1-1-1980

Remaining Responsible: On Control of One's Health Needs in Aging

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INTRODUCTION

American society has traditionally protected individual autonomy. Freedom of choice in personal affairs, whether or not that choice is consonant with majoritarian opinion, has been vigorously defended in our legal system as a necessary precondition for autonomy and self-sufficiency. Until the last decade, however, a second current ran through social thought and action: state paternalism.¹ The concept of the state as parent was attended by two complementary assumptions: that a non-adversarial relationship existed between the state and its citizens,² and that the state could define the best interests of citizens and thereby enhance their freedom.³ The proponents of the paternalistic model were not concerned with the potential of their programs to be more coercive than they were liberating.⁴

Paternalistic coercion functions both overtly and covertly and the most insidious threats to liberty may be concealed beneath ostensibly well-intentioned actions. Overt intervention pervades the involuntary psychiatric commitment system; procedures directly wrest personal control from subjects under the guise of improved mental health. Covert intervention exists in governmental health benefit programs that require recipients to accede to manifold conditions in order to qualify as participants. These conditions are founded upon majoritarian

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¹ See Rothman, The State as Parent, in Doing Good 69-70 (1978), for a discussion of the recent transformation from “the commitment to paternalistic state intervention in the name of equality . . . to a commitment to restrict intervention in the name of liberty.” Id. at 74.

² Id. at 77.

³ Id. at 74.

⁴ Id. at 72.
views of health, disease and cure. The impact of state intervention is compounded by the penchant of contemporary physicians to relegate their patients to the role of passive recipients of the physician's efforts, rather than to educate the patient concerning "the meaning of the illness and the [possible] methods for its remedy." 5

Overt paternalistic intervention results in the involuntary manipulation of the subject's person and property and frequently culminates in institutionalization. Covert intervention likewise may result in undesired and undesirable treatment and unnecessary institutionalization. In the latter situation, the reality of the coercion is obscured behind a veil of voluntariness because the patient's "need" for treatment and the consequent decision to participate in the program are ostensibly determined by the subject rather than by others. Certainly, individual participation in public assistance programs is rarely mandated by the state; for many persons, the elderly in particular, however, the receipt of public assistance is necessary in order to obtain health care.

In recent years, the paternalistic model has come increasingly under attack. 6 Challengers emphasize that the preconditions necessary for participation in many public programs are both invasive of individual autonomy and functionally unsound. While society has traditionally focused its attention, in a self-congratulatory manner, on the value of providing care for the subject's benefit, little analysis has been devoted to the ultimate "benefit" and the ramifications of diminished self-determination. Evidence is accumulating, however, that such loss is not negligible, particularly with regard to medical care. The loss of autonomy may entirely vitiate putative benefits by aggravating the subject's morbidity.

The state should reexamine the interests upon which both direct and indirect intervention are based, as well as the dubious assumptions upon which these interests are premised. This article will analyze the suppositions underlying both systems of intervention and will suggest a restructuring that will better foster personal autonomy.


OVERT INTERVENTION

A particularly flagrant example of overt intervention into the life of an individual proceeds from involuntary commitment to a psychiatric institution. This intrusion is commonly premised upon the "best interests of the subject." The process of psychiatric intervention begins with a decision that the subject, because of a mental disorder, either is unable to provide adequately for basic needs or is otherwise in need of treatment. The decision to intervene may be simple and nonadjudicative or it may involve an elaborate judicial hearing, but once intervention is authorized, the subject may be treated, within varying limits, irrespective of his or her articulated wishes.

Several assumptions underlie overt psychiatric intervention: first, that it is possible to judge validly whether the subject is incompetent to manage personal needs; second, that someone other than the subject can better determine the content of those needs; third, that intervention will result in better care for the subject than would have occurred without intervention; and finally, that the care provided will be effective, result-


8. See 3 MENTAL DISABILITY L. REP. 206-14 (1979), for a survey of state laws governing civil commitment, especially criteria for extended confinement of the mentally ill.


10. See R. Plotkin, Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment, 72 NW. U.L. REV. 461 (1978), for an excellent discussion of the issue, an analysis of the four most intrusive forms of therapy and a survey of the statutes of the 50 states and the District of Columbia. See also Developments in the Law, supra note 7, at 1344-58; B. Ennis & R. Emery, supra note 9, at 131-42; Special Reprint, supra note 7, at 111-17; LEGAL AND ETHICAL ISSUES, supra note 7, at 106-11.
ing in an improvement in the subject’s quality of life. Each of these assumptions is often incorrect.

Inability to Provide for Self-Care and Psychiatric Expertise

The determination of “inability to provide” is essentially a predictive judgment drawn from an assessment of the person’s present condition and past behavior. This judgment avers that the person will, as a result of “mental disease,” be unable to choose to provide for his own personal needs. The judgment of mental disease/inability-to-provide is viewed as a medical diagnosis/prognosis effectively within the province of the medical profession since the model of “mental illness” is commonly assimilated to the biomedical model of physical illness. Great reliance is placed upon the testimony of psychiatrists, therefore, in all stages of the decision-making process.

There is growing evidence, however, that psychiatrists are unable to diagnose reliably the status of “mental illness” in their patients. The literature further demonstrates that psy-

11. Mental illnesses are thus regarded as basically similar to other diseases. The only difference, in this view, between mental and bodily disease is that the former, affecting the brain, manifests itself by means of mental symptoms; whereas the latter, affecting the other organ systems—e.g., the skin, liver and so on—manifests itself by means of symptoms referable to those parts of the body. T. Szasz, Ideology and Insanity 13 (1970). But, “insanity or mental illness is not so much the name of a medical condition as it is a strategic label invoked to justify a policy decision.” Szasz & Alexander, supra note 7, at 622. See also, E. Goffman, Asylums 321-86 (1961); T. Szasz, The Myth of Mental Illness (2d ed. 1974); T. Szasz, The Manufacturer of Madness (1970); Roth, Dayley & Lerner, supra note 9, at 400-11; Developments in the Law, supra note 7, at 1254-55 and sources cited therein. “[C]ritics argue that mental illness is simply a label placed on behavior which, although often not criminal, is annoying, burdensome, or frightening.” Id. at 1255.

12. “[S]ince the courts seek the verification of claims about mental illness and mental incompetence through the expert testimony of physicians (psychiatrists) and other mental health professionals, the triers of fact tend to be overawed by medical (and pseudo-medical) testimony.” Szasz & Alexander, supra note 7, at 622 (citation to T. Szasz, Ideology and Insanity (1970)). For a discussion of the similar domination of psychiatric testimony in the criminal justice system, see United States v. Brawner, 471 F.2d 969 (D.C. Cir. 1972) (esp. Bazelon, J., concurring in part and dissenting in part). See also, Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 Cal. L. Rev. 693, 694-96 and sources cited therein (1974).

13. Reliability refers to the degree of correspondence between judgment of professionals; validity refers to the degree of correspondence between the professional judgment and the external world. See Ennis & Litwack, supra note 12, for an extensive overview of the professional literature. “[T]he reliability of psychiatric judgments of specific diagnostic categories (schizophrenia, paranoid type, depressive reaction, passive-aggressive personality, and so on) is even lower [than 50 percent] somewhere
chiatrists have neither the training nor the expertise to predict a patient’s proclivity for violence to others or to self.\textsuperscript{14} By analogy, evidence of psychiatry’s diagnostic confusion regarding dangerousness suggests a likelihood of inaccuracy in predictions of capacity for self-sufficiency as well.\textsuperscript{15} An inadequacy of predictive skills is magnified by psychiatrists’ natural tendency toward overprediction of both dangerousness and need for treatment.\textsuperscript{16} The failure to predict future violence may expose the professional to ridicule, legal action, loss of reputation and personal guilt should the subject, upon release, injure himself or others. Involuntary intervention, on the other hand, insulates the decision maker from future criticism. Moreover, many psychiatrists err on the side of intervention since, in their view, the result is, at worst, the provision of sound treatment. In recent years, however, a rising awareness has developed, catalyzed by dramatic litigation, that institutionalization results in the neighborhood of 40 percent.” Id. at 702. “[P]sychiatric judgments are not only unreliable with respect to the ultimate diagnoses, but lack consistency even in the perception of the presence, nature and severity of symptoms. . . . [Some] psychiatrists . . . saw both different and more severe symptoms than other diagnosticians.” Id. at 706. Psychiatric diagnoses are likely to be no more valid than they are reliable. Id. at 698. See also B. Ennis \& R. Emery, supra note 9, at 15-20; Roth, Dayley \& Lerner, supra note 9, at 402-06; Rosenhan, On Being Sane in Insane Places, 13 Santa Clara Law 379, 379 n.1 (1973).

14. See B. Ennis \& R. Emery, supra note 9, at 20-22 \& nn.6 \& 7. Professor Alan Derschowitz states:

Considering the heavy-indeed exclusive reliance on psychiatric predic-
tions, one would expect there to be numerous follow-up studies establish-
ing their accuracy. Over this past year, I conducted a thorough survey of
all the published literature on the prediction of anti-social conduct. . . .
We were able to uncover fewer than a dozen [follow-up] studies. And
even more surprisingly, these few studies strongly suggest that psychia-
trists are rather inaccurate predictors; inaccurate in an absolute sense,
and even less accurate when compared with . . . psychologists, social
workers and correctional officials; and when compared to actuarial de-
vices, such as prediction and experience tables.

