OA 5-8-97

STATE OF FLORIDA
IN THE SUPREME COURT OF FLORIDA

BARRY KRISCHER, in his official capacity as State Attorney of the 15th Judicial Circuit,

Defendant/Appellant

v.

CECIL McIVER M.D., et al.,

Plaintiffs/Appellees

CASE NO. 89,837

DISTRICT COURT OF APPEAL
FOURTH DISTRICT NO.97-379

CIRCUIT COURT
NO. CL-96-1504-AF

On Writ Of Certiorari To Review Trial Court Judgment *of* January 31, 1997.
Review Certified by the District Court *of* Appeal

BRIEF AMICUS CURIAE OF INTERNATIONAL ANTI-EUTHANASIA TASK FORCE

IN SUPPORT OF APPELLANT

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TABLE OF CONTENTS

TABLE OF CONTENTS. i

TABLE OF CITATIONS iii

STATEMENT OF THE CASE. 1

STATEMENT OF THE FACTS 1

STATEMENT OF INTEREST. 1

SUMMARY OF THE ARGUMENT. 2

ARGUMENT

I. THE CIRCUIT COURT ERRED IN TRANSFORMING ASSISTED SUICIDE INTO "MEDICAL TREATMENT" 5

A. There Is an Important Distinction between Refusing Medical Treatment and Receiving Assisted Suicide. 5

B. If Assisted Suicide Is a "Medical Treatment," Protected under Florida's Privacy Amendment, It Cannot Be Limited to Competent, Terminally 111 Adults 7

11. THE CIRCUIT COURT ERRED WHEN IT FAILED TO ADEQUATELY CONSIDER THE SOCIAL AND ECONOMIC PRESSURES THAT WOULD FORCE INDIVIDUALS TO CHOOSE ASSISTED SUICIDE 9

III. THE CIRCUIT COURT ERRED WHEN IT FAILED TO CONSIDER THE IMPACT OF MANAGED CARE ON THE CONTEXT IN WHICH ASSISTED SUICIDE WOULD BE CARRIEDOUT. 12

A. Managed Care Has Changed the Very Basis upon Which Health Care Is Provided 14

B. Managed Care Programs Use a System of Financial Incentives and Disincentives Which Impose Conflicts of Interest between Patients and Doctors. 18

C. Undertreatment of AIDS Patients Is Exacerbated by Managed Care 21

D. Managed Care Programs Have Created Barriers Which Often Limit Access to Necessary Care. . . 22

E. To Preserve a Competitive Edge in the Marketplace, Managed Care Organizations Resists Attempts to Assure Patients' Rights . . 23

F. Managed Care Programs Often Seek Only Short Term Effectiveness and Maximum Cost Containment. 25

G. Patients' Fears of Dependence, Unremitting Pain and Loss of Dignity Are Often Increased by the Practices of Managed Care Programs . . . 28

H. The Appeals Process under Managed Care Is Often So Complex That Patients Could Consider Assisted Suicide to Be Their Only Recourse . . 33

I. The Policies of Managed Care Corporations Compromise the Quality and Expertise of the Medical Profession, Making It Imperative That Florida Protect Residents from Assisted Suicide.. 37

IV. THE CIRCUIT COURT ERRED WHEN IT FAILED TO CONSIDER POLICIES WHICH PUT COST CONTAINMENT AND HEALTH CARE INDUSTRY PROFITS BEFORE PATIENT WELL-BEING. 38

CONCLUSION 41

TABLE OF CITATIONS

CASES	PAGES
B.B. v. State, 659 So.2d 256 (Fla. 1995)	7
In re Guardianship of Barry, 445 So.2d 365 (Fla.App.2d Dist. 1984)	7,8
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STATEMENT OF THE CASE

Amicus, International Anti-Euthanasia Task Force (IAETF), adopts Defendant/Appellant's Statement of the Case.

STATEMENT OF THE FACTS

Amicus, IAETF, adopts Defendant/Appellant's Statement of the the Facts.

STATEMENT OF INTEREST

The International Anti-Euthanasia Task Force (IAETF) is the trade name of the Family Living Council, a non-profit corporation formed in 1976 to provide education in matters related to family life, health and related matters. The IAETF, with networkers throughout the world, addresses the medical-ethical issues of death and dying, health care delivery, the rights of the terminally ill, the chronically ill, the elderly, persons with disabilities and their families. Involvement of the IAETF in such matters includes education, advocacy, consultation, legislative analysis and networking. The IAETF is a major resource for individuals and groups seeking information about the rights of medically vulnerable individuals and their families.

This amicus curiae brief has been filed with consent of the parties. Letters of consent were filed with this brief with the Clerk of the Court.

SUMMARY OF THE ARGUMENT

The matter at bench is one of the most important ever to face this Court. At stake is the determination of the very purpose for which laws exist.

This Court will decide whether the state's foundational role as protector of the lives of all of its residents is consistent with existing principles and law, or whether this traditional state responsibility will be superseded and replaced by a new and radical interpretation of the Privacy Amendment of the Florida Constitution.[1] If this Court embraces the trial court's interpretation of the Privacy Amendment, it will prohibit the state from protecting its residents and, further, it will force the state to countenance and facilitate the deliberate ending of human lives under the guise of privacy, compassion, elimination of suffering, and exercise of individual rights.

The current question before the Court is not whether dying patients have the right to end their suffering, as Plaintiffs/Appellees argue. (Certainly, the ending of suffering is a laudable goal and, if that were the real issue, there would be no controversy.) Rather, the issue before this Court is whether this state has the right to protect weak and vulnerable individuals as well as the greater societal good by prohibiting assisted suicide.

Strong emotional arguments are made by those who seek to have this Court decide that Florida's one hundred twenty-

[1] Art. I, sec.23., Fla. Const.

nine year-old proscription against assisted suicide[2] is in violation of the Florida Privacy Amendment. Proponents of assisted suicide claim that the state has little or no interest in prohibiting assisted suicide because permitting assisted suicide would allow a patient "to die at a time of his choosing"[3] and would be used as "a treatment of last resort,"[4] to take place only after people have exhausted all treatment and comfort care possibilities.

As this brief will demonstrate, such conclusions and facile arguments are designed to deflect attention from the context in which legalized assisted suicide would be practiced.

The "last resort" claim is based upon the false premise that virtually every American citizen or resident has access to wanted medical treatment and necessary health care. Further, it mistakenly assumes that all necessary time and health care resources would be at the disposal of each suicidal patient prior to any implementation of physician facilitated death.

The reality of the current health care delivery system belies these soothing assurances. An increasing number of people are experiencing great difficulty in obtaining necessary medical services, in part because of the ongoing transition from "fee for service" medicine to "managed

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[2] Fla. Stat. Ann., § 782.08.
[3] Third Amended Complaint of Plaintiffs/Appellees at 13.
[4] F. Miller, T. Quill, et al, Resulatins Physician-Assisted Death, 331 New Eng. J. Med. 119,120 (1994).

care." In such a milieu, this brief argues, assisted suicide would be especially dangerous.

