

Two Precipices, One Chasm: The Economics of Physician-Assisted Suicide and Euthanasia

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Introduction

First, they did no harm. Although invited to invalidate the laws of at least thirty-five states that prohibit assisting another person to commit suicide, the Supreme Court has produced two decisions whose most salient feature is judicial restraint. Most obviously, not a single member of the Court was willing to invalidate either of the statutes at issue in *Washington v. Glucksberg*¹ and *Vacco v. Quill*.² This is particularly noteworthy because the courts of appeals in both cases had struck down the challenged statutes, using substantive due process in *Glucksberg*³ and equal protection analysis in *Quill*.⁴

A majority of the Justices, moreover, expressed a strong reluctance to engage in the kind of free-wheeling constitutional adventurism that has been the source of so many excesses throughout our history. Insisting that substantive due process is a narrow doctrine, though one now firmly em-

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1. 117 S. Ct. 2258 (1997).
2. 117 S. Ct. 2293 (1997).
3. *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc), *rev'd sub nom.* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).
4. *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

bedded in our law, the *Glucksberg* Court declared that it can be used only to protect certain precisely described fundamental rights that have deep and objectively verifiable roots in our Nation's history and traditions.⁵ Finding that the asserted right to assistance in committing suicide is actually inconsistent with centuries of legal doctrine and practice (which has not even recognized a right to suicide), the Court refused to set its face against the continuing refusal of almost every state in the union to legalize assisted suicide.⁶ With similar restraint, the *Quill* Court declined to engage in the kind of patent sophistry that would be required to conclude that laws against assisted suicide suffer from some kind of constitutionally objectionable irrationality.⁷

The Court's judicial restraint in these cases also had another aspect, however, and one from which proponents of assisted suicide can take more comfort. Although the *Glucksberg* majority was unwilling to declare a sweeping new constitutional right, it did not rule out the possibility of its ever deciding to insulate some would-be suicide "assisters" from government interference. Some members of the Court insisted on characterizing the decision merely as a rejection of a facial challenge to the statutes at issue,⁸ and even the majority was forced to concede that a new challenge framed in different terms could conceivably produce a different outcome.⁹ In the short run, the technical narrowness of the Court's decision is probably of little moment. Only Justice Stevens expressed a strong itch to begin the process of judicially supervising the nation's approach to assisted suicide.¹⁰ Justice O'Connor, who provided the fifth vote for the majority

5. See 117 S. Ct. at 2268.

6. See *id.* at 2268-75.

7. Rejecting the analysis of the court below, the Supreme Court held that New York law, which permits patients to refuse lifesaving medical treatment but forbids physicians to assist their patients in committing suicide, is not making a distinction that is "arbitrary" or "irrational." See *Quill* 117 S. Ct. at 2295. The distinction between letting a patient die and making that patient die, said the Court, is both "important and logical; it is certainly rational." See *id.* at 2298.

8. See *Quill*, 117 S. Ct. at 2303 (O'Connor, J., concurring); see also *id.* at 2310 (Stevens, J., concurring in the judgments); see also *id.* (Ginsberg, J., concurring in the judgments) (indicating "substantial" agreement with O'Connor's opinion); see also *id.* (Breyer, J., concurring in the judgments) (joining O'Connor's opinion except insofar as she joined the majority opinions).

9. See *Glucksberg* 117 S. Ct. at 2275 n.24 (noting that the Court's *Glucksberg* opinion does not "absolutely foreclose" the possibility that a plaintiff might prevail on a "more particularized challenge," but asserting that such a claim would have to be "quite different" from the claims in *Glucksberg*).

10. See, e.g., *id.* at 2305 (Stevens, J., concurring in the judgments):

[J]ust as our conclusion that capital punishment is not always unconstitutional did not preclude later decisions holding that it is sometimes impermissibly cruel, so is it equally clear that a decision upholding a general statutory prohibition of assisted sui-

opinions while writing a separate concurrence, suggested that she might be willing to create a new constitutional right in this area, but only if governments began interfering with physicians' efforts to ameliorate their patients' pain.¹¹ Leaving aside O'Connor's puzzling omission of any reference to cases where individuals find life itself intolerably painful,¹² the only significant legal threat to normal forms of pain relief arises from aggressive enforcement of the anti-narcotics statutes and parallel regulatory supervision by state medical boards. O'Connor, however, gave no hint that she was interested in slowing down the war on drugs.

As the Supreme Court's personnel changes, *Glucksberg* and *Quill* might be read narrowly, or even overruled. More significantly, however, no one on the Court suggested that the states would be required to maintain their laws against assisted suicide. On the contrary, as the *Glucksberg* majority emphasized in its closing paragraph: "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."¹³ Thus, the future of assisted suicide almost surely lies for now in the hands of the state and federal legislatures. The immediate prospects here seem strongly to favor the status quo. Several states have recently strengthened their laws against assisted suicide or rejected efforts to weaken them,¹⁴ and Congress has forbidden federal funds from being used for assisted suicide.¹⁵ Only Oregon, which legalized assisted suicide by a narrow referen-

cide does not mean that every possible application of the statute would be valid. . . . [T]here are situations in which an interest in hastening death is legitimate. Indeed, not only is that interest sometimes legitimate, I am also convinced that there are times when it is entitled to constitutional protection.