Derschowitz, Psychiatry in the Legal Process: A Knife That Cuts Both Ways, 4 Trial
29 (1968). See also Developments in the Law, supra note 7, at 1236-45; Ennis \& Litwack, supra note 12, at 711-16 and sources cited therein.


They describe one study in which 44 percent of mental patients released from a psychi-
atriic hospital by the court over the objections of the psychiatrists and 42 percent of the patients who escaped therefrom made a satisfactory adjustment to the community.

“[T]he investigators concluded that . . . the courts may be considered [to have] a
better prediction rate [than psychiatrists].” Id. at 717 \& nn.77-78.

16. Derschowitz, supra note 14, at 29; Ennis \& Litwack, supra note 12, at 711-
12 \& n.57; notes 12 \& 15, supra; Rosenhan, supra note 13, at 385.
severe debilitation and stigmatization as well as a massive loss of liberty.¹⁷

**Surrogate Decisions**

The second assumption underlying overt intervention—that a surrogate decision maker can effectively determine the best interests of the subject—is also doubtful. Such a surrogate, it is thought, most likely can facilitate the achievement of a normative state; that is, a desirable state as characterized by majoritarian opinion. The subject may be housed, clothed, fed and cared for “more satisfactorily,” but “satisfaction” is defined by parties other than the subject.¹⁸ This putative improvement in circumstances may carry with it the detrimental effects of the subject’s perceived loss of liberty and autonomy. A “satisfactory” adaptation to one’s world involves a series of balancings. Personal volition in striking the balance is itself an essential factor.

A danger of unrecognized, and therefore unchallenged, adverse interests exists in the present system of substitute decision making. Psychiatrists may impose treatment not only to protect their patients, but to preserve their professional dominance. Myriad other adverse interests may be buried beneath an ostensible concern for the subject’s welfare. Parents may be unwilling to manage their unruly and rebellious children,¹⁹ heirs or spouses may wish to preserve their inheritance or income,²⁰ or children may desire to remove an elderly parent from their home because the situation proves disruptive or bothersome. Moreover, the facade of altruism deflects attention from

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¹⁷. See Humphrey v. Cady, 405 U.S. 504, 509 (1971) (dictum); Mental Health and the Elderly: Joint Hearings Before the Subcomm. on Long-Term Care and the Subcomm. on Health of the Elderly of the Senate Comm. on Aging, 94th Cong., 1st Sess. 10, 35 (1975) (hereinafter cited as Joint Hearings); Chambers, Alternatives to Civil Commitment of the Mentally Il: Practical Guides and Constitutional Imperatives, 70 Mich. L. Rev. 1107, 1151-68 (1972); Developments in the Law, supra note 7, at 1193-201; Roth, Dayley & Lerner, supra note 9, at 433-35.

¹⁸. See Szasz & Alexander, supra note 7, at 612-14.


the reality of interests adverse to the subject, allowing them to function without impediment. The inherent potential for conflicting interests suggests that caution be exercised in assuming that a surrogate decision maker will genuinely pursue the best interests of the subject.

Quality and Effect of Care

The assumptions underlying involuntary psychiatric intervention are not separable by bright, conceptual lines. Particularly inextricable are the third and fourth assumptions noted above: that better care will ensue by virtue of the intervention and that such care will result in a higher quality of life for the subject. In recent years, the deplorable conditions in state mental institutions have been exposed and decried. The past decade has seen a silent exodus of patients from these institutions and many remaining facilities have improved their physical conditions; the system nonetheless remains profoundly inadequate. Discharged patients often live in circumstances as lamentable as those formerly existing in the large institutions and the persons who remain in institutions con-
continue to suffer from a paucity of appropriate care and individual attention. The effects of this chronic inadequacy of resources are exacerbated by the degrading impact of the institutional routine and the depersonalizing attitudes of service providers toward patients.

Effective care cannot generally be imposed unilaterally. The patient must usually be a willing participant in the process in order that any enduring improvement occur. Hence, there is substantial reason to doubt that involuntary psychiatric treatment is effective in most instances. The subject's cooperation is either absent or only disingenuously present (cooperation hastens release). Inner resources are neither mobilized nor replenished, and instead may be dissipated by the psychological stress of resentment and resistance engendered by the loss of liberty.

"Good" care is that which produces or facilitates a salutary outcome. Benefit, however, can be evaluated and defined from several perspectives. For the service provider, an increase in the manageability and docility of a subject may be considered beneficial. For society at large, an increase and improvement in the quantum of nutrition, care and longevity may


The record in this case clearly demonstrates that Partlow and the developmental centers failed to comply with the standards for habilitation established by this court. Residents of Partlow receive grossly inadequate habilitation programming. Many Partlow residents' lives consist only of long hours and empty days of boredom and neglect—periods with little or none of the staff interaction, supervision or guidance necessary for learning and development.

Id. at 2-3. Judicial victories may be vitiated by recalcitrant non-compliance.


28. See B. Ennis & R. Emery, supra note 9, at 18 & n.6; Special Reprint, supra note 7, at 18 & n.6.

constitute benefit. For the subject, however, all so-called “objective” improvements may be vitiated by his sense of degradation, dependency and meaninglessness. In fact, such imposed “improvements” may inherently derogate from the subject’s sense of self-efficacy and autonomy. These normative improvements, then, may be misinterpreted as ends in themselves rather than a means toward a greater end—the enhancement of an individual’s sense of well-being that includes the perception of self-determination and liberty. One mechanism that would more surely serve such an end would be the effectuation of a competent decision articulated by the subject prior to the alleged psychiatric disability.

The elderly population, in particular, suffers from the often glaring discrepancy between majoritarian and individual evaluation of benefit. An older person may, for example, wish to remain at home even under conditions which may endanger health and safety, rather than live in the more protected environment of an institution. “The place where one lives is profoundly connected with who one is and how one expresses this sense of self. . . . Many older people also associate home with autonomy and control.” Hence, for the aged, the benevolence of others may directly produce dependency, depression and even death.

The loss of familiar roles, norms and expectations may be further exacerbated by the deprivation of autonomy authorized by the protective service and civil commitment procedures. Numerous studies attest to the danger of involuntary intervention for the aging. A Benjamin Rose Institute report has sug-

31. See text accompanying note 10 supra.
33. See notes 34 & 35 infra.
34. See Blenkner, Environmental Change and the Aging Individual, 7 Gerontologist 101 (1967), discussing numerous studies documenting the negative relationship between survival and institutionalization and postulating that:
   If service to infirm or incapacitated older persons is primarily directed toward securing the necessary care in settings other than the person’s own home, the survival rate of the clientele will be lower than that resulting from a service which provides the necessary care in the client’s own home, or from a program that makes no attempt to provide any personal care.
   Id. at 101. See also, G. Alexander & T. Lewin, supra note 20, at 63; Aldrich & Mendkoff, Relocation of the Aged and Disabled: A Mortality Study, 11 J. Am. Geriatrics Soc. 185 (1963); Lieberman, Relationship of Mortality Rates to Entrance for a
gested that intrusion beyond basic housekeeping assistance may produce more detriment than benefit, as evidenced by the increase in mortality among the "intensively served" aging population as compared with a "minimally assisted" group.\footnote{35}

Financial insecurity, another frequent concomitant of senescence in our society, further facilitates medical intervention. The method by which the medical benefit system is delivered to patient-beneficiaries differs from that used to impose psychiatric treatment. Services are offered but not compelled; their compensation, however, is conditioned upon obedience to societal dictate.

COVERT INTERVENTION: GENERAL MEDICINE

General medical treatment is normally provided on a voluntary basis.\footnote{36} Save for exceptional situations such as individual emergency\footnote{37} or public danger from contagious disease,\footnote{38} a

\textit{Home for the Aged}, 16 \textit{Geriatrics} 515 (1961); Regan, \textit{Protective Services for the Elderly: Commitment, Guardianship, and Alternatives}, 13 \textit{Wm. & Mary L. Rev.} 569, 588-89 (1972). Obversely, Leaf, \textit{Unusual Longevity: The Common Denominator}, 34 \textit{Hospital Practice} 75, 84 (1973), upon studying the remarkably long lived inhabitants of three areas in Equador, the Caucasus and Kashmir, averred that psychological factors seem to play a significant role. The elderly did not retire, continued to live and work in their homes, and seemed imbued with a sense of youthfulness and purpose. This combination of factors apparently facilitated the aged population's retention of mental and physical faculties.