Managed care systems often have financial incentives which impose conflicts of interest between patients and their own doctors. These conflicts create the potential for denial of wanted and needed medical care based on pecuniary, rather than medical, considerations. In turn, the suffering caused by denied or delayed care can create a desire for assisted suicide.

The "medical practice" of assisted suicide would not be implemented in a vacuum. There is nothing to indicate that a judicially created transformation of assisted suicide from a crime into a legitimate form of "medical treatment" would cause the health care delivery system to become more responsive to patient needs, nor would it afford a compassionate means to alleviate suffering.

The availability of assisted suicide would likely result in a decreased amount of time and attention given to treating and alleviating significant medical problems, such as pain, particularly when assisted suicide would be far less time-consuming and less costly than interventions which help a patient live comfortably.

It is within this context that this brief argues that the State of Florida has the obligation and the compelling interest to safeguard its residents from the harm of assisted suicide, as it would take place in the "real

world." This state interest can only be achieved by upholding Florida's law which prohibits assisted suicide.

I. THE CIRCUIT COURT ERRED IN TRANSFORMING ASSISTED SUICIDE INTO "MEDICAL TREATMENT"

The trial court describes an intentionally prescribed lethal overdose as a "medical treatment" or a "medical option"[5] and, in its ruling, accorded the right to provide and receive this "option" to Plaintiffs/Appellees. This transformation of the crime of assisted suicide into a medical option, protected under Florida's Privacy Amendment, if allowed to stand, would remove protection from patients and provide a protective shield for third persons who intentionally effect their demise.

A. There Is an Important Distinction between Refusing Medical Treatment and Receiving Assisted Suicide.

Among the states which have a privacy provision in their constitutions,[6] California is the only one until now that has faced the issue of whether such a provision permits assisted suicide or euthanasia. A California appellate court expressly held that a terminally ill man did not have

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[5] "...the individual's constitutional right to determine his or her course of medical treatment, including the option to hasten his or her death..." McIver v. Krischer, No. CL 96-1504-AF, slip op. at 19, n.6 (Fla. 15th Cir. Ct. Jan. 31, 1997)(emphasis added).

[6] Only Alaska, California, Florida, Hawaii and Montana have distinct provisions, specifically guaranteeing the right to privacy provisions in their state constitutions. (Five additional states have constitutional privacy protections related to search and seizure.)

the right to be assisted in committing suicide.[7] The Court found that California's right to privacy provision' does not include abrogating the state's interest in protecting society against the abuses that would inevitably accompany allowing euthanasia or assisted suicide:

> This interest [in protecting society against abuses] is more significant than merely the abstract interest in preserving life no matter what the quality of that life is. Instead, it is the interest of the state to maintain social order through enforcement of the criminal law and to protect the lives of those who wish to live no matter what their circumstance. This interest overrides any interest Donaldson possesses in ending his life through the assistance of a third person in violation of the state's penal laws. We cannot expand the nature of Donaldson's right of privacy to provide a protective shield for third persons who end his life."[9]

The possibility of undue influence was of concern to the Court as well: "The state's interest must prevail over the individual because of the difficulty, if not the impossibility, of evaluating the motives of the assister or determining the presence of undue influence."[10]

Additionally, the California Supreme Court, citing Donaldson, recognized a "necessary distinction*' between refusing medical treatment and deliberately enlisting others to assist in a suicide.[11] In a recent ruling, U.S. District Court Judge Consuelo Marshall noted that "there is no

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[7] Donaldson v. Lunqren, 2 Cal.App. 4th 1614, 4 Cal.Rptr.2d 59 (1992).
[8] Art. I, sec. 1, Cal. Const.
[9] Id. at 1622.
[10] Id. at 1623.
"Thor v. Superior Court, 5 Cal.4th,725, 742, n.13, 21 Cal.Rptr. 2d 357, 367 (1993).

persuasive authority to believe that the California Supreme Court would hold otherwise if directly presented with the issue" of assisted suicide being permitted under the California's right to privacy provision.[12]

B. If Assisted Suicide is a "Medical Treatment," Protected under Florida's Privacy Amendment, It Cannot Be Limited to Competent, Terminally 111 Adults.

If assisted suicide is deemed to be a medical option, afforded under Florida's right to privacy provision, it cannot be limited to competent, terminally ill adults who request it.

The Florida Privacy Amendment permits parents to exercise a child's right to privacy regarding medical treatment.[13] Additionally, minors themselves are afforded privacy rights, as this Court clearly noted when it said that "[t]he right to privacy extends to '[e]very natural person.' Minors are natural persons in the eyes of the law and '[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority'"[14] "[T]he rationale for declaring a right of privacy in T.W. was based on the fact that a minor possessed

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[12] Kevorkian v. Arnett, 939 F.Supp. 725, 731-732 (C.D.Cal. 1996).

'"In re Guardianship of Barry, 445 So.2d 365 (Fla.App.2d Dist. 1984) in which parents were permitted to assert right to privacy of ten-month-old child.

[14] B.B. v. State, 659 So.2d 256,258 (Fla. 1995), citing In re T.W., 551 So.2d 1186, 1193 (Fla. 1989).

a right of privacy with respect to other types of medical and surgical procedures."[15]

Clearly, those who are incompetent would also be affected by any purported right to assisted suicide under Florida's Privacy Amendment: "That section [Florida's right to privacy provision] provides an express right of privacy for every natural person and makes no distinction as to whether a natural person is competent to exercise that right."[16] As this Court has further pointed out:

> [O]ur cases have recognized no basis for drawing a constitutional line between the protections afforded to competent persons and incompetent persons. Indeed, the right of privacy would be an empty right were it not to extend to competent and incompetent persons alike.[17]

and

> [W]e do not limit the ability to exercise this right [to privacy] only to a legally appointed guardian, but recognize that it may be exercised by proxies or surrogates such as close family members or friends.[18]

If it is found that assisted suicide is a "medical treatment" which is beneficial for competent adults, it is logical and, indeed, necessary that this same treatment would be available to children and those who are incompetent. Surely if the right to privacy exists for such individuals, the right to a *'medical treatment" which the state deems an appropriate medical option would be.

The motivation for choosing this option on behalf of another may be altruistic or may be for the purpose of

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[15] Jones v. State, 640 So.2d 1084, 1087 (Fla. 1994).
[16] In re Guardianship of Barry, 445 So.2d at 370.
"In re Guardianship of Browning, 568 So.2d 4,12 (Fla.1990).

alleviating difficulties encountered by the decision-maker. In cases where decisions to remove medical treatment were made on behalf of a comatose patient, this Court has pointed out that "the direct beneficiary of the request is the family of the patient and that the benefits are financial savings and cessation of the emotional drain occasioned by awaiting the medico-legal death of a loved one."[19]

Assisted suicide advocates argue that -- because permissive assisted suicide would require that the person who is to die take the last act -- the person who dies must be competent. It could be successfully argued, however, that the act of swallowing a lethal dose is the "last act" -- one which even an infant or a demented individual could easily perform.