Justice Souter also concurred only in the judgments, essentially on the ground that legislatures are better able than courts to make *initial* decisions about what Souter considered the "emerging" issue of assisted suicide. *See, e.g., id.* at 2293:

The experimentation that should be out of the question in constitutional adjudication displacing legislative judgments is entirely proper, as well as highly desirable, when the legislative power addresses an emerging issue like assisted suicide. The Court should accordingly stay its hand to allow reasonable legislative consideration. While I do not decide for all time that respondents' [substantive due process] claim should not be recognized, I acknowledge the legislative institutional competence as the better one to deal with that claim at this time.

11. *See id.* at 2303.

12. Even more puzzling is Justice Breyer's declaration that a successful challenge to laws against assisted suicide would have to involve a patient's effort to avoid "severe physical pain (connected with death)." *Id.* at 2311. Breyer did not explain why the avoidance of physical pain may be entitled to constitutional protection, but only when "connected with death." Nor did he explain why there should be constitutional distinction between physical pain and psychic pain.

13. *Glucksberg*, 117 S. Ct. at 2275.

14. *See, e.g., id.* at 2266 (reviewing recent legislative developments).

15. *See* Pub. L. No. 105-12, 111 Stat. 23 (codified at 42 U.S.C. § 14401 *et seq.*).

dum vote in 1994, has persisted on a contrary course.¹⁶ Below the surface, however, powerful forces are pushing our society toward an acceptance of assisted suicide, as well as much harsher forms of hastened dying. Understanding and dealing with those forces will require more effort than the Supreme Court was required to exert when it restrained itself from constitutionalizing the whole field.

This Article will present two distinct but related arguments. Part I argues that legalizing assisted suicide, whether through judicial or legislative action, would be a mistake because the harms produced by such a step would likely outweigh the benefits. Part II suggests that the most important goals of the laws against assisted suicide may be threatened far more profoundly by seemingly unrelated developments in the practice and financing of medical care. This Article concludes by suggesting that serious attention should be given to reforms that would reestablish a more direct economic relationship between patients and physicians.

I. Agency Costs and Assisted Suicide

Why should the law prevent physicians from helping their patients to commit suicide? It is not self-evident that such prohibitions are consistent with the individualistic presuppositions in which our polity and legal system are rooted. If we begin with the premise that our lives and our bodies are our own property, a strong justification should be required before we accept prohibitions against suicide. Such a prohibition, after all, would seem to smack either of an illegitimate government effort to enforce God's claim on our lives or of alien socialistic notions under which people's lives belong first to the state and only derivatively to themselves.¹⁷ It may therefore be unsurprising that efforts to create sanctions against suicide are only a distant memory in most American jurisdictions.¹⁸ But if suicide is treated almost unquestioningly as the prerogative of free citizens, how can

16. In November, 1997, Oregon voters rejected by a substantial margin a referendum initiative that would have repealed the 1994 law. See William Claiborne and Thomas B. Edsall, *Affirmation of Oregon Suicide Law May Spur Movement*, WASH. POST, Nov. 6, 1997, at A19.

17. This does not necessarily imply that laws punishing suicide (by asset forfeitures, for example) could not be justified on secular grounds that are compatible with the principles of the American polity. For purposes of this article, however, I will assume for the sake of argument the libertarian view that a right to suicide is an aspect of personal autonomy that the law should not deny to competent adults.

18. For a review of the evolution of laws relating to suicide, see Thomas J. Marzen, Mary K. O'Dowd, Daniel Crone, and Thomas J. Balch, *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1, 63-100 (1985). The authors emphasize that there is little reason to believe that the relaxation of laws imposing penalties for suicide and attempted suicide has been driven by the theory that citizens have a right to suicide based on personal autonomy. See *id.*

one justify interfering with the right to procure assistance in carrying out this permitted act? Part I of this Article will suggest an answer to that question. At least in the case of assistance by physicians (and other health care workers under their control), there are powerful consequentialist arguments for banning assisted suicide, arguments that do not require a challenge to the libertarian premises of our modern legal tradition.

A. The Hippocratic Bargain

Begin by assuming an unregulated market in medical services. In such a market, the providers of health care would have to invest in acquiring a medical education, and would then have to market their services to prospective patients. Because knowledge is power, and because medical services give their practitioners exceptionally dangerous opportunities to harm those to whom they sell these services, physicians would want a mechanism for assuring prospective patients that they will act as faithful agents for the patient's interests. Without such a mechanism, patients would have incentives to avoid treatment or use home remedies in some circumstances in which a doctor could have provided better care at a price the patient would have been willing to pay. Suppose, for example, that a woman suffering lower back pain would be willing to pay as much as \$100 for an educated diagnosis, but if the price is higher she would decide to wait and see whether the condition cleared up by itself. If a doctor can cover the costs of providing such a diagnosis for less than \$100, a bargain should be reached. If, however, the patient believes there is a 50 percent chance that the doctor will dishonestly prescribe unnecessary and expensive surgery, she may not seek the diagnosis even at a price well below \$100. Or suppose that a man has symptoms consistent with venereal disease, and he believes that a home remedy costing \$50 would give him a 40 percent chance of a cure, whereas a doctor's treatment costing \$50 would give him a 95 percent chance of a cure. Clearly, he would prefer to be treated by the doctor. If, however, he believes there is a 25 percent chance that the physician will disclose to his friends and neighbors that he has contracted a venereal disease, he may choose to rely on the home remedy instead.