\textit{35.} See, e.g., \textit{Benjamin Rose Institute, Protective Services for Older People: Findings from the Benjamin Rose Institute Study} (1974):

Unquestionably the demonstrated service relieved stress among collaterals and met with the approval of community agents, yet for the typical protective there was no significant improvement. Furthermore although more "protected" he was no less likely to die when given intensive protective services than when left to the usual and limited services of the community. In fact, the findings on functional competence together with those on death and institutionalization force one to entertain the hypothesis that intensive service of the sort supplied in the project with a heavy reliance on custodial care may actually accelerate decline.

\textit{Id.} at 183 (emphasis in original).

\textit{36.} "[N]o state has a statute under which a physically ill individual can be involuntarily hospitalized solely because he needs treatment to protect his own welfare. Moreover, no court has ever ordered a competent adult to accept hospitalization and medical treatment solely for his own benefit." \textit{Developments in the Law, supra} note 7, at 1216 n.84.


\textit{38.} \textit{See} Jacobson v. Mass., 197 U.S. 11, 22-39 (1905) (compulsory adult vaccination is a reasonable exercise of the state's police power); \textit{Developments in the Law, supra} note 7, at 1224 n.127, 1225 n.129. A further exception has been made to protect the interests of the patient's dependents. \textit{See} Application of President & Directors of Georgetown College, Inc., 331 F.2d 1000, 1008 (D.C. Cir. 1974), cert. denied, 377 U.S.
competent person cannot be subjected to the intrusion of medical procedures without his or her informed consent.39 Conversely, a person possessed of private resources is free to choose any form of legally-sanctioned medical therapy. Beneficial, even life-saving, treatment may be rejected in order that self-determination flourish.40 It would be unthinkable for the majority to impose a particular form of therapy on an independent adult citizen, yet an individual who must obtain needed health care through a medical benefit program or an insurance scheme must conform to predetermined therapeutic orientation. The participation in such a program, then, results in a serious derogation of participant autonomy.41

The varied interests that underlie a conditional benefit system should be distinguished as clearly as possible in order to facilitate analysis. The state, in its own right or as insurance regulator, has an interest in fostering general health. Widespread health conduces to greater productivity, reduction of contagious disease and increased contentment. This interest may be expressed aggressively, via legislation that prohibits certain activities or substances, or more indirectly, through programs that improve access to various health services.42

Generally, however, societal interest in individual health is subordinated to the interest of the subject in autonomy. Society cannot legitimately mandate the pursuit of a lifestyle


39. "[Informed consent exists when the following three conditions are met: the physician makes a reasonable disclosure to the patient of treatment risks; a voluntary decision is made by the patient based on this disclosure; and the patient is competent to make such a decision." Plotkin, supra note 10, at 486. See generally G. Annas, The Rights of Hospital Patients 57-87 (1975); W. Prosser, supra note 37, at 165-66; R. Veatch, supra note 38, at 116-23 and 146-63. The common law protects persons from unprivileged, harmful or offensive contacts with their persons. Medical treatment imposed without consent is actionable as battery. See W. Prosser, supra note 37, at 34-37, 102-05.

40. See notes 36-39 supra.

41. See Developments in the Law, supra note 7, at 1194-95 & n.12, for a discussion of the inchoate "constitutional right to bodily privacy which has been adumbrated in various judicial statements." See also, Plotkin, supra note 10, at 463 & n.7: "'[L]iberty' includes the freedom to decide about one's own health."

42. See, e.g., Paris Adult Theatre v. Slaton, 413 U.S. 49 (1973) (prohibition against exhibition of obscene materials).


that is conducive to health or economic productivity even though the failure of a person to conduct himself so may result in his requiring public assistance for support or medical care. For instance, we would find abhorrent any governmental dictate commanding all citizens to live so as to avoid obesity, to reduce their salt, sugar and fat consumption, to exercise regularly, or to forego tobacco and alcohol use. Medical literature, however, is replete with evidence that such simple actions would, in all probability, substantially improve well-being, increase longevity and reduce the incidence of most serious (and expensive) diseases. Similarly, the state may order neither sterilization nor contraception for persons receiving Aid to Families with Dependent Children (AFDC) benefits.

45. But cf. state statutes mandating family support, e.g., CAL. PENAL CODE § 271a (West 1970) (making willful abandonment or nonsupport of a child under the age of fourteen a criminal offense); CAL. CIV. CODE § 196 (West 1970) (requiring parents to suitably support and educate children); Id. § 206 (imposing a duty to support upon the father, mother, or children of a poor person who cannot work to support himself). Cf. also the right to refuse medical treatment exception for adults with dependents, note 38, supra. The loss of the parent would allegedly cause the dependent to become a ward of the state.

46. See Diet Related To Killer Diseases: Hearings Before the Select Comm. on Nutrition and Human Needs of the U.S. Senate, 94th Cong., 2d Sess. (July 27 & 28, 1976) [hereinafter cited as Hearings on Disease]. Dr. Theodore Cooper stated that six out of ten leading causes of death are directly related to diet. He noted further that nutritional inadequacies are exacerbated in the elderly amongst whom loneliness, economic strictures, inadequate dentition and decreased physical activity all contribute to a pattern of decreased food intake and deficit nutrition. Id. at 9, 11-12. Dr. Beverly Winikoff noted that the Framingham study in 1973 indicated that each 10 percent reduction in weight in men 35-55 years old would result in about a 20 percent decrease in the incidence of coronary disease; each 10 percent increase in weight would result in a 30 percent increase in coronary disease. Id. at 128. Dr. Gio B. Gori averred that 40 percent of the total incidence of cancer in males and about 60 percent of the incidence in females appears to be related to diet. Id. at 190. The notion that diet and not other environmental contaminants is involved in the causation of certain forms of cancer is further "sustained by the strong differences of cancer incidence among populations that live in the same environment and that differ principally because of dietary intake," such as Seventh-Day Adventists and Mormons. Id. at 178-79; Bello & Brerlow, Relationship of Physical Health Status and Health Practices, 1 PREV. MED. 409, 418-19 (1972), report that the physical health status of those persons who followed all of seven simple good health practices (moderate exercise, moderate alcohol consumption, three meals a day with little snacking, daily breakfast, moderate weight, sleep of 7-8 hours, no smoking) was consistently about the same as those thirty years younger who observed few or none. See also Knowles, The Responsibility of the Individual, in DOING BETTER AND FEELING WORSE 57 (J. Knowles ed. 1977); LEAF, supra note 34, at 82-84 (long-lived inhabitants maintained moderate calorie intake, a diet low in animal and saturated fats and continuous physical activity).

47. But cf. Watanabe, Reproduction and Capitalist Development: Uses of Birth Control and Abortion, in WELFARE IN AMERICA 119 (B. Mandell ed. 1975) who claims that government programs indirectly coerce sterilization and abortion amongst poor
ever, once a person enters into participation in a health benefit program, particularly a program for the aged, that individual's lifestyle is very effectively regulated and circumscribed.44

The state is clearly concerned with preventing the dissipation of its resources, a concern that frequently conflicts with state benevolence. The former interest is, at times, unexposed, as in many guardianship/conservatorship proceedings in which the state wishes to prevent a level of financial impoverishment that would cause the person to become a public charge. It is occasionally explicit, as in the "medically necessary" provisions of the medical benefit programs.45 These provisions, and the requirement that care be prescribed by a physician,46 ostensibly serve the further purpose of protecting the consumer from superfluous, inappropriate or detrimental therapies. Finally, the apparent voluntariness of the individual's participation in the benefit programs and the common characterization of a public benefit as a privilege rather than an entitlement serve further to rationalize covert intervention.

State covert intervention is premised upon several assumptions that parallel those underlying overt psychiatric intervention. Again, the validity of these assumptions is problematic.

Inability to Provide for Self Care and the Biochemical Model

The first assumption—that the recipient's inability adequately to provide for health needs is objectively determinable—is premised on the recipient's financial impoverishment and technical ignorance. The subject is presumed to lack the necessary knowledge, rather than the necessary rationality, to

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44. See generally, Watanabe, supra note 47, describing the constant tensions between the goals of social control and the goals of individual happiness and self-determination and suggesting that public benefit programs function to enforce the norms and values of the dominant sector and to quell civil discontent.


determine his or her own health needs. Licensed professionals, on the other hand, are presumed to possess the requisite expertise and objectivity to judge effectively and efficiently the content of the recipient's health needs. The accuracy of these assumptions is belied by the realities of the present system.

Many medical diagnostic techniques are no more reliable than psychiatric diagnosis, rendering the resulting prognosis equally questionable. The traditional biochemical model conceives of the body as a mechanism and of disease as a derangement of underlying physical processes to the exclusion of behavioral and psychosocial factors. The model comprises the beliefs that disease must be conceptualized in terms of physiochemical principles, that a mind-body dualism exists, and that proper medical treatment consists of intrusive procedures directed only at the biochemical abnormality. Thomas McKeown notes:

The approach to biology and medicine established during the seventeenth century was an engineering one based on a physical model. Nature was conceived in mechanistic terms, which might lead in biology to the idea that a living organism could be regarded as a machine which might be taken apart and reassembled if its structure and function were fully understood. In medicine, the same concept leads further to the belief that an understanding of disease processes and of the body's response to them would make it possible to intervene therapeutically, mainly by physical [surgical], chemical, or electrical methods.