II. THE CIRCUIT COURT ERRED WHEN IT FAILED TO ADEQUATELY CONSIDER THE SOCIAL AND ECONOMIC PRESSURES THAT WOULD FORCE INDIVIDUALS TO CHOOSE ASSISTED SUICIDE

The trial court totally ignored the possibility, much less the reality, of the significant economic and psychological pressures that would be placed on individuals if the state was barred from prohibiting assisted suicide. This may have been due to the fact that, in finding a right to receive and to provide assisted suicide, the court failed to consider much of the written material submitted into evidence: "The Court has not necessarily reviewed all the

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[18] Id. at 13.

[19] John F. Kennedy Memorial Hosp. V. Bludworth, 432 So.2d 611, 618 (Fla. DCA 1983), aff.d 452 So. 2d 921 (Fla. 1984).

written materials except to the extent they were specifically brought to the Court's attention by counsel during the trial."[20]

Significant social pressures were carefully explored by the New York State Task Force on Life and the Law,[21] which clearly outlined and documented the peril in which citizens would be placed if assisted suicide were permitted.

These pressures have also been described by Yale Kamisar, a University of Michigan law professor and one of the country's foremost authorities on constitutional law, who has cautioned:

> In a suicide-permissive society, I fear that family members so inclined will be more likely to alter or manipulate a sick, elderly person's circumstances (for example, by providing shoddy or even hostile care) so that suicide becomes a reasonable, even an attractive choice. In a climate in which suicide will often be the "rational" option, I think there is a real possibility that it will become the unreasonable thing not to do -- the noble thing to do.[22]

Concerns about the impact of assisted suicide have also been expressed by leaders in the black community. "People know they don't get the health care they need while they're living," explained University of Colorado research associate

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[20] McIver, at 2.
[21] New York State Task Force on Life and the Law, When Death Is Souqht: Assisted Suicide and Euthanasia in the Medical Context (May 1994).
[22] Kamisar, Right to assisted suicide: a complex issue, a bad idea, Boston Globe, Dec. 19, 1993 at 91.

Annette Dula. "So what makes them think anything's going to be more sensitive when they're dying?"[23]

Nowhere does the trial court indicate awareness of economic considerations which could lead to subtle and not so subtle pressures on an individual to "choose" assisted suicide. Such pressures, to which older people are particularly vulnerable, could be seductively exerted by those who would benefit by the early demise of a family member:

> . ..[H]ow long will it be before HMO's are running gauzy TV ads encouraging euthanasia? Can't you just see them? The elderly woman, propped up on pillows, pictures of her kin around her. "I don't want my great-grandchildren's college money to go to providing me with a new liver that will only add months to my life," she says, sad music playing. "That's why I'm visiting a Healthmax Mercy Center. To end my suffering. And theirs..."[24]

While the trial court noted that a person has the right under the Privacy Amendment "to choose or refuse medical treatment, and that right extends to all relevant decisions concerning one's health,"[25] the court failed to recognize that, in the current medical context, one's treatments and health care are governed largely by the economic decisions of others. Just as one might choose to have a good job, a new automobile or a personal family physician, the

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"Montgomery, Blacks fearful of white doctors, Detroit Free Press, Feb. 26, 1997.

[24] Steinberg, Issue of mercy killing calls for calm discussion, Chicago Sun-Times, Feb. 23, 1997.

[25] McIver at 13, citing Matter of Dubreuil. 629 So. 2d 819, 822 (Fla. 1993), citing In re Guardianship of Browning, 568 So. 2d 4, 11 (Fla. 1990).

intellectual exercise of making such choices is often far removed from a person's ability to actually obtain that which she chooses.

At a time when it is becoming increasingly difficult for the vast majority of people to obtain the medical treatment and care they desire, the trial court's transformation of a crime into a "medical treatment" seems particularly ironic, particularly in light of the fact that this new "treatment" could become the only one which many people would be able to afford. As acting United States Solicitor General Walter Dellinger has stated, "The least costly treatment for any illness is lethal medication."[26] The trial court paid no attention to this reality.

In fact, by concluding that Florida's constitution permits the right for patients to receive, and others to provide, assisted suicide, the trial court sent a bold message that access to death producing drugs is a constitutional right, but access to life saving or life enhancing medical intervention is not.

III. THE CIRCUIT COURT ERRED WHEN IT FAILED TO CONSIDER THE IMPACT OF MANAGED CARE ON THE CONTEXT IN WHICH ASSISTED SUICIDE WOULD BE CARRIED OUT

The trial court seemed to labor under an illusion that patients would be able to freely choose assisted suicide after carefully discussing it with a caring physician:

"[T]he Court must leave the final determination of when to die to the privacy of the physician patient relationship where it belongs."[27] The days of Marcus Welby-type physicians -- who knew their patients and discussed their needs, fears and cares, as well as their medical conditions, with them -- have passed into history.

A survey of people in twelve states (including Florida), conducted by the American Hospital Association, found that "medical centers are a 'nightmare to navigate,'" where patients are sent home before they are ready and where care-givers are uncaring: "From impoverished Medicaid and frail Medicare recipients to individuals with top-of-the-line health plans, many expressed angst about reduced access to care, higher expenses and a sense that decisions aren't

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[26] Transcript of Oral Arguments before the U.S. Supreme Court in Washington v. Glucksberg (No.96-110), 143 Chi. Daily L. Bull. 2 (Jan. 10, 1997)

[27] McIver at 22.

In fact, the relationship between McIver and Hall, to whom the Court granted the right to provide and receive assisted suicide was nonexistent until they were selected to be plaintiffs in the case to challenge Florida's law against assisted suicide.

In the summer of 1994 and the Fall of 1995, the Florida Hemlock Society ran front-page articles in its newsletter, recruiting terminally ill patients and cooperative doctors to serve as plaintiffs in the court action. Hemlock of Florida Legal Plans Update, Hemlock Beacon Newsletter, Summer 1994 at 1, and The Search Is On, Hemlock Beacon Newsletter, Fall 1995 at 1.

McIver and Hall had never met before the lawsuit. Lade, Group carefully orchestrated doctor-patient right-to-die test, Ft. Lauderdale Sun-Sentinel, Jan. 12, 1997. Additionally, since meeting, Dr. McIver's relationship with Hall has been limited to a "review of Mr. Hall's medical and hospital records" and to observing Hall "on several occasions." McIver at 6.

being made in their best interest."[28] Furthermore, the report stated that patients "see an increasing trend toward care that is cold and impersonal."[29]

These patients' observations about the lack of any meaningful physician patient relationship were affirmed by William Speck, president of Columbia-Presbyterian Medical Center in New York. "The whole system has become depersonalized," according to Speck, and "[a] lot of the decisions have not been made in the best interest of the patients, but on financial imperatives -- and that is a shame."[30]

A. Managed Care Has Changed the Very Basis upon Which Health Care Is Provided.

In an effort to control unnecessary medical costs and improve the efficiency of health care, a transition of monumental import is currently taking place in the health care system. This transition is from a traditional "fee-for-service" system to a "managed care" system of health care delivery.

