); Kathleen M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. PAIN & SYMPTOM MGMT. 289 (1991).

mendous debates about how to measure health care quality.<sup>73</sup> Thus some studies focus on which patient population gets more services, while others try to compare treatment outcomes.<sup>74</sup> Yet, the literature bearing on these three problems teaches some lessons, especially the literature on depression.

Certainly there are interventions at which MCOs seem to excel, such as various forms of preventive screening.<sup>75</sup> When it comes to treatment of depression, however, there is evidence that MCOs fall short. In general, “[d]epression. . . is associated with high rates of service utilization and therefore high costs.”<sup>76</sup> Thus, one would expect health plans that emphasize cost containment to approach it somewhat differently.

That is indeed what one sees. Evaluating treatment of depression entails analysis of detection rates, the treatment provided, and outcomes. Wells et al. have assessed detection in three different practice settings, all of which included at least some practitioners being paid on a prepaid basis, thus creating incentives to limit treatment.<sup>77</sup> They found that “patients . . . receiving prepaid care were less likely to have their depression detected or treated.”<sup>78</sup> Somewhat lower detection rates are cited elsewhere as well.<sup>79</sup>

Once detected, the way depression is treated appears to be different in managed care settings. Researchers have found that prepaid plans control the costs of outpatient mental health care through “fewer visits per user and. . . greater reliance on group. . . therapy and on nonphysician providers.”<sup>80</sup> Stewart et al. comment on substantial differences in treatment style, with HMOs providing “much less intensive and less costly” treat-

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73. This author reviews much of this literature in Susan M. Wolf, *Quality Assessment of Ethics in Health Care: The Accountability Revolution*, 20 AM. J. L. & MED. 105 (1994).

74. Compare, e.g., Kenneth B. Wells et al., *Use of Outpatient Mental Health Services in HMO and Fee-for-Service Plans: Results from a Randomized Controlled Trial*, 21 HEALTH SERVICES RES. 453 (1986) with William H. Rogers et al., *Outcomes for Adult Outpatients with Depression Under Prepaid or Fee-for-Service Financing*, 50 ARCHIVES GEN. PSYCHIATRY 517 (1993).

75. See Robert H. Miller & Harold S. Left, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512 (1994).

76. Roland Sturm et al., *Mental Health Care Utilization in Prepaid and Fee-for-Service Plans Among Depressed Patients in the Medical Outcomes Study*, 30 HEALTH SERVICES RES. 319, 320 (1995) (citations omitted).

77. Kenneth B. Wells et al., *Detection of Depressive Disorder for Patients Receiving Prepaid or Fee-for-Service Care*, 262 JAMA 3298 (1989).

78. *Id.* at 3300.

79. See, e.g., Kenneth B. Wells & Roland Sturm, *Care for Depression in a Changing Environment*, HEALTH AFF., Fall 1995, at 78, 84-85.

80. Rogers et al., *supra* note 74, at 517 (citing Wells et al., *supra* note 74). See also Sturm et al., *supra* note 76, at 321.



ment.<sup>81</sup> The Sturm et al. study found that "depressed prepaid patients obtained substantially fewer mental health services than similar patients in fee-for-service care."<sup>82</sup>

Turning to outcomes, Rogers et al. found that outcomes were worse for depressed patients of psychiatrists with prepaid rather than fee-for-service financing.<sup>83</sup> This contrasted with a lack of outcome differences for patients receiving nonpsychiatrist care, a population that the researchers interpreted to have less psychological sickness.<sup>84</sup> Consequently, the different mix of providers offered by MCOs seems significant.<sup>85</sup> Indeed, a number of authors report suicides and attempted suicides among managed care patients facing barriers to more intensive care.<sup>86</sup>

Thus, the picture is not reassuring when one considers how well MCOs are doing in treating depression. What about treatment of suffering and pain? Here, the evidence is more sketchy.

Assessing managed care's treatment of suffering is difficult. "Suffering" includes a wide range of phenomena, from physical discomfort that is not pain (such as nausea or shortness of breath), to suffering over the conditions of one's existence (such as dismay over being bedridden), to suffering in a more spiritual sense (such as over the perceived meaninglessness of one's life). Thus, comparing MCOs with fee-for-service along this dimension would be an ambitious undertaking, which is not yet reflected in the literature. The literature does shed light on the accessibility of hospice, however, which is a treatment modality that specializes in addressing suffering as well as pain at the end of a patient's life.<sup>87</sup>

This literature suggests that although a hospice benefit is increasingly available within MCOs, it is not universally avail-

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81. Anita L. Stewart et al., *Do Depressed Patients in Different Treatment Settings Have Different Levels of Well-Being and Functioning?*, 61 J. CONSULTING & CLIN. PSYCHOL. 849, 849 (1993).