Obviously, patients seldom make such numerical calculations explicitly. They do, however, frequently make choices about whether to seek medical care that are informed by the risks entailed in putting their trust in doctors. Who has not been warned that physicians are often too quick to recommend profitable but dangerous surgeries? And who has not had to remind himself that doctors are supposed to keep embarrassing information about their patients to themselves? Both physicians and patients would be

better off if patients could place a high degree of trust in their doctors because the absence of such trust will prevent many mutually beneficial bargains from being reached. The same could be said of many other commercial relationships, but medicine is a field in which the problem of agency costs seems especially acute.¹⁹ In this case, there is typically a large gap between the expertise of the seller and buyer of the service,²⁰ and the stakes for the buyer are often extremely high; this makes it very costly for the buyer to monitor the seller's honesty and faithfulness.

Thousands of years ago, physicians addressed this problem by developing and popularizing the Hippocratic Oath, through which they professionalized their business. The Oath offers the following bargain to prospective patients: "In return for your placing more trust in us than you do in ordinary tradesmen, we promise to behave in a less self-interested manner than other tradesmen." There are advantages here for both parties. Physicians get more business because sick people will be less inclined to practice home remedies, and patients get better medical care when they are treated by experts. The Oath, and more important the ethical patterns of behavior it represents,²¹ were a success, as Hippocratic medicine survived in a competitive market and eventually became dominant.²² Because the

19. Stated generally, agency costs may be defined as the sum of a) the resources used by the principal to control the behavior of the agent; b) the resources used by the agent to assure the principal that he will forego certain actions harmful to the principal; and c) the cost of any residual divergence between the agent's actual decisions and the decisions that would have maximized the principal's welfare. See Michael C. Jensen & William H. Meckling, *Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure*, 3 J. FIN. ECON. 305, 308 (1976). As I will show below, the Hippocratic Oath reduces agency costs in the physician-patient relationship by investing a relatively small amount of resources in category b), thereby preventing the need for larger investments in category a) and, in many cases, reducing the costs in category c).

20. Because of this gap, "[e]conomists normally use the monopolistically competitive model to describe and to analyze market behavior in health care, especially for physician services." H.E. FRECH III, *COMPETITION & MONOPOLY IN MEDICAL CARE* 6 (1996).

21. In this Article, I use the term "ethics" and its cognates to refer to norms of behavior appropriate to a certain occupational group, whether or not such behavior is appropriate elsewhere. The United States Marine Corps, for example, cultivates ethical norms appropriate to the organization's peculiar mission. See, e.g., THOMAS E. RICKS, *MAKING THE CORPS* (1997). Some ethical standards that are completely appropriate for people in that organization might be out-of-place in other contexts. Similarly, some ethical standards that are appropriate and quite important among physicians might be unneeded, or even harmful, elsewhere.

22. For a concise account of the survival of Hippocratic medicine during antiquity, and its eventual success in displacing other ethical approaches, see Ludwig Edelstein, *The Hippocratic Oath: Text, Translation and Interpretation*, in *ANCIENT MEDICINE: SELECTED PAPERS OF LUDWIG EDELSTEIN* 62-63 (Oswei Temkin & C. Lillian Temkin, eds., 1967). Edelstein argues that the Oath was the product of Pythagorean philosophy, and that its eventual widespread adoption was the result of its compatibility with Christianity and other monotheistic religions. However that may be, the fact remains that it survived and succeeded for many centuries in a variety of cultural contexts without being dictated by government regulations.

market ratified the Oath for a very long time before governments began regulating medical practice,²³ it is entitled at the very least to respectful consideration by anyone interested in identifying the norms and rules that should control the conduct of medical practice.

The Hippocratic Oath reads as follows:

I swear by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold the one who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Into whatever houses I may enter, I will come for the benefit of the sick, remaining clear of all voluntary injustice and of other mischief and of sexual deeds upon bodies of females and males, be they free or slave.

Things I may see or hear in the course of the treatment or even outside of treatment regarding the life of human beings, things which one should never divulge outside, I will keep to myself holding such things unutterable [or “shameful to be spoken”].

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.²⁴

23. See, e.g., RODERICK E. MCGREW, *ENCYCLOPEDIA OF MEDICAL HISTORY* 179 (1985) (“As in classical antiquity, popular medicine [during the Middle Ages] was a practical affair carried on according to market principles and with no effective regulatory oversight. Advances in medical education, licensing procedures, and regulatory agencies did not eliminate this sort of practice until the twentieth century.”); *id.* at 179-82 (discussing spotty development of state regulation in Europe during the modern period and the absence of regulation in the United States through the mid-nineteenth century).