Under the fee-for-service system, health providers were paid for each service performed. This sometimes led to patients' being overtreated and subjected to interventions that were futile. In the fee-for-service system, health providers had a financial incentive to exhaust all treatment

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[28] Lagnado, Hospital Patients Complain About Going Home Too Early, Wall St. J., Jan. 28, 1997.
[29] Id.
[30] Id.

possibilities or provide unnecessary care since the more treatment that was given, the greater was a provider's income.

Managed care operates in a manner that is almost a reverse of the fee-for-service system. Under managed care, health providers are encouraged by a myriad of incentives and disincentives to control costs by limitinq treatment and care. Health care professionals now find that their incomes, in large part, depend upon providing fewer, not more, services.

While there is nothing inherently wrong with the concept of managed care, nor with the attempt to appropriately control health care costs, managed care, as it presently operates, has caused enormous problems: "Prodded by large companies fed up with rising medical costs, the new medicine's entrepreneurs have turned health care into a corporate battlefield increasingly governed by the promise of stock market wealth, incentives that reward minimal care and a brand of aggressive competition alien to front-line doctors...."[31]

The usual and traditional presumptions about health care financing and delivery have been turned inside out, and its effects are being felt by millions of people.

[31] Larson, The Soul of an HMO, Time, Jan. 22, 1996, at 45.

In 1995 up to 130 million people were in some type of managed care program.[32] Among American workers who are covered by health insurance, seventy-one percent are in managed care programs[33] and, according to the Health Care Financing Administration's Office of Managed Care, eighty thousand Medicare beneficiaries are being transferred each month from traditional fee-for-service health plans into managed care programs.[34]

The number of physicians affected by the growth of managed care is also increasing rapidly. Whereas physicians used to be self-employed and, thus, were ultimately in charge of how much time they spent with patients and how much care they wished to provide for a certain fee, more and more doctors are now becoming employees who are subject to control by managed care organizations. According to the American Medical Association, only slightly over half of doctors remained self-employed by 1995.

Indicative of the new way in which medicine is practiced is the terminology now used in conjunction with medical care. Provider-consumer business terminology has largely replaced references to what was formerly called the

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[32] D. Blumenthal and S. Thier, Managed Care and Medical Education, 276 J.A.M.A. 725 (1996).

[33] Myerson, Executives Are Cradled while Medicaid Benefits Are Cut for Rank and File, N.Y.Times, March 17, 1996, at 1, 13.

[34] Johnsson, Manased Care Fraud, Am. Med. News, May 20, 1996, at 3, 26.

physician-patient relationship. Such business oriented designations have caused grave concern among physicians.[35]

The agreements used in that provider-consumer relationship has undergone such a significant transformation that the meanings of commonly used words and phrases may now mean something far different to the consumer than they do to the provider.[36] Additionally, this consumer-provider construct bears striking similarity to one which is contractual in nature. In a contractual relationship, however, there is generally some type of parity as it relates to information. That parity is lacking in the medical realm under managed care. It is the provider who has virtually all of the information. It is the provider who may withhold information on the basis of possible benefit or potential harm to the provider. It is the consumer who often does not have adequate information, because the provider has withheld it.

This presents a clear conflict for physicians and increases the possibility of grave harm to patients, a matter clearly relevant to the issue before this Court. If this Court were to find that Florida's Privacy Amendment prevents the state from banning assisted suicide, patients who are denied full access to information about the availability of treatment could be led to believe that

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[35] See, e.g., J. Olivero, Why "Providers" Instead of Physicians?, 156 Arch. Inter. Med. 2148 (1996).
[36] See, e.g., R. Marker and W. Smith, The Art of Verbal Engineering, 35 Duq. L. Rev. 81 (1996).

assisted suicide was their only remaining option.

B. Managed Care Programs Use a System of Financial Incentives and Disincentives Which Impose Conflicts of Interest between Patients and Doctors.

Under the doctrine of informed consent, physicians have a common law duty to provide a patient with all information that is material to that patient's treatment decisions. This duty encompasses informing patients about all reasonable treatment alternatives, and the risks and benefits of each, regardless of cost.[37]

Additionally, a patient has the right to be told about financial incentives that may exist to induce physicians to manipulate the range of options offered to the patient. The physician has an obligation to "disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment."[38]

Despite the existence of clear requirements for such disclosure, managed care programs have created barriers between physicians and patients which threaten a patient's right to receive complete and accurate information and which compromise the professional responsibility of physicians. These barriers arise from a combination of factors: a method for health services payment referred to as

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[37] Cobbs v. Grant, 8 Cal. 3d 229 (1972).
[38] Moore v. Resents of the University of California, 793 P. 2d 479, 271 Cal. Repr. 146 (1990).

"capitation," a combination of financial incentives and disincentives, and the existence of what are called "gag rules" in managed care contracts.

These approaches, used by managed care organizations, hold down costs by controlling physicians' fees and limiting patients* access to services. They could be accurately described as a "carrot and stick" method which compensates physicians in direct proportion to how little they do for patients.

Under the "capitation" approach, the managed care organization pays a flat fee per patient per month to a physician or group of physicians. For example, under one managed care plan, physicians receive $8.43 each month for every male patient between the ages of twenty-five and forty-four and $10.09 per month for each female patient between the ages of twenty and twenty-four.[39]

In return for the monthly fee per patient, the physician is to provide all medical services (subject to the terms of the managed care contract) for each covered patient. These services generally include primary care,

[39] Compromising Health Care, Wash. Post, June 16, 1996, at C8. At the same time that doctors and other health professionals are being pushed to see more and more patients for less and less pay, and as patients are often being denied needed treatment, it is estimated that profits of twenty to thirty percent are going into the pockets of investors. In 1995, the total compensation package of the typical health care corporate CEO was close to $2.9 million. Auerbach, As the Marketplace Changes, Consumers Are Caught in the Middle, Wash. Post, June 25, 1996, at Z12. Several earned between $8.8 and $15.5 million per year. Freudenheim, Health Chief's Big Paychecks for Chopping Costs, N.Y. Times,

specialty care, hospitalization, prescriptions, and a broad range of other health care services. If, during any given month, the actual cost of care for the covered patients is lower than that of the fees paid, the doctor retains the excess. If, however, the actual cost of care exceeds the fees, the health provider loses money. The possibility of losing money by providing care can be a powerful incentive to deny even needed care.[40]

Another cost control method, often coupled with capitation, depends upon what is referred to as a "withhold" in which the managed care organization withholds a percentage of the per patient fee that would ordinarily be paid to the physician. At the end of a certain period of time, the managed care program reviews the physician's practice and determines whether the physician should receive any of the withheld fees. If the managed care program determines that the physician is spending too much time per patient or that he or she is ordering too many diagnostic tests or providing too much treatment, the managed care organization retains the withheld fee. Amounts withheld in this manner vary from a low of eleven percent (withholds of less than eleven percent have been found ineffective as an incentive for physician's to limit services and referrals)

Apr. 11, 1995. That does not take into account stock dividends paid to investors.