82. Sturm et al., *supra* note 76, at 332.

83. Rogers et al., *supra* note 74.

84. See also Wells & Sturm, *supra* note 79, at 84-85. Similarly, Ware et al. do not find differences in mental health outcomes for chronically ill patients in HMO and fee-for-service settings, but they do not report analyses by type of provider and they note significant variation by HMO. Ware et al., *supra* note 57, at 1044.

85. See Stewart et al., *supra* note 81.

86. See David J. Rissmiller et al., *Factors Complicating Cost Containment in the Treatment of Suicidal Patients*, 45 HOSP. & COMMUNITY PSYCHIATRY 782, 784 (1994) (citing Daniel B. Borenstein, *Managed Care: A Means of Rationing Psychiatric Treatment*, 41 HOSP. & COMMUNITY PSYCHIATRY 1095 (1990); Nicole Lurie et al., *Does Capitation Affect the Health of the Chronically Mentally Ill? Results from a Randomized Trial*, 267 JAMA 3300 (1992); J. Westermeyer, *Problems with Managed Psychiatric Care Without a Psychiatrist-Manager*, 42 HOSP. & COMMUNITY PSYCHIATRY 1221 (1991)).

87. On hospice, see generally Jill Rhymes, *Hospice Care in America*, 264 JAMA 369 (1980).

able.<sup>88</sup> Moreover, mere approval of a patient's entrance into a hospice program does not guarantee the MCO will then approve specific treatments for the patient that may be relevant.<sup>89</sup> In addition, MCO coverage of hospice has been attributed to the cost savings that can be realized by steering terminally ill patients away from acute hospital care to hospice care.<sup>90</sup> Yet, there is a growing debate on whether hospice care indeed generates significant savings at the end of life.<sup>91</sup> This raises the question of whether MCO enthusiasm for hospice care may dampen in the future, and hospice benefits decrease. None of this analysis is a substitute for an in-depth empirical picture of how well MCOs do in providing hospice benefits and more broadly in addressing patient suffering. It does suggest, however, that one area of concern is whether MCOs will continue to regard hospice coverage as in their financial interests.

Finally, research on access to pain relief is still in its infancy. The Cancer Pain Panel of the United States Agency for Health Care Policy and Research reported in 1994 that "[c]ost issues have been minimally explored," in part because pain relief in the past was limited to oral administration or intramuscular injection of medication, which are both relatively inexpensive.<sup>92</sup> The inadequacy of the old approach has been documented, with large numbers of patients undermedicated and many experiencing substantial pain.<sup>93</sup> Pain relief has thus now become a focus for research and far more sophisticated. As two authors have noted: "Current treatment options for cancer pain. . . range from the orally administered opioid to the epidural opioid with an implanted infusion device."<sup>94</sup>

Just as research on pain is in its infancy, research on how well or poorly MCOs do in treating pain similarly seems to be at an

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88. See Judith Randall, *Hospice Services Feel the Pinch of Managed Care*, 88 J. NAT'L CANCER INST. 860 (1996). Note that Medicare offers a hospice benefit to covered patients. See Rhymes, *supra* note 87, at 369.

89. See Scott Becker & Robert J. Pristave, *Managed Care and the Provision of Hospice Care*, 3 MANAGED CARE Q. 39, 42 (1995); Randall, *supra* note 88, at 861.

90. See *id.* at 39, 42.

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

92. Betty R. Ferrell & Hurdis Griffith, *Cost Issues Related to Pain Management: Report from the Cancer Pain Panel of the Agency for Health Care Policy and Research*, 9 J. PAIN & SYMPTOM MGMT. 221, 222 (1994).

93. See, e.g., Charles S. Cleeland et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 NEW ENGL. J. MED. 592, 593, 595 (1994); The SUPPORT Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT)*, 274 JAMA 1591, 1595 (1995), and *Correction*, 275 JAMA 1232 (1996).