24. Translation taken from LEON R. KASS, *TOWARD A MORE NATURAL SCIENCE: BIOLOGY AND HUMAN AFFAIRS* 228-29 (1985) (emphasis added).

Within the Oath, the proscription against assisted suicide is the first of the negative promises involving professional self-restraint, and it is a somewhat puzzling one because it is a promise not to give patients what they want.²⁵ In that respect, assisted suicide is like abortion, with which it is linked in the Oath. It is much easier for us to see why patients will benefit from the subsequent negative promises in the Oath than it is to see why they would benefit from having their requests for assisted suicide and abortion denied.

The answer to this puzzle, I believe, is that patients benefit when physicians specialize to the greatest extent possible in pursuing a single goal: health. Not profit maximization. Not market share. And not "giving the customer what he wants." The Hippocratic physician promises to the world, and thus to every prospective patient (even legally powerless individuals like slaves), that he will both refrain from making sexual advances to patients *and* that he will resist sexual advances *from* his patients. He also promises more generally to come only for the benefit of the sick, and thus to refrain from euthanasia, even if euthanasia is demanded by the one who is paying the doctor (such as the parents of a minor or the child of an elderly person). Similarly, the Hippocratic physician promises not to help patients kill themselves or their unborn children, even when the patient wants such actions taken, because this is not consistent with the pursuit of health.

This self-imposed professional forbearance, which was not required by the Greek laws or customs of the time,²⁶ is rooted in a coherent and defensible understanding of the nature of medicine.²⁷ First, it recognizes the dangerous neutrality of medical technique, which can be used either to cure or to kill. Only if the means used serve a professionally appropriate end will medical practice be ethical. Accordingly, the Oath rules out assisting in suicide because the end that medicine pursues—the health of the living human body—would be contradicted should the physician engage in delivering death. Most importantly, the taboos against euthanasia and assisted-suicide—like the taboos against violating patient confidentiality and against sexual relations with patients—address a prominent "occupational

25. A complete economic analysis of the Hippocratic Oath is beyond the scope of this Article, which will focus on those elements of the Oath most directly relevant to the issues raised by physician-assisted suicide.

26. See EDELSTEIN, *supra* note 22 at 13 ("Suicide was not censured in antiquity. Abortion was practiced in Greek times no less than in the Roman era, and it was resorted to without scruple." (footnote omitted)).

27. For a detailed discussion of the Oath's rational coherence, see KASS, *supra* note 24, at 224-46.

hazard" to which the medical professional is especially prone: a temptation to take advantage of the vulnerability and exposure of patients. Just as patients necessarily divulge and reveal to the physician private and intimate details of their personal lives, and just as patients necessarily expose their naked bodies to the physician's objectifying gaze and investigating hands, so patients necessarily expose and entrust the care of their very lives to the physician's skill, technique, judgment, and character. Conscious of the meaning of such exposure and vulnerability, and of his own human penchant for error and mischief, the Hippocratic physician voluntarily sets limits on his own conduct, pledging not to take advantage of or to violate the patient's intimacies, naked sexuality, or life itself.

The Hippocratic physicians' refusal to assist in suicide was not part of an aggressive so-called "vitalist" approach to dying patients or an unwillingness to accept mortality. On the contrary, understanding both human finitude and the limits of the medical art, they refused to intervene when the patient was deemed incurable, and they regarded it as inappropriate to prolong the process of dying when death was unavoidable.²⁸ Insisting on the importance of distinguishing between letting patients die (not only permissible but laudatory in some circumstances) and actively causing death (impermissible), they protected themselves and their patients from their own possible weaknesses and folly, thereby preserving the ethical integrity of their profession.

The Oath and its ethical vision of medicine is the product of classical Greek antiquity, and the ban on physician-assisted suicide was not and is not the result of religious impulses alone. The Oath is fundamentally pagan and medical; and it is not the product of biblical religion or Judeo-Christian doctrines of the sanctity of human life. Nor is the Oath merely a parochial product of ancient Greek culture. Notwithstanding the fact that the Oath begins by invoking Apollo and other deities no longer worshiped, it reflects and articulates a coherent, rational vision of the art of medicine. That is why it has been so widely received in the west as a document for all times and places. The Oath's survival through the centuries is a sign of the usefulness of its contents, and the fact that it survived for so long without government support reflects its consistency with the *mutual* interests of doctors and patients.

28. See Darrel W. Amundsen, *The Physician's Obligation to Prolong Life: A Medical Duty Without Classical Roots*, 8(4) HASTINGS CENTER REP. 23-30 (1978).

B. Is the Hippocratic Approach Still Viable?

I will argue below that technological advances in medicine have not rendered the Hippocratic Oath untenable. A different kind of objection to my defense of the Hippocratic position on assisted suicide, however, is that our law no longer supports the Oath's companion proscription against abortion. More generally, doctors have gotten involved in a variety of other activities, such as cosmetic surgery and birth control, that bespeak a profound alteration of the notion that physicians should be specialists devoted to a goal—namely, health—set by nature itself. Perhaps we have simply abandoned the ideal of medicine as a profession and converted it to yet another trade in which technical expertise is purchased for ends chosen entirely by the customer.