[40] See generally: Freudenheim, Health Care in the Era of Capitalism, N.Y.Times, Sept. 4, 1996, at 6E; and T. Bodenheimer and K. Grumback, Capitation or Decapitation, 276 J.A.M.A. 1025 (1996).

to more than thirty percent.[41] Even when income is not withheld, some managed care organizations place a lien on future earnings or reduce the capitation fee as a means of penalizing a physician's failure to meet the fiscal expectations and requirements of the managed care program.[42]

According to data compiled in 1995 by the American Medical Association, one-third of doctors have capitated commercial contracts, and forty-eight percent are subject to some method of fee withhold. For doctors who have such contracts with manage care programs, nineteen percent of their income is attributed to capitation accounts.[43]

Such financial incentives and disincentives place a wedge between patients and doctors.

C. Undertreatment of AIDS Patients Is Exacerbated by Managed Care.

Pain control for people with HIV infection and AIDS is woefully inadequate, according to William Breitbart, M.D., who says AIDS pain is "dramatically undertreated, even in academic centers with a focus on HIV care." Breitbart, stated that the "story of pain in AIDS has been a story of neglect," and its problematic nature may be increased by the pressures of managed care, since more and more people with

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[41] E. Morreim, Balancing Act: The New Medical Ethics of Medicine's New Economics, 35 (Georgetown University Press, 1995).
[42] Id.
[43] Johnsson, Trial Focus: Public Unease with Physician Incentives, Am. Med. News, Aug. 12, 1996, at 1, 34.

AIDS are being cared for by primary care physicians who have little or no training in pain management."

Even routine medical procedures are difficult for AIDS patients to obtain within the context of managed care. Dr. Paul Volberding of San Francisco General Hospital has described managed care an "a new world" in which the doctor faces real pressures when treating AIDS patients. "Heaven help your bottom line if during your contract year a new drug or expensive laboratory test is approved, as you will have to absorb this by a reduced income or by delivering fewer services than you had planned to other patients."[45]

D. Managed Care Programs Have Created Barriers Which Often Limit Access to Necessary Care.

In many managed care programs, it is the primary care physician who serves as the "gatekeeper." Physician gatekeepers may come under considerable pressure to deny access to services as evidenced by a warning, given by one managed care organization to physician gatekeepers in its program, stating that the physicians' contracts would be terminated if they approved too many specialist referrals.[46]

Other programs rely on outside gatekeepers (who may be physicians, nurses or persons who are not trained in medicine). Outside gatekeepers may be located in a

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[44] Stephenson, Experts Sav AIDS Pain "Dramatically Undertreated," 276 J.A.M.A. 1369 (1996).
[45] Knox, AIDS Remedies Give Little Hope to Poor, Boston Globe, July 16, 1996.
[46] Reuters Health News Service, HMOs Respond to Member Complaints, Aug. 20, 1996.

different city or state and have no personal contact with the patient or the patient's primary care physician. This type of gatekeeper or reviewer is often compensated on the basis of cost saving for the managed care organization.

The role of an outside reviewer was described by Dr. Linda Peeno when she testified before the House Commerce Health Subcommittee. Dr. Peeno, who had served as a medical reviewer for a managed care program, said she saved her employer money by denying treatment. She explained that, in one such case, her decision led to a man's death but, rather than being held accountable, she was financially rewarded. She earned an annual six-figure income by using her medical expertise to bring financial gains to the organization. "According to the managed care industry, it is not an ethical issue to sacrifice a human being for a 'savings,"' she said.[47]

E. To Preserve a Competitive Edge in the Marketplace, Managed Care Organizations Resist Attempts to Assure Patients' Rights.

Until very recently, health institutions, both public and private, were overwhelmingly non-profit endeavors. However, for-profit organizations are becoming the rule, rather than the exception, so that more than seventy percent of all HMOs are now for-profit corporations. With this change has come a shift in focus. Within the non-profit realm, any excess money is earmarked to improve services,

[47] Gianelli, Congress Considers Ban on Managed Care "Gag" Clauses, Am. Med. News, June 19, 1995, at. 5, col. 1.

access and care for the served population. In the for-profit sphere, money saved by limiting services benefits corporate shareholders. Meeting profit projections supplants meeting patient needs and is the driving force in the for-profit arena.

It would seem reasonable to assume that if patients demand types of care that may increase costs, managed care programs would respond since pleasing the customer has always been considered good business practice. The program could then pass on the costs to the consumer by raising premiums. However, this assumption misses a crucial point. In most cases, employers, not individual subscribers, pay the premiums, so employers are the "customers" who must be pleased. Further, it is the employer, seeking to keep expenditures for employee benefits down, who will opt for a program that keeps rates down.

In 1995, a broad coalition of patient and provider groups drafted a set of standards on the rights of patients, including the right to information about provider incentives or restrictions that might influence practice patterns. Managed care organizations refused to sign on. Although the principles were endorsed by over one hundred groups including the American Medical Association, American Cancer Society, American Association of Retired Persons, and the Joint Commission on Accreditation of Health Care Organizations, a managed care representative explained that the principles seemed to be "too close to the operational

issues" of managed care.[48] A subsequent attempt to adopt government regulations restricting managed care organizations' practice of incentives and gag rules was successfully resisted by managed care programs. The managed care industry claimed that such practices are important in "a fast-moving, intensely competitive industry."[49]

With their sites firmly on profit margins and beating the competition, it seems reasonable to predict that managed care corporations would be more than willing to reimburse for inexpensive assisted suicide services that would eliminate the need for some costlier services.

F. Managed Care Programs Often Seek Only Short Term Effectiveness and Maximum Cost Containment

For medical conditions, like appendicitis or minor infections that can be addressed in the short term, managed care programs do relatively well. Problematic, however, is the care received by people who have conditions that require long term care. Thus, a relatively healthy person who enters into a managed care program will generally be satisfied with the program as long as his or her health remains good overall. If, however, a person develops a condition, like multiple sclerosis, that requires on-going care, managed care often falls short of expectations.[50]

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[48] Page, Manased Care Firms Balk at Patient Riqhts Aqreement, Am. Med. News, Dec. 4, 1995, at 3, 23.
[49] Pear, U.S. Shelves Plan to Limit Rewards to HMO Doctors, N.Y.Times, July 8, 1996.
[50] Rosenthal, Patients Say N.Y. HMOs Don't Deal Well with Complex Illnesses, N.Y. Times, July 15, 1996, at A19.