51. One study, in which causes of death diagnosed before autopsy were compared with those established by the same clinicians after autopsy, determined that the original clinical diagnosis was erroneous in 30 percent of the cases. Britton, Diagnostic Errors Discovered at Autopsy, 196 Acta Med. Scand. 203, 204 (1974). The author summarizes various studies of diagnostic error conducted from 1912 to 1974, concluding that although numerous variables preclude the studies from being easily compared, it may be said that "[t]here is no convincing sign that the rate of errors has diminished over the years, although the diseases and types of mistakes have changed." Id. at 208. See also Ennis & Litwack, supra note 12, at 734 n.149; Sheenan, Diagnostic Errors in Clinical Practice, 74 Tex. Med. 92 (1978). Reasons for such prevalent error have been alleged to include excessive reliance on laboratory data to the point of ignoring physical data and the patient's history. Id. at 98.


53. Powles, On the Limitations of Modern Medicine, 1 Sci., Med. & Man. 1, 13 (1973) (quoting McKeown, A Historical Appraisal of the Medical Task, in Medical History and Medical Care (G. McLaugh & T. McKeown eds. 1971)). This "engineering" approach is well-exemplified by Powles' description of Bailey and Love's famous A Short Practice Of Surgery, published in 1968, that contains extensive discus-
Moreover, the rise of the germ theory of disease which "identified discrete, specific and external causal agents for disease processes,"54 gave further support to the mechanistic model. The germ theory emphasized the use of specific therapies and neglected the importance of host resistance or predisposition to infection.55

Recent articles have impugned the biochemical model's continued appropriateness to general medicine.56 George Engel contends that "medicine's crisis derives from the same basic fault as psychiatry's, namely, adherence to a model of disease no longer adequate for the scientific tasks and social responsibilities of either medicine or psychiatry."57 In his analysis, failure to consider the influence of psychosocial factors on health and disease interferes with the patient's healing process. Neither patient nor physician focuses upon these factors, which may be the true determinants of the time of onset of the disease, the variations in its course and the effectiveness of therapeutic measures.58 This omission may result in mutual distrust between physician and patient, frustration, and a consequent exacerbation of the disease. The conventional medical model further aggravates the imbroglio by legitimizing the physician's propensity to rely on technical procedures and laboratory measurements, deemphasizing the patient's verbal ac-

sions of operative techniques for the removal of tumors and of all pelvic organs:

In contrast to this readiness to consider drastic attempts at cure there is no discussion of etiology and there is no acknowledgement of the possibility that these cancers might be caused by our way of life and therefore be preventable.

_Id. at 14.

54. _Id._ at 15.

55. _Id._


57. Engel, _supra_ note 52, at 129. Present medical education emphasizes the "dismemberment of man" and is responsible for numerous diagnostic errors. Physicians, particularly in emergency room situations, tend to "dichotomize prematurely, and to concentrate upon either the patient's body or his mind. . . . [This] may interfere with the patient's obtaining necessary treatment." Leeman, _Diagnostic Errors in Emergency Room Medicine: Physical Illness in Patients Labeled "Psychiatric" and Vice Versa_, 6 _Int'l J. of Psych. in Med._ 533, 534 (1975).

58. Engel, _supra_ note 52, at 132.
count of his experience. Excessive dependence on technology causes an important professional skill to be neglected: the ability to understand the "psychological, social, and cultural determinants of how patients communicate symptoms of disease." Biomedical reductionism and its attendant professional dominance of health care have been further alleged to cause unnecessary hospitalization, overuse of drugs, excessive surgery and inappropriate utilization of diagnostic tests. Yet, physicians continue to be trained primarily in accordance with the biomedical model.

Abundant evidence exists, however, of the significant impact of psychosocial factors in the development of disease. Excessive stress, produced by our competitive, rapidly changing social order, has been found to contribute to the etiology of many disorders. Certain personality configurations have been linked to a variety of serious disorders, including coronary heart disease and cancer. The "Type A" personality, characterized by an excessive, chronic competitiveness, ambitious...

60. Engel, supra note 52, at 132.
   [T]he same words may serve to express primary psychological as well as bodily disturbances, both of which may coexist and overlap in complex ways. . . . [E]ach of the symptoms classically associated with diabetes may also be expressions of or reactions to psychological distress. . . . The most essential skills of the physician involve the ability to elicit accurately and then analyze correctly the patient’s verbal account of his illness experience.

Id.

61. Id. at 134. See Holman, The "Excellence" Description in Medicine, 11 Hosp. Prac., April, 1976 at 11, 18-19. The medical model fosters the physician’s self-conception as primarily responsible for conducting the healing process. This attitude motivates the physician to overdiagnose illness in order to give the appearance of actively controlling the situation. Watson, The Causes and Treatment of Non-Disease, 114 CAN. MED. Assoc. J. 402 (1976). As in psychiatry, the physician believes that to err on the side of false positives merely results in treatment, albeit unnecessary, and avoids error which could lead to serious results. Id. at 403. See also letter from Jacob, Bar-Nathan & Iuchtman to LANCET (Error-Rate in the Management of Appendicitis, 2 LANCET 1032 (1975)) (removal of 25-30 percent innocent appendices not excessive in order to avoid mortality).

62. See Engel, supra note 52; K. Pelletier, supra note 56.

63. K. Pelletier, supra note 56, at 3-36. Holmes and Rahe have devised a Social Readjustment Rating Scale to rank the stress-impact of various life events. They have concluded that an excessive number of readjustments, which may be caused by either positive or negative life events, is definitely correlated with subsequent illness. Holmes & Rahe, The Social Readjustment Rating Scale, 11 J. PSYCHOSOMATIC RESEARCH 213 (1967). See also K. Pelletier, supra note 56, at 108-14, 117-55 discussing this and related studies.

64. K. Pelletier, supra note 56, at 117-55 and sources cited therein.
ness and a continual sense of urgency and impatience, has been found to suffer from clinical coronary heart disease (CHD) four to seven times more frequently than persons who exhibit the converse type of behavior pattern (Type B). Friedman and Rosenman claim that the Type A pattern "alone and independently [appears] to exert a strong pathogenetic force." That is, such a personality pattern bears a causal and not merely an associative relationship to CHD. According to reputable, but still controversial studies, a cancer-prone personality also exists.

Separation and personal loss have been correlated with the subsequent appearance of numerous disorders. These findings are of particular importance to the aged, who suffer the effects of long-term stress and who are particularly likely to experience an acceleration of disruptive personal losses. The elderly are more prone to be afflicted with chronic rather than acute diseases; psychosocial factors are particularly implicated in the former. The traditional medical model, therefore, is ill-equipped to provide expertise in the evaluation of the health needs of the aged. It focuses upon acute rather than chronic disease and upon curative intervention rather than preventive or supportive measures.

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65. Friedman & Rosenman, Type A Behavior Pattern: Its Association with Coronary Heart Disease, 3 ANNALS CLIN. RESEARCH 300, 305 (1971).
66. Id. at 306. See also M. Friedman & R. Rosenman, Type A Behavior and Your Heart (1974); K. Pelletier, supra note 56, at 124-34.
68. Schmale, Relationship of Separation and Depression to Disease, 20 PSYCHOSOMATIC MED. 259 (1958) (real or threatened loss can lead to feelings of helplessness or hopelessness which may in turn be related to increased biological vulnerability). See also D. Bakan, supra note 56, at 3-11 and sources cited therein.
70. See K. Pelletier, supra note 56, at 6; Powles, supra note 53, at 7-10. Powles characterizes the degenerative diseases as "diseases of maladaptation" which result from human unsuitability to industrialized society.
71. See Hearings on Health Care, supra note 69, at 13, 81, 121, 124; SUBCOMM. ON HEALTH AND LONG-TERM CARE, HOUSE SELECT COMMITTEE ON AGING, NEW PERSPECTIVES
Physicians receive little training in stress detection and alleviation and in the relationship of nutrition to the predisposition to, and recovery from, disease, although these areas are extremely important to the understanding of disorders in the elderly. Furthermore, few medical schools provide even a conventionally-oriented education in geriatric medicine. Despite these facts, both medical benefit programs and health care professionals adhere to the biochemical model. As a result, elderly persons in need of health care are victims of a therapeutic orientation that may be inappropriate to their situation.

The Lack of Objectivity in Surrogate Decisionmaking

Surrogates cannot be presumed to assess the health needs of the elderly objectively. Medicine has long served to provide "scientific" legitimizations for the social prejudices of the more powerful sector. Illustrations abound in which medicine has promoted stereotypes of women, minorities and the poor. Several illustrations may clarify this point. At the turn of the twentieth century, medical texts described women of the upper classes as frail creatures whose delicacy required them to be home bound. The fact that lower class women were able contemporaneously to work long hours in factories was explained as the consequence of their "baser natures." When racism was acceptable, the medical descriptions of Chinese laborers and blacks were riddled with conclusory statements concerning the greater susceptibility of darker-skinned persons to infectious diseases and the likelihood that such persons were carriers of syphilis. The social undesirability of the darker-skinned was thus transmitted into an "objective" undesirability based on the perceived threat these subgroups posed to the safety and welfare of American society.