94. Ferrell & Griffith, *supra* note 92, at 222.

early point.<sup>95</sup> It is clear that "HMOs' outpatient prescription drug benefits frequently are subject to restrictions. . . such as generic substitution, therapeutic substitution, and [limited] formularies."<sup>96</sup> Moreover, these benefits may be available in some HMOs only by subscriber purchase of an extra "rider" to the coverage contract,<sup>97</sup> and coverage affects access to pain-relieving drugs.<sup>98</sup> Much remains to be determined about the effectiveness of MCOs in addressing pain, however, especially for patients at the end of life.

The above analysis thus suggests that there is documented reason for concern about MCOs' treatment of depression. This raises the fear that MCO patients will be differentially driven to assisted suicide by systemic neglect, since depression is the primary reason patients seek assisted suicide. Data on treatment of suffering and pain are less clear, but the adequacy of MCO coverage may have much to do with whether such treatment is seen as worth the cost to the organization.

### III. CONSTITUTIONAL AND POLICY IMPLICATIONS

What do these features of managed care, physician incentives to encourage assisted suicide and systemic failures that may drive patients to assisted suicide, suggest both for constitutional analysis of assisted suicide and for the legislatures' and public's policy analyses? On the constitutional front, these features first suggest that even if the Ninth Circuit's finding of a patient's constitutionally protected liberty interest in assisted suicide stands, the court's analysis of the state's countervailing interests is seriously mistaken. The court acknowledges that the state has clear countervailing interests in preserving life, preventing suicide, and precluding undue influence by third parties.<sup>99</sup> The court, however, then finds physician involvement in the process to be a great safeguard, a bulwark against abuse and error.

The court's outdated reliance on assumptions about physician behavior and the doctor-patient relationship that are under frontal attack in managed care makes its analysis unpersuasive. Instead, examination of the incentives in managed care versus

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95. See David Joranson, *Are Health Care Reimbursement Policies a Barrier to Acute and Cancer Pain Management?*, 9 J. PAIN & SYMPTOM MGMT. 244, 249 (1994); Jonathan P. Weiner et al., *Impact of Managed Care on Prescription Drug Use*, HEALTH AFF., Spring 1991, at 140.

96. Maren Anderson & Jonathan Dunn, *Disclosure of Outpatient Prescription Drug Benefits in HMOs*, HEALTH AFF., Summer 1991, at 143, 143.

97. See Joranson, *supra* note 95, at 249.

98. See *id.*

99. *Compassion in Dying*, 79 F.3d at 816.

fee-for-service paints a sharp contrast. Under the incentives in a fee-for-service system, physicians profit by offering patients treatments for their illness, interventions for their depression, pain relief, and encouragement to go on with life if possible. Under managed care incentives, physicians and organizations lose money by doing all of these things and profit instead by encouraging patients considering assisted suicide to go ahead with the practice.

Constitutional analysis must rest on the realities of the U.S. health care system as it exists now rather than as it was and may be nostalgically remembered. These realities mean that the states have acute countervailing interests in protecting against error and abuse. In an era of managed care, physician involvement, far from being a safeguard, would be very much part of the problem.

Rigorous state regulation of assisted suicide should thus be easy to justify. The question is whether this regulation would conceivably be enough. Given the pervasiveness of managed care and managed care techniques, it is not at all clear that anything short of a ban on assisted suicide can succeed in preventing the use of the practice as subtle or overt cost-containment. Here, Kamisar's long-standing concern that it is simply impossible to devise safeguards that are both workable and adequately protective applies.<sup>100</sup>

One might reply to this by stating that the same concerns apply to the termination of life-sustaining treatment yet the Supreme Court in *Cruzan* nonetheless suggested that one can infer from past opinions a constitutionally protected right to refuse treatment. Certainly, error and abuse are concerns in the termination of treatment realm as well. Thus, the courts routinely recognize that the states have countervailing interests in that realm. Indeed, the majority in *Cruzan* found that Missouri's countervailing interests permitted the state to protect an incompetent patient by denying the patient's surrogates the authority to terminate the patient's artificial nutrition absent "clear and convincing" prior instructions from the patient.

However, there are substantial differences between the problems surrounding assisted suicide and those surrounding termination of treatment, especially in the context of managed care. Systems and physicians driven by cost containment are likely to find assisted suicide much more tempting than termination of treatment for several reasons.

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100. See Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958).