Additionally, while all managed care programs emphasize preventative care, not all have programs to prevent complications that can result from chronic disease. The way in which managed care deals with diabetes is an illustration of the quest for short term cost effectiveness. Fewer than one-half of HMOs have implemented programs to manage diabetes[51] even though more than 14 million Americans are known to have diabetes,[52] a disease that can cause blindness, kidney failure, nerve damage and is the fourth leading cause of death in the United States.[53]

Regimens that could result in greatly reduced costs in terms of patients' lives and health care resources have sometimes been ignored in the interest of immediate monetary saving. When the National Institute of Health (NIH) supported a study on diabetes that showed that good control would reduce the complications of diabetes, managed care organizations indicated a marked lack of interest in the program. According to Dr. Judith Vaitukaitis, director of the National Center for Research Resources at NIH, this stance on the part of managed care programs was due to the fact that the managed care organizations did not want to spend the extra time and resources that good control would require. She explained that "the benefit of reduced

[51] Reuters Health News Service, HMO Enrollment Surpasses 59 Million in U.S., Oct. 23, 1996.
[52] Blakeslee, Program to Cut Risks of Diabetes Surprisingly Fails to Lure Patients, N.Y.Times, Feb. 28, 1994, at A1,5.
[53] New Diabetes Treatment May Block Worst Effects, San Francisco Chron., June 14, 1993, at A3.

complications is not seen for years ahead and they [managed care organizations] don't see the benefit in reduced costs because of the rapid turnover of their members."[54]

This emphasis on quick profits has also been described by Dr. George Lundberg, editor-in-chief of the Journal of the American Medical Association, who stated, "Getting managed care companies to think in terms of the long term is starry-eyed. Profit is to be made here. The managed care companies are not interested in the long term."[55]

It would seem logical for managed care organizations to promote long term preventative care since this would result in future savings. However, according to health care consultant Theodore J. Weinberg, individuals change health care programs about every three or four years.[56] The advantages of long term preventative measures may not show up for ten years or more and, by that time, a person may be in another managed care program. Consequently, competitive managed care programs are unlikely to invest in outcomes that would not pay off within a short period since the investment in a prevention program paid for by one managed care organization may result in better health (and thus lower expenditures) for enrollees in a competitor's program.

With this short sighted approach to health care, the long term consequence could be greater numbers of

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[54] C. Marwick, Effect of Manased Care Felt in Every Medical Field, 276 J.A.M.A. 768 (1996).
[55] Id.
[56] Id.

debilitated individuals who would create additional strain on the health delivery system. This, in turn, could spur greater incentives for managed care programs to promote assisted suicide referred to by one euthanasia advocate as "a new age form of hospice care."[57]

G. Patients' Fears of Dependence, Unremitting Pain and Loss of Dignity Are Often Increased by the Practices of Managed Care Programs.

A 1996 Gallup poll on public attitudes about assisted suicide, conducted for the National Hospice Organization, found that what people fear most about dying are the prospects of dependence, pain and loss of dignity.[58] In many ways, the current practices in managed care programs operate in a manner that turns these fears into reality.

It is often chronically ill patients, particularly those who are elderly or poor, who are hardest hit by the cost containment aspects of managed care. Within HMO plans, such patients fare poorly in comparison to similar patients in fee-for-service plans.[59] Their plight may become even more pronounced in the future since these patients "account

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[57] Kevorkian Takes Stand in Own Defense, N.Y. Times, Apr. 28, 1994, at A8. Dr. Stanley Levy, an internal medicine physician who specializes in geriatrics, called the activities of Jack Kevorkian "new age hospice care" while testifying for the defense during Kevorkian's trial in the death of Thomas Hyde, who died of carbon monoxide poisoning on August 4, 1993.

[58] National Hospice Organization, Press Release, Oct. 3, 1996, at 2.

[59] J. Ware, M. Bayliss, W. Rogers, M. Kosinski, A. Tarlov, Difference in 4-Year Health Outcomes for Elderly and Poor,

for a disproportionate share of health care expenditures and are therefore prime targets of cost containment."[60]

It is well known that chronic conditions can often be controlled or, at least, their progression can be slowed down if appropriate and necessary care is provided. The lack of emphasis placed on chronic care by managed care organizations can actually lead to patients' becoming dependent sooner than they would have been if appropriate care had been provided. Thus, managed care's lack of attention to chronic conditions may serve to heighten dependence which a great number of people fear and could actually lead to a greater number of people considering assisted suicide.

The fear of unremitting pain which causes great anxiety for patients and which some have said could lead them to seek assisted suicide is heightened due to the inaccessibility of pain control for many people. It is the lack of access, not an absence of such interventions, that creates this tragic situation. Patients are often forced to endure pain because third party payers refuse to reimburse for its treatment. In effect, "by rationing pain management on a financial basis, patients are being forced to consider death as their only option."[61]

Chronically 111 Patients Treated in HMO and Fee-for-Service Systems, 276 J.A.M.A. 1039 (1996).

[60] Id., at 1040.

[61] K. Foley, The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide, 6 J. Pain and Symptom Mgmt. 289, 292 (1991).

Navigating the murky waters of services not covered, services not approved and the complex methods of co-payments is particularly difficult for patients who are in pain. They have precious little energy to deal with a system that seems to block their access to necessary pain relief at every turn.

This denial of needed pain control is most pronounced within certain categories of patients. In 1994, the State of California's "Summit on Effective Pain Management"[62] found that third party payers often restrict payment for pain-related services.[63] It further found that pain is more likely to be undertreated if the patient is a member of a minority, female, elderly, or a child.[64]

Among these groups who are undertreated, the problem of pain relief is especially difficult for the elderly. Until recently, management of pain in elderly patients was largely ignored, although findings indicate that the prevalence of pain in the elderly is known to be twice that of younger people and can be as high as eighty-five percent in older people living in long-term care settings,[65] even though

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[62] In March 1994, the State of California sponsored a "Summit on Effective Pain Management" at which more than 120 health care practitioners, professional and public educators, representatives of professional schools and associations, and health care consumers met to identify and recommend solutions to legal, professional, and educational barriers to effective pain management.

[63] State of California, Report on "Summit on Effective Pain Management: Removing Impediments to Appropriate Prescribing," 5 (1994).

[64] Id.

[65] B. Ferrell, Pain Management in Elderly People, 39 J. Am. Geriatr. Soc. 64 (1991).

individualized pain management plans for older people can be highly effective.[66] The problem in a managed care context is that individualized plans are time consuming.

The failure to allocate the necessary time and resources to giving adequate pain management creates the untenable situation, so greatly and rightfully feared by many people. This could well lead a patient to believe erroneously that "nothing can be done" to alleviate suffering and, in turn, this could result in a patient's choosing assisted suicide as the only available means to escape pain.

Patient concerns about loss of dignity are also heightened by the cost containment policies and requirements of managed care programs. It is difficult for patients to feel valued and cared for when physicians are compelled to treat them as though they were assembly line products being processed in an allotted number of minutes. This production line mentality was described by Dr. Leonard Laster, distinguished professor of medicine and health policy at the University of Massachusetts Medical Center in Worcester:

> "Business managers working in the interests of cost-cutting now tell doctors how much time to spend with a patient, and many allow only ten minutes for a returning patient and no more than twenty minutes for a new patient. How can anyone perform even a passable evaluation in twenty minutes

[66] T. Fulmer, L. Mion, M. Bottrell, Pain Manasement Protocol: Inappropriate Pain Management Leaves Both the Elder and the Nurse Feeling Unfulfilled and Unhappy with the Care, 17 Geriatr. Nurs. 222 (1996).

on an elderly patient with a massive written clinical record...?"[67]

Mandated time restrictions are not the only things that can leave patients feeling demeaned and unimportant. Sometimes the greatest assaults on one's sense of self-worth emanate from small indignities. When one of the nations largest managed care companies experienced losses in 1995, it instituted cost cutting measures which included the refusal to provide gowns for gynecological exam patients. Patients were told to disrobe and then, instead of being provided with a gown, they were given a small square of paper on which they were to sit while awaiting the examination.[68]

It stretches credulity to think that managed care programs -- which fail to reimburse for adequate pain control, control exam times down to the minute, and deny a patient even a simple gown with which to cover herself -- would allot large sums of money for comprehensive services so that assisted suicide would be used only as a last resort.