Although we do seem to be headed in this direction, there are good reasons for trying to hold the line at assisted suicide. Our experience with abortion since *Roe v. Wade*²⁹ does not undermine this conclusion, but reinforces it. Whatever one thinks about the merits of the constitutional analysis in that case, it is hard to avoid noticing that many of the early warnings about the bad effects of *Roe* have proven far more accurate than advocates of legalized abortion predicted at the time. Vast numbers of abortions are now being performed on a routine basis, often for trivial reasons or as part of an informal but still morally dubious eugenics movement.³⁰ The legalization of abortion has also had a coarsening effect on the medical profession, which now includes in its ranks the people who invented and carry out the grisly form of infanticide known as "partial birth abortion."³¹ The

29. 410 U.S. 113 (1973).

30. See, e.g., Ivonne Prieto, *International Child Health and Women's Reproductive Rights*, 14 N.Y.L. SCH. J. INT'L & COMP. L. 143, 156 (1993) (two groups most commonly using abortion are young unmarried women seeking to delay their first childbirth and married women over thirty-five who want to space additional children or end childbearing); Dena S. Davis, *Genetic Dilemmas and the Child's Right to an Open Future*, 28 RUTGERS L.J. 549, 561 (1997) ("a significant percentage of genetic counselors (a majority of American counselors, in one study) have supported clients' right to use the techniques of amniocentesis and abortion to choose the sex of their children"); John A. Robertson, *Genetic Selection of Offspring Characteristics*, 76 B.U. L. REV. 421, 429-30 (1996) ("Many women over thirty-five have amniocentesis or chorion villus sampling for Down's Syndrome. It is estimated that doctors now screen over 60% of American pregnancies for neural tube defects." (footnotes omitted)); Lori B. Andrews, *Prenatal Screening and the Culture of Motherhood*, 47 HASTINGS L.J. 967, 989-91 (1996) (describing pressures and subterfuges used by physicians to induce pregnant women to undergo genetic screening and abortion).

31. See, e.g., *Joint Hearings Before the Comm. on the Judiciary of the United States Senate and the Subcommittee on the Constitution of the Comm. on the Judiciary of the United States House of Representatives on S. 6 and H.R. 929 (The Partial-Birth Abortion Ban Act)*, March 11, 1997.

increasing enthusiasm for assisted suicide within the medical profession may well be largely a result of the initial major breach of the Hippocratic rules that legalized abortion brought about.

But why not continue on this path, which its proponents might simply characterize as the road to customer satisfaction? Many people have an entirely understandable fear of an overly medicalized death, in which obsessive and callous doctors mindlessly prolong the dying process with machines and tubes and "heroic" measures that result in nothing but pointless suffering and indignities. If the customer wants to put a stop to all that by demanding a poison pill, why should the law or medical ethics say no?

The answer can be summed up in one word: euthanasia.³² Before explaining that answer at greater length, however, it is worth pausing to emphasize that the law and medical ethics already give patients the clear right to refuse unwanted medical treatments and to discontinue unwanted medical interventions, even when death is the probable outcome.³³ That right can be exercised, through living wills, advance directives, and durable powers of attorney, even by those who become incompetent in the final stages of a fatal disease.³⁴ A right to physician-assisted suicide is often confused with a right to terminate unwanted medical treatments, but it is fundamentally different.³⁵ In the one case, physicians are required to do what the ethical practice of medicine has always required anyway: letting

32. I use the term "euthanasia" in a broad sense, which includes the deliberate killing of patients in the course of medical care, for whatever reason and through whatever means. The term does not, however, include attempts to heal or reduce suffering, even when those efforts carry with them a high risk of death for the patient. Thus, for example, performing a dangerous surgery that had a small chance of curing the patient would not be euthanasia; nor would giving dangerously high doses of morphine to relieve the pain of patients with advanced cancer, unless the physician intended thereby to kill the patient.

33. See, e.g., *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 269-70 (1990) (noting that informed consent is generally required before medical treatment can be administered and that the right to refuse unwanted treatment is the logical corollary of the doctrine of informed consent).

34. See, e.g., WESLEY J. SMITH, *FORCED EXIT: THE SLIPPERY SLOPE FROM ASSISTED SUICIDE TO LEGALIZED MURDER* 240-42 (1997). Proponents of physician-assisted suicide are inclined to emphasize that physicians frequently ignore patient directives to withhold heroic measures. See, e.g., RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* 71 (1997). Assuming that advance directives such as "do not resuscitate" orders are in fact frequently ignored, the most obviously plausible inference is that physicians have a strong tendency to do what *the physician* thinks is best, even if the patient thinks otherwise. That in itself would seem to be a powerful reason to continue the age-old practice of inculcating physicians with a strong ethical aversion to participating in the deliberate killing of their patients.