72. See Hearings on Health Care, supra note 69, at 1-2, reporting that of 120 American medical schools, only 51 have courses in geriatrics. In 1971, only 27 of 512 nursing schools featured programs and courses in geriatrics. Id.
73. New Perspectives, supra note 71, at 2.
75. Ehrenreich & Ehrenreich, supra note 74, at 148.
Psychiatric practice is replete with similar examples of prejudicial stereotyping. When homosexuality was widely held in disrepute, the American Psychiatric Association (APA) categorized it as a mental disease. When the "condition" achieved greater respectability, the APA expunged it from the disease lexicon.

The propensity for medicine to legitimate social prejudice is especially dangerous with respect to the aged. Physicians have incorporated the dominant culture's fear and avoidance of aging, dying and death. Dr. Robert Butler has termed this pervasive societal and professional prejudice "ageism"—"the process of systematically stereotyping and discriminating against people because they are old . . . Ageism is a thinly disguised attempt to avoid the personal reality of human aging and death." Dr. Gene Cohen states:

A wide range of myths, stereotypes, and misinformation have interfered with the approach of the health care system to the geriatric patient. Symptoms that elicit concern in younger people are frequently ignored in older ones. As a result, many treatable problems in later life are neither identified nor acknowledged. Instead, they are dismissed as inevitable, irreversible concomitants of the aging process.

For instance, pathological changes in sleep patterns would be explored in a younger person as symptoms of an underlying physical or psychological problem. Physicians are less likely to pursue the source of such changes in an elderly person, assuming perhaps, that the elderly normally sleep less. Similarly, a nutritional iron deficiency may never be discovered because frailty and confusion are expected in an octogenarian. And insidious congestive heart failure may be termed "fatigue" in a nursing home patient.

76. Alexander, supra note 7, at 1008 n.22; Ennis & Litwack, supra note 12, at 741 & n.167; Morse, Crazy Behavior, Morals & Science: An Analysis of Mental Health Law, 51 S. CAL. L. REV. 527, 557 (1978).
77. See note 76 supra.
78. R. Butler, supra note 69, at 179.
81. Cohen, supra note 80, at 856.
82. R. Besdine, supra note 80.
83. Id.
Physicians and psychiatrists are inclined to posit an inexorable correlation between senescence and senility. The label of "senility" is misapplied with alarming frequency, although studies indicate that fewer "than five percent of persons over sixty-five manifest true senile dementia." Furthermore, senility is not properly a diagnosis or a disease, but rather a designation of intellectual impairment. This impairment often has an underlying, treatable cause. A National Institute on Aging Task Force estimates that at least 300,000 persons afflicted with dementia could have been restored to useful life by appropriate evaluation and treatment.

The present system, therefore, forces the older person to rely upon the decisions of experts who share and reinforce societal myths concerning senescence, and whose prescriptions of care may be countertherapeutic. Internment in a nursing home

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84. Cohen, supra note 80, at 856; Butler notes that psychiatrists utilize the term "senility" indiscriminately to categorize any older person with a problem: "Having invoked this magic word, they need not undertake . . . to determine a proper course of treatment. Indeed, in most cases, when the label 'senility' is applied, no course of treatment is started." Butler, Psychiatry and the Elderly: An Overview, 132 AM. J. PSYCH. 893, 894 (1975). See also Butler, supra note 69, at 225-59; SUPPORTING PAPER No. 7, supra note 23, at 707-09.

85. Cohen, supra note 80, at 856. A Task Panel of the President's Commission on Mental Health noted that there are over 100 reversible syndromes that may mimic senile dementia. PRESIDENT'S COMM. ON MENTAL HEALTH; REPORT OF THE TASK PANEL ON THE MENTAL HEALTH OF THE ELDERLY 1131 (1978) [hereinafter cited as TASK PANEL ON ELDERLY]. Butler lists malnutrition and various other physical disorders such as unrecognized incipient congestive heart failure, infection, heart attack, nonketotic hyperosmolarity diabetic syndrome, and excessive tranquilization, among the "mock" dementias. Butler, supra note 84, at 894-95.

86. See NATIONAL INSTITUTE OF AGING, NATIONAL INSTITUTE OF HEALTH, TREATABLE DEMENTIAS IN THE ELDERLY 2 (1978) (pre-publication draft) [hereinafter cited as TREATABLE DEMENTIAS]; Butler, supra note 84, at 894. Butler suggests that the term "senility" should be altogether discarded in favor of "emotional and mental disorders in old age," which would encourage more careful diagnosis and treatment. Id.

87. See generally TREATABLE DEMENTIAS, supra note 86.

88. Id. at 1.

89. Cohen, supra note 80, at 858.

90. See Diamond, Aging and Cell Loss: Calling For an Honest Count, 12 PSYCH. TODAY 126 (1978); Castenbaum, Getting There Ahead of Time, 5 PSYCH. TODAY 53, 54 (1971); Cohen, supra note 80; TREATABLE DEMENTIAS, supra note 86, at 7, 10, 15.
may aggravate a depression syndrome; the sterile atmosphere and lack of stimulation may speed brain deterioration. The covert coercion of the conditional benefit, then, cannot be justified by the purported objectivity and competence of its surrogate decision makers.

Quality and Effect of Care

The final assumptions supporting covert restrictions of choice—that better care will ensue and that such care will be effective—are the most egregiously defective, particularly as they pertain to the aged. The current structure of medical benefit programs severely limits the freedom of elderly persons to choose care appropriate to their needs, and, by strict adherence to the biochemical model, the opportunity for autonomy in hospital and convalescent environments is reduced.

The highly touted accomplishments of modern medicine have proved to be more mythical than actual; and the expectations maintained by the lay public have proven unrealistic in light of the results of epidemiological studies of disease. The actual increase in the average life span has been due to the decrease in mortality among infants.\(^91\) The course of most infectious diseases had begun to decline prior to the advent of modern antibiotics, and the slope of that decline was not significantly altered thereby.\(^92\) For example, the data on deaths from tuberculosis in England and Wales demonstrate that the mortality rate from this disease has been declining steadily since the middle of the nineteenth century and has continued to decline during the past 100 years.\(^93\)

\[^{91}\] The overall decline in deaths from tuberculosis was not altered measurably by the discovery of the tubercle bacillus, the advent of the tuberculin test, the appearance of BCG vaccination, the widespread use of mass screening, the intensive anti-tuberculosis campaigns, or the discovery of streptomycin.\(^94\)

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94. *Id.*
Similar patterns have emerged with respect to diphtheria, scarlet fever and measles.\textsuperscript{5} Deaths from bronchitis, pneumonia and influenza had also begun to decline before effective medical treatment became available.\textsuperscript{6} This decline in mortality from infectious disease was attended by the introduction of basic hygienic measures: purification of water, efficient sewage disposal and improvements in the preparation and treatment of foodstuffs.\textsuperscript{7} Hence, authors have argued persuasively that the true determinants of health are proper nutrition\textsuperscript{8} and a sanitary, wholesome environment.\textsuperscript{9} Yet physicians are but nominally trained to investigate and consider these factors, and furthermore, the compensation schemes of medical programs provide no incentive for them to do so.\textsuperscript{10}

\textit{The Structure of Medical Benefit Programs}

Just as surrogates rarely are better able to judge the needs of the aged in medical benefit programs, the established bureaucratic structure fails to promote an efficient use of public resources. Current "controls" notwithstanding, medical costs have risen at a faster rate than the consumer price index.\textsuperscript{101} The

\begin{itemize}
\item \textsuperscript{95} Id. at 111-12.
\item \textsuperscript{96} McKeown, supra note 91, at 19.
\item \textsuperscript{97} Id.
\item \textsuperscript{98} McKeown, supra note 91, at 19-21, avers that increased food production led to better nutrition which in turn resulted in enhanced disease resistance.
\item \textsuperscript{99} McKeown, supra note 91, at 19; Kass, supra note 92, at 112-13, states that rates of rheumatic fever are almost linearly related to crowding in the home.
\item \textsuperscript{100} See Hearings on Disease, supra note 46, at 133-35. Dr. Winikoff emphasizes the need for
\item \textsuperscript{101} Between 1950 and 1976, medical care prices increased 3.4 times while the Consumer Price Index increased 2.4 times. Health 1976-1977, supra note 69, at IX. In 1976, prices in the medical care sector rose 10 percent while prices for all consumer goods and services rose 6 percent. U.S. DEPT. OF HEW, Health: United States 1976-1977 Chartbook 6 [hereinafter cited as Chartbook]. Hospital charges for semiprivate rooms increased 13 percent in 1976 over the previous year; physician's fees rose more than 20 percent over the two year period 1975-1976. Id. The total amount of all funds spent for health care of the elderly rose from $8.2 billion in 1966 to $34.9 billion in 1976. About 50 percent of the increase was due to increases in the price of medical care. Health 1976-1977, supra note 69, at 20.
\end{itemize}
proportion of public funds expended has also increased rapidly.102 Government reports and scientific studies have decried the monetary loss and human suffering caused by the prevalence of unnecessary surgery103 and diagnostic procedures104 and the utilization of expensive technologies whose efficacy has not been substantiated. The Office of Technology Assessment estimates that only ten to twenty percent of all procedures used in present medical practice have been shown to be of benefit by controlled clinical trials.105 Furthermore, while conditional

102. In FY 1966, only 30 percent of the funds expended on health care of the elderly were public; in FY 1976, 68 percent of such expenditures came from public funds. CHARTBOOK, supra note 101, at 6.