First, patients may raise the possibility of suicide and assisted suicide early in the disease process. Indeed, it may be prompted by the initial announcement to the patient of a frightening diagnosis. Thus physician incentives and systemic biases may begin to play a part in encouraging assisted suicide early. Indeed, if a patient concludes that the best way out is assisted suicide, the patient must act while still competent and able to commit suicide.

In contrast, the largest empirical study to date of patient care at the end of life and forgoing treatment showed that, for seriously ill patients, "discussions and decisions substantially in advance of death were uncommon. Nearly half of all DNR [do not resuscitate] orders were written in the last two days of life."<sup>101</sup> In fact, the researchers' effort to devise an intervention to promote earlier decisions failed.<sup>102</sup> There is further evidence that most decisions to forgo treatment are effectuated late in the disease course, after the patient has lost competence.<sup>103</sup> Of course, some patients may consider forgoing treatment early, and perhaps complete an advance directive while still competent. The data indicate, however, that a minority of Americans complete advance directives,<sup>104</sup> despite Congressional enactment of the Patient Self-Determination Act which encourages their use.<sup>105</sup> Consensus is also emerging that advance directives are not big cost-savers within the health care system.<sup>106</sup> Thus, a rational physician and MCO should have little financial incen-

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101. The SUPPORT Principal Investigators, *supra* note 93, at 1595.

102. *See id.* at 1596.

103. *See* Nicholas G. Smedira et al., *Withholding and Withdrawal of Life Support from the Critically Ill*, 322 NEW ENGL. J. MED. 309 (1990). Note that this is a study of patients admitted to intensive care units (ICUs) and so underrepresents those who forgo treatment and die without admission to an ICU.

104. *See, e.g.*, Ezekiel J. Emanuel et al., *How Well Is the Patient Self-Determination Act Working? An Early Assessment*, 95 AM. J. MED. 619 (1993).

105. *See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508 §§4206, 4751, 104 Stat. 1388-115, 1388-204 (codified in scattered sections of 42 U.S.C., especially §§ 1395cc, 1396a).

106. For a comprehensive analysis, *see* Emanuel, *Cost Savings at the End of Life*, *supra* note 91. *See also* Ezekiel J. Emanuel & Linda L. Emanuel, *The Economics of Dying: The Illusion of Cost Savings at the End of Life*, 330 NEW ENGL. J. MED. 540 (1994); Lawrence J. Schneiderman et al., *Effects of Offering Advance Directives on Medical Treatments and Costs*, 117 ANNALS INTERNAL MED. 599 (1992); J. Teno et al., *Do Advance Directives Save Resources?*, 41 CLIN. RES. 551A (1993); Joan M. Teno et al., *Do Formal Advance Directives Affect Resuscitation Decisions and the Use of Resources for Seriously Ill Patients?*, 5 J. CLIN. ETHICS 23 (1994); The SUPPORT Principal Investigators, *supra* note 93. *But see* Christopher V. Chambers et al., *Relationship of Advance Directives to Hospital Charges in a Medicare Population*, 154 ARCHIVES INTERNAL MED. 541 (1994); William B. Weeks et al., *Advance Directives and the Cost of Terminal Hospitalization*, 154 ARCHIVES INTERNAL MED. 2077 (1994) (both analyzed and reconciled by Emanuel, *Cost Savings at the End of Life*).

tive to push patients to consider forgoing life-sustaining treatment in advance, at least by an advance directive.

Certainly competent patients can forgo treatment verbally without an advance directive.<sup>107</sup> As noted above, however, that is likely to happen late in the course of illness. Even analysis that goes beyond advance directives to project cost savings from hospice or denial of futile care, however, has concluded those savings are modest at best.<sup>108</sup> In part, this may be because patients who forgo life-sustaining treatment "do not necessarily require less medical care, just a different kind. . . . [and] [h]igh-quality palliative care. . . is. . . costly."<sup>109</sup>

Moreover, as noted above, by the time a competent patient's decision to forgo treatment has to be effectuated, it is likely that the patient will have lost competence. At that point, the physician can no longer "push" the patient to decide anything. Instead, the physician is required to collaborate with the patient's surrogate to make decisions. Even though both the physician and the surrogate should ordinarily honor past choices by the patient, commentators routinely note that the ultimate choice may be different from what the patient contemplated.<sup>110</sup> Moreover, indications are that many patients may want their surrogate to consider their past choices only as general guidance.<sup>111</sup> Thus, the surrogate may have considerable latitude. Since the surrogate is not the one suffering from disease, depression, pain, or the like, the surrogate is far more likely to be able to hold his or her own with the physician.