35. Professor Epstein rightly argues that a *logical* distinction between withholding needed medical treatment and providing lethal poisons is an insufficient basis for treating these practices differently. See EPSTEIN, *supra* note 34, at 290-93. My argument, which is strictly consequentialist, does not depend on a logical distinction between acts and omissions.

nature take its course when the patient refuses to be treated or when medicine can no longer do any good. In assisted suicide, by contrast, physicians participate in the deliberate killing of their patients. As the following discussion will show, once physicians begin treating these practices as interchangeable, the Hippocratic bargain will be at an end, and patients will have to begin taking costly new precautions against their doctors. Physicians and patients will both be worse off, but the bigger losers will be the patients.

1. Assisted Suicide and the Physician-Patient Relationship

Once death becomes a "therapeutic option" that physicians can choose, we shall almost certainly see a great increase in suicide and physician-assisted death, far beyond the few and limited kinds of cases now invoked to justify a change in the law. Incentives will be altered, not only for patients given new means to time their deaths, but also for physicians, families, hospitals, health maintenance organizations, and insurers. It is especially important to focus on these incentives, which operate almost invisibly and are therefore easy to forget, whenever we are confronted with extreme cases that are brought forth to gain sympathy for overturning the prohibition against assisted suicide. As we shall see, the few patients caught up in genuinely heart-rending medical situations are very hard to separate, both logically and practically, from countless other potential "candidates" for assisted death.

Many families and physicians will find that the option of electable death presents an opportunity to relieve themselves of the emotional burdens of caring for difficult or incurable patients. Others will be able to avoid huge economic costs or to achieve financial gain connected to an earlier demise, especially where an inheritance will be jeopardized by the expense of caring for long-lingering illness. Although relatives and physicians may not be consciously aware that they are succumbing to such temptations, they will subtly but surely be pulled in that direction.

Proponents of assisted suicide may object that only the patient will be legally entitled to initiate the request for lethal poisons. They can also point out that concern for the economic well-being of one's survivors is not a contemptible reason for electing an earlier death. But such arguments, though appealing in theory, naïvely idealize the usual situation of patients who are severely ill. The assumption of rational autonomy, which has considerable value in many legal contexts, deserves to be treated with special caution when applied to medical practice. Illness nearly invariably means dependence, and dependence means relying for advice on physician and

family. This is especially true with the seriously or terminally ill, where there is frequently also depression or diminished mental capacity that clouds one's judgment or weakens one's resolve. With patients thus reduced—helpless in action and ambivalent about life—someone who will benefit from their death need not proceed by overt coercion. Rather, requests for assisted suicide can and will be subtly engineered. To alter and influence choices, moreover, physicians and families need not be driven entirely by base motives. Indeed, they need not even be consciously manipulative. Well-meaning and discreet suggestions, or even unconscious changes in expression, gesture, and tone of voice, can move a dependent and suggestible patient toward a choice for death.³⁶ Simply by making assisted suicide an option available to gravely ill persons, will we not “sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or cowardly act?”³⁷ It does not require much imagination or experience with the elderly and the incurable to recognize that many of them will experience—and be helped to experience—their right to choose physician-assisted death as a *duty* to do so.

Idealized assumptions of doctor-patient equality and of patient autonomy in medical decision-making can be useful in some contexts, but they do not accurately reflect the reality of most of our encounters with physicians. This is so even in the best of circumstances, when the patient is in relatively good health and where there is an intimate doctor-patient relationship of long standing. But with the seriously ill, the hospitalized, and, especially with the vast majority of patients who are treated by physicians who know them little or not at all, many choices for death by the so-called autonomous patient will not be truly free and fully informed. Physicians have far less costly access to the necessary information regarding prognosis, alternative treatments, and their costs and burdens. Like many technical experts, they are masters at framing the options to guarantee a particular outcome.³⁸ This they almost always do already in presenting therapeutic options to the “autonomous patient” for his decision, and there

36. “The most successful form of manipulation is to lead a person to think that someone else's idea is actually his or her own, or to nudge that person's already existing ambivalence one way or the other.” Daniel Callahan & Margot White, *The Legalization of Physician Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICH. L. REV. 1, 7 (1996).

37. Yale Kamisar, *Some Non-religious Views Against Proposed “Mercy Killing” Legislation*, 42 MINN. L. REV. 969, 990 (1958).

38. See, e.g., NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT* 121-22 (1994).

is no reason to think this will change should one of those options become assistance for death. When the physician presents a depressed or frightened patient with a horrible prognosis and includes among the options the offer of a "gentle quick release," what will the patient likely choose, especially in the face of a spiraling hospital bill or resentful children? The legalization of physician-assisted suicide, ostensibly a measure enhancing the freedom of dying patients, will in many cases be a deadly license for physicians to recommend and prescribe death, free from outside scrutiny and immune from possible prosecution.