It could be assumed that, if patients are faced with demeaning policies and life threatening conditions such as have been described, they need only avail themselves of the appeal or complaint procedures that are in place in large

[67] Laster, Manased Care Translates to "Let the Patient Beware," Am. Med. News, Feb. 19, 1996, at 18.
[68] Auerbach, supra note 39.

corporations, including large health care corporations. However, the process of appealing a managed care program's decision is often time-consuming, costly and beyond the ability of many patients who are already using every ounce of energy and every financial resource to exist on a daily basis. Meanwhile, as the quest for administrative remedies drags on, the patient's agony remains unrelieved.

H. The Appeals Process under Managed Care Is Often So Complex That Patients Could Consider Assisted Suicide to Be Their Only Recourse.

When essential treatment is denied, the appeals procedure under managed care is often so complex and time consuming that the accompanying delays can cause a patient grave harm. Additionally, personnel investigating the appeal may lack expertise in assessing the actual medical condition or its appropriate treatment.

One such case involved a child with an extremely rare kidney tumor that is fatal if not treated but has a ninety-seven percent cure rate with prompt surgery. The child's primary care physician sought permission from the group plan to refer the child to an out-of-group specialist, since the group itself had no one with the needed expertise in treating the child's condition. The group's acting medical director, an ophthalmologist (eye specialist), refused to authorize the referral, saying that an in-group physician should perform the surgery. When the child's parents

appealed, the appeal procedure was handled by a nurse who also denied the referral.

This left the family with two options: Have the surgery performed by a surgeon who was unqualified or personally bear the cost of an experienced medical team outside the group. Her parents opted for the latter, and the child's condition was cured. However, the managed care group not only refused to pay for the surgery but also denied any reimbursement for the accompanying hospital costs, even though the hospital costs were identical to those that would have been incurred if an in-group physician had performed the surgery.

It took close to four years but, in October of 1996, the managed care program was fined by the California Department of Corporations for failing to provide the child "as well as all member patients with all medically necessary physician services." It was also found that the managed care program had failed to demonstrate that its refusal to refer the child to a qualified surgeon was unhindered by fiscal and administrative considerations.[69]

Unfortunately, many people who are denied care, give up. They have neither the money to obtain care outside their managed care program nor the inclination to embark on court challenges. The outcome for such individuals can mean that a potentially fatal, yet curable, condition is allowed

[69] Comm'r of Corp. v. Takecare Health Plan, (Cal. Dept. of Corp., No. 933-0290, OAH No. N 9412060, Oct. 29, 1996).

to progress. If assisted suicide is permitted, such individuals may well find that the same managed care organization that denied reimbursement for life-saving interventions will approve reimbursement for life-ending medication.

Obtaining necessary services through HMOs has been particularly difficult for Medicare patients. For many elderly patients, the process required for peer review of an HMO's decision to deny them care is too confusing, involves long time delays, and ultimately ends up being a useless endeavor. These facts prompted a class-action lawsuit on behalf of the millions of Medicare beneficiaries who are in HMOs.[70]

The administration and the HMO industry contended that federal Medicare law "does not require an impartial review procedure for Medicare beneficiaries enrolled in HMOs before a termination or denial of their HMO services."[71] However, U.S. District Court Judge Alfredo C. Marquez found otherwise. He stated that Medicare patients in HMOs are entitled to immediate hearings whenever they are denied medical services.[72]

The need for immediacy is particularly important for

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[70] Between 1987 and 1995, the number of Medicare beneficiaries covered in capitated programs almost tripled. D. Berwick, Payment by Capitation and the Quality of Care, 335 New Eng. J. Med. 1227 (1996).

[71] Pear, Medicare Patients in HMOs Win Case, N.Y.Times, Oct. 31, 1996.

[72] Griialva v. Shalala, No. 93-711 (D. Ariz. Oct. 17, 1996) (1996 WL 627497).

Medicare patients since, "[w]hen Medicare services are denied, they are often foregone and, depending on the medical condition, final adjudication may come too late to rectify the situation, especially if the deprivation contributed to or resulted in unnecessary pain and suffering or death."[73]

In a strongly worded opinion, Judge Marquez noted that, even though there were regulations and guidelines that should have protected Medicare beneficiaries, they were not being followed. Complex and confusing in-house review procedures amounted to little more than "a 'rubber stamp' of the initial denial,"[74] which has "grave consequences because an HMO denial may mean the enrollee will go without medically necessary service."[75] He further noted, "Given the length of time it takes for further appeal of the HMO denial, deprivations will certainly have significant impacts on quality of life and some may even be life threatening."[76]

According to Judge Marquez, an HMO often "hides the ball"[77] and frequently doesn't let Medicare patients know that they have a "right to present additional evidence to the HMO for reconsideration."" He concluded, as did the District of Columbia in Circuit Court in Gray Panthers v.

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[73] Id., at 8.
[74] Id., at 10.
[75] Id.
[76] Id.
[77] Id., at 9.
[78] Id., at 10.

Schweiker,[79] that "[c]urrent procedures allotted to the elderly Medicare claimant, probably disadvantaged by disability and poverty, resemble playing against a stacked deck...."[80]

Yet, it is not only patients that are detrimentally affected by the manner in which managed care organizations are presently operating. The impact on the medical profession as a whole and, along with it, the increased risk to patients which may not be evident for several years must also be considered.

I. The Policies of Managed Care Corporations Compromise the Quality and Expertise of the Medical Profession, Making It Imperative That Florida Protect Residents from Assisted Suicide.

Among physicians there is growing concern that managed care organizations are placing patients at great risk, not only by failing to appropriately screen physicians but also by forcing qualified physicians to compromise their ability to provide high quality medical care. Since managed care programs can modify quality assurance procedures or eliminate independent reviews of disputes over patient care at any time, physicians recognize that both patient well being and medical integrity is threatened.

This concern, both for their patients and for their own professional liability is well founded. For example, in

[79] Gray Panthers v. Schweiker, 652 F.2d 146 (D.C. Cir. 1980).
[80] Id., at 172.

one case, premature discharge from the hospital was mandated by a third party payer, even though the patient's own doctor had recommended longer hospitalization. As a result of the discharge, the patient suffered severe complications that led to amputation of her leg. The court found the physician liable, stating:

> a physician who complies without protest with the limitations imposed by a third party payer, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payer as the liability scapegoat when the consequences of his own determinate medical decisions go sour.[81]

It is not beyond the realm of possibility to opine that the availability of assisted suicide could become a panacea to solve the conflict of interest and liability problems that physicians encounter.