Finally, decisions about whether to use or forgo treatment of all sorts are intrinsic to health care. Patients and physicians make such decisions every day. Two decades ago, when litigation first erupted about forgoing life-sustaining treatment,<sup>112</sup> the basic question was whether the long-established principles governing refusal of other treatment apply even when the predicted consequence of honoring the refusal is the patient's death. The

107. There is some indication that achieving agreement between physician and patient on the patient's choice to forgo cardiopulmonary resuscitation can save money. See Joan M. Teno et al., *Preferences for Cardiopulmonary Resuscitation: Physician-Patient Agreement and Hospital Resource Use*, 10 JGIM 179 (1995).

108. See, e.g., Emanuel, *Cost Savings at the End of Life*, *supra* note 91; Emanuel & Emanuel, *The Economics of Dying*, *supra* note 106.

109. Emanuel & Emanuel, *The Economics of Dying*, *supra* note 106, at 543.

110. See, e.g., Susan M. Wolf et al., *Sources of Concern About the Patient Self-Determination Act*, 325 NEW ENGL. J. MED. 1666 (1991).

111. See Ashwini Sehgal, *How Strictly Do Dialysis Patients Want Advance Directives Followed?*, 267 JAMA 59 (1992).

112. See *In re Quinlan*, 355 A.2d 647 (N.J.), *cert. denied sub nom.*, *Garger v. New Jersey*, 429 U.S. 922 (1976).

courts, ethicists, and clinicians have clearly answered yes to this question. Decisions about whether to forgo life-sustaining treatment are an integral part of caring for terminally ill patients. That is not to say all problems are solved, but that a vast literature evidences the integration of forgoing treatment into the approaches governing clinical practice generally. Physicians must honor patients' refusal of any unwanted bodily invasion. The usual rules and ethics governing doctor-patient relationships apply.

This is not so, however, in the case of assisted suicide. Whether one favors or opposes its legalization, the practice clearly represents a departure from the past ethics of the doctor-patient relationship. The physician is not honoring a patient's refusal of bodily invasion. Indeed, the physician is breaching the Hippocratic injunction to "give no deadly drug, even if asked."<sup>113</sup> This does not mean the practice cannot be legalized. It means that it does not fit into the general practice of medicine, and that the ethics otherwise governing the doctor-patient relationship will not help the physician in this case. Physicians are not normally trained to deliberately take life or to help the patient in taking his or her own life.

Thus the physician facing the incentives and ethical conflicts imposed by managed care will far more easily resort to the traditional ethics of the doctor-patient relationship to guide termination of treatment than assisted suicide. Physicians' traditional obligations to place patients' need first have a fighting chance of prevailing when the question is forgoing treatment. They have less of a chance when the question is whether to supply drugs or other means to the patient in order to help the patient commit suicide.

All of this suggests that physician incentives and systemic biases in favor of forgoing treatment in MCOs will be much less threatening than the incentives to assist suicide. State countervailing interests in the case of assisted suicide will be substantially greater than those in the termination of treatment area.

This analysis assumes so far that future courts, most importantly the Supreme Court, may get to the point of considering the state's countervailing interests by finding a constitutionally protected right to be free to seek assisted suicide. This article puts aside, but the author elsewhere develops at length, the argument that there is no such protected liberty interest.<sup>114</sup> Nothing in the

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113. See Kass, *supra* note 1.

114. See Wolf, *Physician-Assisted Suicide, Abortion, and Treatment Refusal*, *supra* note 2.

text of the Constitution protects such a right. Nor does precedent support a right to invade a patient's body in order to end the patient's life. *Cruzan* concerns a right to be free of unwanted bodily invasion, and most of the Justices' opinions in *Cruzan* make clear they are writing about bodily invasion.<sup>115</sup> Indeed, Justice O'Connor, later writing for the governing plurality in *Casey* in a portion of the opinion joined by two further Justices, states that the liberty interest in abortion "stands at the intersection of two lines of decisions."<sup>116</sup> The first line has to do with procreation, and includes cases based on "the liberty relating to intimate relationships, the family, and decisions about whether. . .to beget or bear a child."<sup>117</sup> The second line, however, which is more relevant to assisted suicide, relates to end-of-life issues. Here, liberty concerns "personal autonomy and bodily integrity."<sup>118</sup> This is where the Justice cites *Cruzan*. Therefore, *Casey* reinforces rather than undermines the notion that *Cruzan* protects a right to be free of bodily invasion. Broad language in *Casey* on Fourteenth Amendment protection of "intimate and personal choices"<sup>119</sup> relates to the long line of precedent on procreative choice, not the end-of-life precedent most germane to assisted suicide.