103. See Getting Ready for National Health Insurance: Unnecessary Surgery: Hearings Before the Subcomm. on Oversight and Investigations of the House Comm. on Interstate and Foreign Commerce, 94th Cong., 1st Sess. (1975). A Study by Eugene G. McCarthy, M.D., suggests that 17.6 percent of the 18.4 million operations performed in this country the previous year were unnecessary (unconfirmed when, under a union health and welfare plan, a second opinion was mandatorily obtained), resulting in a total wastage of $4.8 billion. Id. at 67, 111-13. The mortality rate for elective surgery has been estimated to be .5 percent. If this rate is applied to unnecessary operations, the U.S. mortality rate due to unnecessary surgery may be 16,000 deaths per year. Id. at 67. Persons whose health is covered by Blue Cross and Blue Shield (the carriers through which the government administers Medicare) were found to have had 44.3 percent more surgery than those participating in prepaid group plans (HMO's). Id. at 67.

Another study covering four hospitals in New York revealed rates of unnecessary hysterectomies to be from 16 percent (based on criteria of the New York State Obstetricians and Gynecologists) to 43 percent (based on criteria of a committee appointed by Saskatchewan College of Physicians and Surgeons). Quality of Surgical Care (Vol. II): Hearings Before the Subcomm. on Oversight and Investigations of the House Comm. on Interstate and Foreign Commerce, 95th Cong., 1st Sess. 198 (1977).

104. One study reports that radiographic skull examinations are ordered indiscriminately: 20 percent were performed for trivial injuries, 34 percent for medical reasons and 50 percent when the estimate was one chance in 100 of finding a fracture. Bell & Loop, The Utility and Futility of Radiographic Skull Examination for Trauma, 284 NEW ENG. J. MED. 236, 239 (1971). The authors developed a simple list of 21 high yield criteria, of which the presence of any one would indicate an appropriate use of X-ray. The use of these criteria in one hospital, despite a compliance rate of only 55 percent by physicians, decreased the number of such X-rays by 39 percent. OFFICE OF TECHNOLOGY ASSESSMENT, ASSESSING THE EFFICACY AND SAFETY OF MEDICAL TECHNOLOGIES 38 (1978) [hereinafter cited as OTA EFFICACY & SAFETY]. All federal programs for medical care and reimbursement provide for skull X-rays ordered by a physician. Id.

105. See OTA EFFICACY AND SAFETY, supra note 104, at 94.

Such widely used technologies as tonsillectomy, appendectomy, and the PAP smear have not been completely assessed for efficacy . . . . Others, such as electronic fetal monitoring (EFM) and coronary by-pass surgery, have been diffused rapidly before careful evaluation . . . . Concern about risks has led to questions regarding the use of mammography and skull X-ray . . . .

Id. The report notes further that “the [present] systems for assessing efficacy and safety have made the compilation of such a list possible.” Id.
benefit programs provide an incentive for patient institutionalization in nursing homes and acute-care hospitals, a recent General Accounting Office report proposed that home care health services for the elderly would significantly reduce public expenditures while providing more appropriate care. At present, costly medical technologies and procedures are compensable, but personalized service, such as nutritional counseling, is not covered. The former, however, often may not result in commensurate patient benefit, particularly in the case of coronary heart disease or cancer.

106. This "incentive" is created by a concomitance of the broad coverage afforded institutional care and the restricted coverage provided for home health care and other medical services. Under Medicare Part A, for example, the beneficiary must be homebound in order to qualify for home health services, 42 C.F.R. § 405.133 (1978); those services must require a high degree of skill, id., and are limited in number to 100 visits to be distributed over a one year period following discharge, id. at § 405.131.

The home health agency must meet the requirements of Medicare. See id. at § 405.1201. A physician is inclined to place a patient in a hospital or nursing home, simply because the patient cannot obtain necessary services at home. Similarly, under Medicare Part B, the beneficiary must be homebound, id. at § 405.234, and home health services are restrictively defined, id. at § 405.236. Furthermore, Medicare does not cover the costs of routine or preventive care by a physician or nurse, nor the costs of eyeglasses, hearing aids, orthopedic shoes, or dental services, id. at § 405.310; all of these services and devices would enable the elderly person to maintain health, avoid accidents and detect a disease before it became serious, thereby avoiding a physical deterioration which would necessitate institutionalization. See also Munger, Medicare and Medicaid: The Failure of the Present Health Care System for the Elderly, 17 ARIZ. L. REV. 522, 530-41 (1975); NEW PERSPECTIVES, supra note 73, at 7-25, 48-55; TASK PANEL ON ELDERLY, supra note 85, at 1126-30.

107. GENERAL ACCOUNTING OFFICE: HOME HEALTH—THE NEED FOR A NATIONAL POLICY TO BETTER PROVIDE FOR THE ELDERLY (1977). "Until older people become greatly or extremely impaired, the cost for home services, including the large portion provided by families and friends, is less than the cost of putting these same people in institutions." Id. at i. See also Home Care for the Elderly, The Need for a National Policy: Hearing Before the House Select Comm. on Aging, 95th Congress, 2d Sess. 139-222 (1978), [hereinafter cited as Home Care], describing the activities of the Minneapolis Age and Opportunity Center, Inc. (MAO). MAO provides a network of extensive and comprehensive services in its center, in the client's home and at 12 decentralized mini centers. Services include: a full range of medical services; psychological and psychiatric services; home delivered meals, including special diets; transportation, including "wheelchair" transportation; home care, chore and handyman services; employment and legal services. Id. at 142. MAO can provide services for nearly twice as many severely impaired persons as can nursing homes under Medicaid for the same cost. Id. at 146-47.

108. See Hearings on Disease, supra note 45, at 133, 155-56.

109. Martin, Donaldson, London, Peterson & Colton, Inputs into Coronary Care During 30 Years, 81 ANNALS INT. MED. 289, 291-92 (1974) [hereinafter cited as Martin & Colton], found that although, over a 30 year period, there had been a statistically significant increase in the frequency of utilization of chemical laboratory tests, bacteriology examinations, electrocardiograms, days of oxygen therapy, etc., there was no improvement in the mortality of the subjects during the whole study period. The
Medical benefit programs are characterized by a conspicuous absence of incentives for provider and consumer to reduce health expenditures. Medicare Part A will compensate most medical expenses incurred (above the amount of the deductible) by a hospital inpatient. And although routine physical examinations and preventive health care are not compensable, various outpatient diagnostic tests are covered.

Perhaps an alternative scheme, which would dispense funds directly to the beneficiary, such as a voucher system, and which permitted a broader range of choice in health services, would ameliorate the present problems. One objection to a voucher system is that beneficiaries would squander their allotment on unproven and ineffective therapies, become more acutely ill, and then turn back to the public trough for further assistance. The concern cannot be entirely disregarded. How-
ever, the current system ultimately relies on monetary or dura-
tional limits to available services as major cost-control devices;
insurance policies do so to a greater extent. Neither scheme,
therefore, is wholly satisfactory in this regard. An advantage of
the suggested voucher system, however, is that perception of
personal autonomy and self-responsibility should have a thera-
peutic effect. Instructors in biofeedback and meditation tech-
niques, for instance, report that the discovery of an ability to
control autonomic physical functions often motivates the pa-
tient to improve other aspects of his life, such as dietary hab-
its.117 Similarly, a study in which a group of elderly nursing
home residents were encouraged to be self-responsible reported
an increase in activity, sociability and general satisfaction
among the tested group as compared with the control group, to
whom the responsibility of the nursing staff for patient welfare
had been emphasized.118