IV. THE CIRCUIT COURT ERRED WHEN IT FAILED TO CONSIDER POLICIES WHICH PUT COST CONTAINMENT AND HEALTH CARE INDUSTRY PROFITS BEFORE PATIENT WELL-BEING

As providers in a managed care environment, many physicians will continue to be sincerely motivated by respect for patient well-being and autonomy, but the cost factor will always lurk in the shadows. As precarious as the situation resulting from managed care is at present, it would only become worse if physician-assisted suicide were to be considered a legitimate and legal medical option. If states are not permitted to protect their citizens from

[81] Wickline v. California, 192 Cal.App.3d 1630, 228 Cal.Rptr. 661, 670-671 (1986).

assisted suicide, the managed care provider would, in many cases, become the managed death provider. Dr. Daniel Sulmasy described the link between managed care and assisted suicide in concise terms when he stated that "the movement toward managed care as a preferred means to control health care cost and the movement toward managed death as the preferred means to control terminal suffering are strong, active and current."[82]

To gauge the accuracy of Dr. Sulmasy's warning, one need only reflect on the vise-like pressure placed on doctors that has been described above and examine what happened when voters in the state of Oregon approved Measure 16, the "Death with Dignity Act," which permits assisted suicide under certain conditions.[83]

Less than five weeks after Measure 16's passage, Oregon's Medicaid director, Jean Thorne, said that assisted suicide would be covered under a part of the Oregon Health Plan called "comfort care."[84] Noteworthy was the fact that, as assisted suicide was being scheduled as a covered

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[82] D. Sulmasy, Managed Care and Managed Death, 155 Arch. Int. Med. 133 (1995). Although Sulmasy refers to managed death for "terminal suffering," it is highly unlikely that assisted suicide would or could be limited to those whose conditions are diagnosed as "terminal." See e.g., E. Chevlen, The Limits of Prognostication, 35 Duq. L. Rev. 337 (1996); and Marker, supra note 36, at 90-94.

[83] As a result of court challenges the Oregon statute has not gone into effect.

[84] Postrel, State Could Cover Assisted Suicide, Statesman Journal (Salem, OR), Dec. 1, 1994, at Al.

service, other existing services for poor Oregonians were being scrutinized for cuts.[85]

While some may question any direct relationship between the passage of Oregon's assisted suicide measure and attempts to cut health services, the cost effectiveness of hastened death is as undeniable as gravity. The earlier a patient dies, the less costly is his or her care. In any event, dead patients do not threaten managed care profits.

Likewise, there are varied opinions about any link between cost of care and euthanasia in the Netherlands where thousands of assisted suicide and euthanasia deaths -- many of which are not requested by the patient -- occur annually.[86] Of note is the cost of performing euthanasia in the Netherlands which, Dutch euthanasia practitioner Dr. Pieter Admiraal has explained, can be performed for about five guilders whereas the cost of a single day of hospitalization is five hundred guilders.[87] Perhaps coincidentally, perhaps not, the Netherlands has the lowest per capita health expenditure in all of Europe." According to Dr. Jeffrey Jackson of the Walter Reed Army Medical

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[85] Deitz, Lawmakers Mav Trim Health Plan, Statesman Journal (Salem, OR) Jan. 9, 1995.

[86] Although the Dutch practice of physician induced death began with the intent of offering patients greater control over their own deaths, the practice of euthanasia and assisted suicide has actually increased the power and control of doctors, not patients. See generally: H. Hendin, Seduced by Death: Doctors, Patients, and the Dutch Cure (New York: W.W. Norton & Co.1997).

[87] R. Marker, Deadly Compassion 146 (New York: Wm. Morrow & co. 1993).

[88] Reuters Health News Service, Lessons on Healthcare Reform from the Dutch, July 22, 1996.

Center in Washington, this low per patient expenditure "reflects an ongoing effort to ensure that Dutch physicians are sensitive to cost and practice economically prudent medicine."[89]

Managed care has been referred to as a "work in progress"[90] which may eventually work very well if improvements are made. But those improvements could take years as legislatures and courts wrestle with the complex problems and conflicts of interest inherent in managed care programs. Meanwhile, the issues before this Court demand immediate resolution.

CONCLUSION

This Court faces the momentous task of determining whether the Florida Privacy Amendment precludes the state from protecting its residents by prohibiting assisted suicide. Proponents of assisted suicide argue that assisted suicide is a matter of personal privacy, but their assertions are wrong.

The issue should not be decided solely on an abstract notion of personal privacy but on the realities of how, and in what environment, assisted suicide would be carried out. It is imperative that the full implications of permissive assisted suicide on all of Florida's residents -- the very

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[89] Id.

[90] P. M. Ellwood, Managed Care: A Work in Progress, 276 J.A.M.A. 1083 (1996).

young, as well as the very old, the very poor as well as the comfortably well off, the demented as well as the competent, disabled as well as terminally ill persons -- be considered.

This brief has demonstrated that the current health care environment is evolving into a system defined by cost-cutting and dominated by a form of health insurance known generically as managed care. It has shown that the very purpose of managed care, which is to reduce the cost of providing medical care, is accomplished, in large part, through a system that rewards reduced levels of care. Further, it has illustrated that, if permitted, assisted suicide would jeopardize the lives of all Floridians. In sum, assisted suicide would create a profound injustice.

This is the reality with which the Court must grapple.

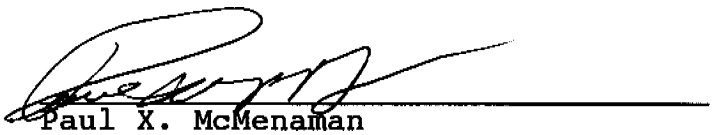
Rather than serving the noble cause of individual liberty, it would make a mockery of freedom, since the "choice" to commit assisted suicide would, in many cases, have essentially been predetermined by financial imperatives and social expectations. Decisions to die would often be based, not on the inability of physicians to control pain and limit suffering but on pecuniary and societal grounds.

That being so, Florida's prohibition against assisted suicide serves a compelling state interest and is necessary to insure that managed health care does not devolve into a system of managed death. Florida's law against assisted suicide protects and reinforces the traditional ethics of

the health care profession. It prevents doctors and others from ending a patient's life to achieve their own ends. Perhaps most importantly, it reinforces the essential moral concept that human beings are not commodities, that lives cannot be measured in pecuniary terms, and that rich or poor, powerful or weak, no one should be sacrificed to benefit financial bottom lines.

Amicus curiae IAETF asks that this Court find that the Florida Privacy Amendment does not include a right to assisted suicide.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that on the 5th day of March, 1997, two true and correct copies of the foregoing Brief of the International Anti-Euthanasia Task Force were mailed, first class, postage prepaid, to the following counsel of record:

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