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115. Chief Justice Rehnquist, writing for the Court in *Cruzan*, conceded: "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278 (1990). He repeatedly framed the protected interest as one in refusing treatment, and stated that it was "the forced administration of. . .treatment" that implicated the interest. *Id.* at 279.

Justice O'Connor's concurrence similarly stated that "[t]he liberty interest in refusing medical treatment flows from decisions involving the State's invasions into the body. . . . Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the. . .Due Process Clause." *Id.* at 287 (O'Connor, J., concurring) (citations omitted).

Justice Brennan in dissent, joined by Justices Marshall and Blackmun, also emphasized a "fundamental right to be free of unwanted" treatment. *Id.* at 302 (Brennan, J., dissenting). He proclaimed the "inviolability of the person." *Id.* at 305 (Brennan, J., dissenting) (citations omitted). Thus, Justice Brennan found "a right to evaluate. . . treatment. . . and. . . [decide] whether to subject oneself to the intrusion." *Id.* at 309 (Brennan, J., dissenting).

Justice Stevens's dissent emphasized, too, that at stake was "[h]ighly invasive treatment." *Id.* at 339 (Stevens, J., dissenting). His broader language about "the liberty to make. . .choices constitutive of private life" and his assertion that "[c]hoices about death touch the core of liberty," is married to language on "rights pertaining to bodily integrity" and the right to be free from "physically invasive" procedures. *Id.* at 341-43 (Stevens, J., dissenting) (citation omitted).

116. *Planned Parenthood v. Casey*, 505 U.S. 833, 857 (1992).

117. *Id.*

118. *Id.*

119. *Id.* at 851.



Thus, this article's managed care analysis, indicating that the state's countervailing interests are greater in the case of assisted suicide than treatment termination, takes place against the background of strong constitutional support for a right to be free of unwanted invasive treatment but dubious support for a right to assisted suicide.

The contrast between assisted suicide and termination of treatment shows as well why the Second Circuit overlooked a critical element in *Quill*. The Second Circuit, like the Ninth Circuit, completely ignored the realities of current health care and the rise of managed care. In finding that the state's difference in approach to termination of treatment and assisted suicide was "not rationally related to some legitimate state interest,"<sup>120</sup> the court failed to analyze the greater physician incentives and systemic bias in the case of assisted suicide. Moreover, by ignoring the managed care context, the court never considered whether widespread concern about managed care and demands for the states to regulate MCOs in ways far more protective of patients<sup>121</sup> could ground special state concerns over assisted suicide in MCOs. Finally, in opining that the state could simply establish "procedures to assure that all choices are free of . . . pressures,"<sup>122</sup> the court never acknowledged the problem of devising adequate procedures in the era of managed care.

Constitutional analysis, whether following the Ninth Circuit's liberty reasoning or the Second Circuit's equal protection rationale, cannot ignore the presence of managed care. Similarly, legislatures and the public cannot ignore managed care when determining whether to legalize assisted suicide. If the Supreme Court rules that the Constitution encompasses no right to assisted suicide, the individual states will then have to determine whether to legalize the practice. To consider this momentous question without focusing on the realities of how health care currently works would be an abdication of state responsibility and public folly.

#### IV. CONCLUSION

The Ninth Circuit extended Constitutional protection to assisted suicide based on nostalgic fictions about the doctor-patient relationship. The Second Circuit did little better. Both courts simply ignored the growing dominance of managed care,

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120. *Quill*, 80 F.3d at 729.

121. See Pear, *Stakes High as California Debates Ballot Issues to Rein in H.M.O.'s*, *supra* note 3.

122. *Id.* at 730.

the upheaval and challenge created, the physician incentives that now prevail, and the organizational biases in place.

The questions of what state interests legitimately apply in the case of assisted suicide, and whether the state rationally distinguishes between assisted suicide and termination of treatment, have to be answered based on health care as it actually exists. To ignore the problems posed by the growing prevalence of managed care is a mistake. In the name of supposed individual rights, it blesses a practice of assisted suicide driven by financial incentives and the needs of health care organizations.