Furthermore, a system that provides greater freedom of
choice would inject a positive element of competition into the
health care industry and would weaken the contemporary med-
ical monopoly fostered by the licensure system.119 Also, licens-
ing is controlled by those presently licensed120 and is used to
prevent new entry into the marketplace.121 The coalescence of
licensure and “professional rules” limits medical practice to
established procedures and admission to practitioners whose
views are in accord with conventional opinion.122 This results in

clearly depends on fact . . . Why restrict the freedom of 99 percent to avoid the costs
that the other 1 percent would impose on the community?” Id. at 188.
117. K. Pelletier, supra note 56, at 208-09.
118. Lang & Rodin, The Effects of Choice and Enhanced Personal Responsibility
for the Aged: A Field Experiment in an Institutional Setting, 34 J. PERSONALITY & SOC.
PSYCH. 191 (1976). They suggest that “some of the negative consequences of aging may
be retarded, reversed, or possibly prevented by returning to the aged the right to make
decisions and a feeling of competence.” Id. at 197.
119. See Martin & Colton, supra note 109, at 290.
120. See generally M. Friedman, supra note 115, at 149-60 (critique of medical
licensure).
121. [In almost every state in the United States, a person must
be licensed to practice medicine, and to get the license, he must be a
graduate of an approved school. In almost every state, the list of approved
schools is identical with the list of schools approved by the Council on
Medical Education and Hospitals of the American Medical Association.
Id. at 150-51. Thus, the licensure statute is the key to the effective control of admission
to medical school. Schools will limit their enrollment in accordance with the dictates
of the A.M.A. Id. Also, the members of the licensure commissions are almost always
physicians. Id.
122. Licensure is also “the key to [the medical profession’s] ability to restrict
technological and organizational changes,” id. at 154, because it has given the A.M.A.
a serious inhibition of innovation. Many physicians are reluctant to provide untraditional, albeit not illegal, therapies; patient choice is thereby further foreclosed as the "unconventional" becomes the "unavailable." Acupuncture, well-established in Asian countries, received harsh treatment upon its introduction into the United States. Even chiropractic, which has a long history of use, is continually under fire. These two examples are nearly conventional forms of medical treatment. The therapeutic use of vitamins is more controver-

indirect control of admission to practice in hospitals. A physician who does not have access to hospital services and facilities is seriously hampered in his ability to practice medicine. Hirsch, A Fish Without Water: Hospital Admitting Privileges, 84 CASE & COMMENT 18 (1979). See also A. NITTLER, A NEW BREED OF DOCTOR 34 (1972). Dr. Nittler, a physician who utilized nutritional and non-toxic therapy, was expelled from the local medical society and consequently denied hospital privileges. Therefore, a physician who wishes to remain in "good standing" in the profession is seriously limited as regards the type of therapeutic experimentation he can attempt. M. FRIEDMAN, supra note 115, at 157. See also Engel, supra note 52, at 134 (medical schools are hostile to psychosomatic research and teaching).

123. See THE YELLOW EMPEROR'S CLASSIC OF INTERNAL MEDICINE (I. Veith trans. 1949); F. MANN, ACUPUNCTURE (1972).

124. The FDA takes the position that acupuncture is an experimental procedure which must be limited to investigational or experimental use. 38 Fed. Reg. 6419 (1973). It bases this posture upon the results of a meeting held September 22, 1972, in which the FDA, NIH, the AMA, the American Society of Anesthesiologists, and others agreed the acupuncture devices should be limited to investigational use only. Id. Many state medical licensing boards concur with the FDA's position. See Dornette, Acupuncture and the Law, 2 J. LEGAL MEDICINE No. 2, at 31, 35 (March-April 1974); Benedict, Pirro & Pisani, Acupuncture: The Practice of Medicine?, 38 ALB. L. REV. 633, 655-61 (1974). Acupuncture treatments are frequently not compensable under health benefit programs. See, e.g., Note, The Future: Medicaid Compensation for Acupuncture in New York State: How Long Must We Wait?, 22 N.Y.L.S.L. REV. 981 (1977); Pickens-Bond Construction Co. v. Case, 266 Ark. 323, 584 S.W.2d 21 (1979). Many states restrict the practice of acupuncture to licensed physicians and osteopaths. Dornette, supra, at 34-35 (chart).

sial. Recently, an effort was made to require prescriptions for simple vitamin A and D capsules. The use of laetrile is proscribed in the interests of preventing consumer deception and channeling people back to more traditional forms of treatment.

Quite aside from other considerations, we have recently learned that there is a scientific basis for the so-called "placebo effect." Body chemistry responds to a person's belief that he or she is being effectively treated. This fact further supports allowing a person freely to choose treatment that he or she believes will be most effective, even though such treatment may be unorthodox. Honoring human autonomy appears in general to have a beneficial effect on health.

While many treatments, procedures and products are banned or otherwise made unavailable, little attention is given to the alternative of supplying information to consumers. The warning alternatives was utilized with respect to saccharin, demonstrating that consumers can independently evaluate comparative risks. If laetrile is considered harmful because people may be deceived as to its utility, informing them that it is thought to be useless would seem to satisfy the need for intervention. This is not to suggest that the sellers of fake nostrums should be immune from prosecution for fraud. It is merely a suggestion that, as in other instances of fraud, the state should have a substantial burden of demonstrating medical inefficacy.

Conditional Benefit Programs and Institutional Care

The conditions of health benefit and insurance systems, as well as the tax provisions delimiting deductible medical expenses, evince a bias toward institutionalization and technologi-


130. Deductible "medical care" is defined as amounts expended:
cal intervention:

Both government and carriers of health insurance accept as given a tightly defined medical model as the premise for defining benefits and payments. It is this carefully defined clinical treatment system that sets in motion the machinery to justify admission, treatment modality, utilization, lengths of stay, and monitoring the quality and quantity of care. While this medical model meets the acute, episodic institutional needs of the patient, it overlooks the patient’s potential to function in the social and family spheres of his life at home.\textsuperscript{131}

The acute-care hospital epitomizes the mechanistic bias of the medical model. It is a locus of enormous investment in diagnostic and therapeutic technologies which alone favors “approaches to clinical study and care of patients that emphasize the impersonal and the mechanical.”\textsuperscript{132} In recent decades, medicine has become increasingly specialized.\textsuperscript{133} The hospital provides an efficient setting for the cooperation and interaction of specialists, the oversight of their high-technology armamentariums and the training of fledgling medical students.\textsuperscript{134}

The hospital fosters among patients an attitude of dependency, helplessness and nonparticipation. Its emphasis on biochemical abnormality and intervention removes the patient’s sense of subjectivity, autonomy and identity. Moreover, hospitalization offers a socially sanctioned opportunity to remove an elderly person from home and to insulate those who remain from their personal responsibilities toward that individual, since “better” care is being provided. But better care is not

\begin{itemize}
  \item for the diagnosis, cure, mitigation, treatment, or prevention of disease,
  \item or for the purpose of affecting any structure or function of the body . . .
  \item for transportation primarily for, and essential to, medical care . . .
\end{itemize}


\textsuperscript{131} New Perspectives, supra note 71, at 2.
\textsuperscript{132} Engel, supra note 52, at 135.
\textsuperscript{133} In 1949, 64 percent of all physicians were general practitioners; 36 percent were specialists. In 1973, the proportion of specialists had increased to 76 percent of the physician population. Rogers, The Challenge of Primary Care, in Doing Better and Feeling Worse 81, 85 (J. Knowles ed. 1977). See also Ebert, Medical Education in the United States, in Doing Better and Feeling Worse, supra at 178-79.
\textsuperscript{134} See Eisenberg, The Search for Care, in Doing Better and Feeling Worse 235 (J. Knowles ed. 1977); Ebert, supra note 133, at 176-78.
a mere quantum of services; rather it includes such ineffable factors as love and personal attention.\textsuperscript{135} Furthermore, hospitalization may hinder rather than facilitate a salutary outcome by increasing the likelihood of one's acquiring a disease, often resulting from drug therapy or diagnostic procedures.\textsuperscript{136} Yet initial hospitalization is frequently a prerequisite for compensation.\textsuperscript{137}

The compensation schemes of conditional benefit programs also favor internment in nursing homes and similar facilities,\textsuperscript{138} although recent exposés have demonstrated that “good” care in such facilities is the exception rather than the rule.\textsuperscript{139} The Senate Subcommittee on Long-Term Care reported, in 1974, that “the entire population of the elderly, and their offspring, suffer severe emotional damage because of dread and despair associated with nursing home care in the United States.”\textsuperscript{140} The report averred that government actions, “as expressed through the Medicare and Medicaid programs, have in many ways intensified problems and have created new ones.”\textsuperscript{141} The report deplored the unsanitary, dangerous and degrading conditions in nursing homes, citing reports of excess-
The unfortunate consequences of the conditional benefit programs cannot be characterized as the provision of better care. The programs have resulted in the inappropriate institutionalization of countless elderly persons, an attrition of available home-care services and thereby, the further foreclosure of alternative care possibilities. Moreover, such care as is offered can but disingenuously be described as effective in improving the health of elderly recipients. It is incontrovertible that the disruption caused by institutionalization or relocation is attended by sharp increases in morbidity and mortality among aging persons. Furthermore, home care for many disorders has proved to be as beneficial as hospital treatment. Intensive, high-cost therapy for coronary occlusion has not been shown to improve prospects for survival and recovery. Cancer rates continue to rise and nursing home populations to burgeon. Contemporaneously, evidence mounts that unconventional or less intrusive care alternatives and therapies are

142. See note 24 supra.

143. [Medicare and Medicaid] virtually force older persons into an institution when a lesser level of care would be enough.