Partly for this reason, the practice of physician-assisted suicide is likely to erode the trust that patients give to physicians. True, some patients may be relieved to know that their old family doctor will now be able to provide suicide-assistance if asked. But many patients—especially those who cannot rely on a strong social network or who lack a close relationship with a trusted personal doctor—will have new reasons to be suspicious of the strangers on whom they must rely for advice and treatment. Once doctors have a license to lure their patients into death, patients will have many occasions to wonder whether they are being led down that road, and they will surely wonder what the doctor is likely to do if they resist his wishes. Nor will it be easy to find a satisfactory alternative to relying on the doctors they encounter. In the very cases where assisted suicide is usually imagined to be most appropriate—among the dying elderly—it will be virtually impossible for patients to adopt effective precautions against irresponsible physicians or to substitute self-help therapies for professional medical care. Some will attempt self-treatment, and others will simply postpone medical care as long as possible. The result, in many cases, will be patients inadvertently shortening their own lives and increasing their own suffering in an effort to avoid having doctors do it for them.

Trust will suffer profoundly in more subtle ways. Should physician-assisted suicide become a legal option, it will enter unavoidably—sometimes explicitly, sometimes tacitly—into many doctor-patient encounters. Though there may be some regulatory attempts to prevent physicians from introducing the subject, once it exists as a patient's legal right there will be even stronger pressures to make sure that the patient knows he has the option.³⁹ Ineluctably, patients will now be forced to wonder about their doc-

39. Analogous pressures now operate in the matter of abortion: even obstetricians opposed to abortion are often compelled to discuss it, if only to avoid later lawsuits should the child be born with abnormalities. See, e.g., Sylvia A. Law, *Silent No More: Physicians' Legal and Ethical Obligations to Patients Seeking Abortions*, 21 N.Y.U. REV. L. & SOC. CHANGE 279, 292 (1994-95) ("Wrongful birth claims arise when a physician who provides prenatal care fails to disclose information that suggests that the woman could give birth to a child with serious dis-

tor, regardless of how he handles the situation. Did he introduce the subject because he secretly or unconsciously wishes to abandon me, or worse, because he wishes I were dead? Does he avoid the subject for the same reason, fearing to let me suspect the truth, or conversely, is it because he wants me to suffer? Few patients will openly express such fears and doubts. Because they must rely on their doctor, they do not want to risk alienating him by seeming to distrust his motives and good will. Anyone who has experienced the subtle psychodynamics of the doctor-patient relationship should see immediately the corrosive effects of doubt and suspicion that will be caused by explicit (or avoided) speech about physician-assisted death.

Trust is not just a moral nicety. It is a valuable device for reducing agency costs by diminishing the need for patients to take costly steps to monitor the faithfulness of their doctors. These steps will often be extremely, and even prohibitively, costly because of the informational asymmetries between doctors and patients. A patient's trust in the physician, moreover, is frequently an important element in the therapeutic relationship and, at least indirectly, in the healing process itself. One does not happily follow advice from people one does not trust. Mistrust produces stress, anger, and resistance to treatment. In the increasingly impersonal world of modern medicine, patients must without any direct evidence presume that their care-givers are trustworthy, even before they have shown that they deserve to be trusted. Especially under these conditions, the trust given to each physician stems largely from the trustworthiness attached to the profession as a whole. Thus, with the taboo against physician-assisted suicide broken, legitimate fears of deadly abuse of the new license to prescribe death will attach even to physicians who seek to adhere to traditional ethical norms. Their ability to heal and comfort their patients will therefore often be compromised.⁴⁰

abilities. The woman's claim is that if she had been informed of the risk, she would have sought an abortion. Most courts have upheld a patient's wrongful birth claims." (footnote omitted)); see also Belinda L. Kimble, *Wrongful Birth: a Practitioner's Guide to a New Arrival*, 55 ALA. LAW. 84, 85 (1994) ("Almost half of the states' highest courts have considered actions for wrongful birth, and all but two states have recognized such actions."); Julie Gantz, *State Statutory Preclusion of Wrongful Birth Relief: A Troubling Rewriting of a Woman's Right to Choose and the Doctor-Patient Relationship*, 4 VA. J. SOC. POL'Y & L. 795, 817-18 & nn.103-04 (1997) (noting that many states recognize actions for wrongful birth); see also Melinda A. Roberts, *Distinguishing Wrongful from "Rightful" Life*, 6 J. CONTEMP. HEALTH L. & POL'Y 59, 60 (1990) ("wrongful birth action is well-established in present-day law") (footnote omitted).

40. For the reasons given here, it is a mistake to assume that trust in the physician-patient relationship is always fostered by physician complaisance. The general point should also be apparent to anyone who has had to rely on a "yes-man" subordinate. Professor Epstein has therefore not presented a convincing argument when he poses the following rhetorical question: "Is a

2. *The Road to Euthanasia*

Even if one supposes that these costs of physician-assisted suicide would be outweighed by its benefits, the practice is virtually certain to expand well beyond the narrow range now envisioned. From assisting the suicide of fully competent patients on the verge of death, it is a very short step to "assisting" the non-terminally-ill and the less-than-fully-competent, and to engaging in euthanasia, both with and without the patient's consent. None of the boundaries among these closely related practices is likely to be defensible in practice.⁴¹

The underlying difficulty arises from the blending of principles that generates the appeal of allowing assisted suicide in certain cases. When someone who seems fully competent asks for help in terminating a life that seems to us obviously not worth living, it seems hard-hearted to say that the request should be denied.⁴² But if this is actually justified by the principle of autonomy and choice, then the whole matter is too personal, intimate, and subjective to be governed by *any* objective criteria, such as certifiable terminal illness or truly intractable pain.⁴³ For who is to say what

relationship of trust advanced or thwarted if a patient cannot be sure that her physician will honor her requests on matters of greatest moment to her?" See EPSTEIN, *supra* note 34, at 307. Professor Epstein's rhetorical question is also inapt because few, if any, physicians will automatically honor all their patients' requests for assisted suicide. See *infra* note 44 and accompanying text.