The net result is that older people who could manage to remain in their homes if they had access to supportive services, often find themselves with no alternatives to the nursing home. Home Care, supra note 107, at 2-3 (statement of chairman Claude Pepper). It is estimated that the percentage of persons unnecessarily institutionalized in nursing homes for lack of alternative arrangements ranges from 10 to 40 percent. New Perspectives, supra note 71, at 23-24. See also Munger, supra note 106, at 533 & n.86. Munger deplores the failure to provide compensable preventive and supportive medical care, which obliges the elderly "to neglect their health until it deteriorates to the point where they must be institutionalized." Id. at 535.

144. See Ricker-Smith & Trager, In-Home Health Services in California, 16 Med. Care 173, 174 (1978) (growth in the home health sector "was not only halted but actually reversed" by the austere policies of the Social Security Administration in the late 1960's). See also Munger, supra note 106, at 533 & n.87.

145. See note 34, supra.


147. See note 109 supra.

148. The number of elderly residents of nursing homes increased from 2,535 per 100,000 in 1964 to 4,454 per 100,000 in 1974. Chartbook, supra note 101, at 15. The number of nursing home beds more than tripled between 1960 and 1970. Introductory Report, supra note 24, at 20-21.
less complicated, less costly and more salutary.\textsuperscript{149}

The facade of "voluntary participation" in such programs has served to justify in part their restrictive and counter-
therapeutic conditions and has deflected attention from reality. With "voluntarily" committed mental patients, it has been
trenchantly noted that many are actually involuntarily confined.\textsuperscript{150} They are immured in an institution because alternative care is unavailable or because considerable pressure for institutionalization has been exerted by family, friends and the medical/judicial system.\textsuperscript{151} Furthermore, this pressure militates against subsequent efforts to seek release; such efforts are often used as evidence to justify later involuntary commitment or the appointment of a guardian.\textsuperscript{152} And although the chasm between involuntary civil commitment "in the person's best interest" and the reality of custodial conditions has prompted an intensification of judicial scrutiny and procedural safeguards, a similar expansion of rights and protections for the voluntarily confined has not been forthcoming.\textsuperscript{153}

The "voluntariness" of participation in conditional benefit programs is similarly factitious, particularly for the aged. General medical treatment is usually not imposed upon competent patients; however, a competency catch-22 coheres to the rule. That is, an elderly person who refuses the medical treatment proffered through conditional benefit programs risks the use

\textsuperscript{149} See, e.g., K. Pelletier, supra note 56, at 310-11. Professor Pelletier describes a program to improve self-care of patients with diabetes at the Los Angeles County Medical Center which emphasized personal responsibility for health. Participants were taught to recognize and alleviate dietary and psychosomatic stress factors which aggravated their condition. The program resulted in a 50 percent reduction in emergency visits, a decrease in the number of patients with diabetic comas from 300 to 100 over a two-year period, and the avoidance of 2,300 visits for medications, at an estimated cost savings of $1.7 million. \textit{Id.}

\textsuperscript{150} B. Ennis & R. Emery, supra note 9; at 90-95 (in most states, a voluntary patient may be detained in the institution despite his desire to leave, for periods ranging from 48 hours to 30 days); Szasz, \textit{Voluntary Mental Hospitalization: An Unacknowledged Practice of Medical Fraud}, 287 \textit{New Eng. J. Med.} No. 6, at 277 (1972); Joint Hearings, supra note 17, at 19-20.

\textsuperscript{151} Rights, supra note 9, at 90-91; Joint Hearings, supra note 24, at 19-20; Legal and Ethical Issues, supra note 7, at 118-19.

\textsuperscript{152} B. Ennis & R. Emery, supra note 9, at 93-94.

\textsuperscript{153} See Special Reprint, supra note 7, at 330-32. But see New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973), modified sub. nom. New York State Ass'n for Retarded Children, Inc. v. Carey, 393 F. Supp. 715, 716-18 (E.D.N.Y. 1975) (mentally retarded persons have right to protection from harm under the eighth amendment regardless of whether their incarceration is characterized as "voluntary" or "involuntary"). \textit{Id.}
of this refusal as evidence establishing his incompetency and the need for a guardian who would then have the authority to subject the person to the treatment plan. Spouses and children would be especially tempted to initiate such a process in order that the elderly person's health expenditures be covered by the benefit program. An unduly restrictive program, therefore, coerces acceptance of its conditions by fostering a coalescence of the threat of incompetency proceedings and the pressing need for care.

Elderly persons do not have adequate resources to satisfy their healthcare needs being particularly victimized by the rising cost of care and the impact of inflation. And the government bears a share of the responsibility for this growing trend by its failure to regulate the growth of the money supply, to curb spending, to improve education and mobility of the working force, and by its enhancement of the medical monopoly through licensure provisions and condonation of medicine's self-serving professional population control. This governmental contribution to the plight of the elderly should preclude the state from characterizing health benefit programs as benevolent gratuities to which any "reasonable" conditions may be attached.

Health care programs should be "devices to aid security and independence," not simply means to achieve a greater quantum of services for, or an improved organic condition in, the recipient. Good health is multifaceted; its most salient feature is the attitude of the individual, as evidenced by the frequent failure of correlation between the determinable presence or absence of biochemical abnormality and the clinical expres-

154. See R. Veatch, supra note 38, at 117-24, 136-49. "There is a clear right of the competent patient to refuse treatment for any reason, but the right not to be declared incompetent while exercising that refusal is only beginning to emerge." Id. at 146.

155. Paradoxical though it may seem, the most serious threat to freedom in our programs of public services and public benefits is to the freedom of the recipient . . . The power of the purse is great; it is sometimes possible by paying people to do things or not to do them, to control their actions as effectively as by threatening to send them to jail. It behooves us to be constantly on our guard lest, out of zeal to better people's lot, we impose on them patterns of behavior in matters in which, under our scheme of things, government ought not to meddle.

Reich, supra note 47, at 1245 n.1 (quoting Willcox, Patterns of Social Legislation: Reflections on the Welfare State, 6 J. Pub. L. 3, 7 (1957)).

156. Reich, supra note 47, at 1255.
sion of disease or health.\textsuperscript{157}

The state has an interest in a healthy populace; but "health" at the cost of individual autonomy and privacy is a contradiction in terms. Health will, in all likelihood, be more effectively and efficiently attained through societal enhancement of individual strength and responsibility.\textsuperscript{158}

\section*{Expanding Alternatives for Health Care}

In recent years, alternative health service programs that enhance self esteem and individual responsibility have produced encouraging results. The Task Panel Report of the Commission on Mental Health recommended a variety of services applicable to general medicine as alternatives to hospitalization. These included hot lines, drop-in centers and crisis programs, as well as home birth and healing centers. Many of the workers administering care saw themselves as "friends, staff, helpers, healers, educators, members of a collective community of workers, or advocates."\textsuperscript{159} The Minneapolis Age and Opportunity Center (MAO) reports that elderly persons who are encouraged to do as much as possible for themselves very often become more capable and require fewer supportive services.\textsuperscript{160} Even the seriously impaired have been able to remain at home if they have had the will to do so. MAO provides an extensive array of services but never asserts control over such functions as the elderly person can still perform.\textsuperscript{161} The results have been outstanding. The Senior Actualization and Growth Explorations (SAGE) project in Berkeley, California has been similarly

\textsuperscript{157} See Engel, supra note 52, at 131-32. "The abnormality may be present, yet the patient not be ill." Id. at 131. Similarly, a documented correction or major alleviation of the abnormality may not restore the patient to health. Id. at 132.


\textsuperscript{159} Alternative Services, supra note 158, at 378. If professionals assume that they will be more effective when cast as friends, helpers, and educators it is possible that people who are, in fact, friends, helpers, and educators without a traditional medical role might be useful if involved in health delivery systems.

\textsuperscript{160} See Home Care, supra note 107, at 139.

\textsuperscript{161} Id. at 144-46.
successful in fostering both autonomy and improved health amongst elderly persons.\textsuperscript{162} SAGE addresses itself to the psychophysiological well-being of the elderly and does not accept physical decrement or declining intellectual capacity as inevitable concomitants of aging.\textsuperscript{163} Elderly persons are encouraged to learn natural nonpharmacological self-help techniques drawn from a variety of cultural traditions and to become actively participating staff members in the project.\textsuperscript{164} These projects demonstrate that a benevolence which fosters autonomy and health is not only attainable but is functionally efficacious and efficient.

MAO, SAGE and similar projects are included not as prescriptions of how alternative health delivery systems might be structured, but as examples of non-traditional programs that work. With time, the programs should benefit from each others' experiences. For the present, we should endeavor to create an atmosphere accepting of innovation and ending hostility toward non-traditional methods.

Fostering personal participation in the restoration and maintenance of health and motivating mutual cooperation and support within community and family groups will serve the best interests of both provider and recipient of the public benefit. To that end, health programs should seek the widest dissemination of health-oriented information so that freedom of choice may be meaningful; in other words, they should promote the autonomy of the individual. Finally, health benefit programs should seek to create incentives that will enable a person to maintain a sense of meaningfulness and purpose in life.

\textsuperscript{162} See Alternative Services, supra note 158, at 395-96; Fields, supra note 158, at 387.
\textsuperscript{163} Alternative Services, supra note 158, at 395.
\textsuperscript{164} Id.