41. The step from assisted suicide to euthanasia is so short that it is virtually inevitable. What if the patient's infirmity prevents him from putting the pills into his mouth or from swallowing them? What if he vomits them up or if, for some other reason, the usually "lethal dose" does not produce death in his case? The physician will surely not stand idly by: he is now committed to the patient's death, and he will certainly lend a hand.

42. There are no doubt some cases in which the appeal of helping a resolute patient who is suffering terribly to kill himself must be extremely strong. It is probably also safe to assume that many physicians throughout history have violated the Hippocratic Oath by providing assistance in such cases. While we all know that virtually every general rule produces bad results in some cases, we should recognize that this does not mean that all general rules are pernicious. One virtue of a robust Hippocratic tradition is that it inculcates in most physicians a deep aversion to promoting the deaths of their patients, and thereby discourages them from doing so in doubtful cases or for inappropriate reasons. Within the Hippocratic tradition, it may be and probably has been the better part of wisdom to avoid exercising the utmost vigilance in flushing out into the light every deviation from the strict Hippocratic rule. This kind of hypocrisy, which sensible and civilized people practice in many areas of social life, has many advantages over the alternative usually proposed: bringing it out of the shadows and letting the lawyers make up some regulations to "control" it. I will suggest briefly in subsection (3) below why the regulatory impulse is particularly misguided in this context.

43. Terminal illness is notoriously difficult to define precisely and almost as difficult to predict accurately. For example, the frequently used estimate of "less than six months to live" leaves unanswered whether it means six months *with* or *without* specific forms of treatment. Besides, a new legal right to determine the time and manner of one's death would, if limited to the terminally ill, seem to discriminate unfairly against those who are fated to suffer their illnesses for longer periods of time. Patients with early Alzheimer's disease or Lou Gehrig's disease or multi-

makes suffering or life "unbearable" or death "electable" for another person? The autonomy argument on which the case for assisted suicide is supposed to rest will sooner or later undermine all criteria proposed for evaluating the patient's choice. If the justification, however, is the worthlessness of the life in question, then there is no reason to confine the benefits of hastened death to those who are competent and who request it.

In practice, the governing principle is likely to become the physician's judgment about the worthiness of particular lives. Almost no physician is going to accede to a patient's request for deadly drugs unless the *physician* believes that there are good reasons to justify the patient's choice for death: too much pain, loss of dignity, lack of self-command, poor quality of life. Only if the physician accepts the patient's verdict that "life is no longer worth living" will he comply with the request. Unless one supposes that physicians will routinely give lethal poisons to lovesick college students or those temporarily deranged by recreational drugs, it is obvious that doctors will often try to persuade patients to accept some other course of treatment or palliation, including psychotherapy for suicidal wishes.⁴⁴ Physician-assisted suicide *in practice* will be performed by physicians not out of simple deference to patient choice but for reasons of mercy: this is a "useless" or "degrading" or "dehumanized" life that pleads for active merciful termination, and therefore deserves my medical assistance.

Once physicians begin assisting suicide for reasons of "mercy," it will become very tempting to begin delivering the dehumanized, whether the dehumanized choose it or not. Only if we supposed that most of the dehumanized were also fully competent would it make sense to believe that

ple sclerosis, for example, are not considered terminally ill, yet they are obvious candidates for assistance in dying. Indeed, Jack Kevorkian's career began with such cases. See generally MICHAEL BETZOLD, *APPOINTMENT WITH DOCTOR DEATH* (1993).

44. In the Netherlands, where assisted suicide and euthanasia have been effectively legalized for some two decades, some two-thirds of patient requests for such "treatment" are rejected. See P.J. van der Maas, et. al., *Euthanasia and other Medical Decisions Concerning the End of Life: An Investigation Performed upon Request of the Commission of Inquiry into the Medical Practice Concerning Euthanasia*, 22/2 HEALTH POLICY (Special Issue) 193-94 (1992) (hereinafter cited as "van der Maas Report"). Similarly, one survey of American physicians indicated that about three-quarters of requests for assisted suicide and two-thirds of requests for euthanasia were rejected (and that only a small number of these rejections were based on fear of the legal consequences). Anton L. Back, et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 922 (March 27, 1996).

Such data do not imply that all physicians will be highly discriminating. Oddly enough, even the most intellectually rigorous proponents of patient autonomy, physician-assisted suicide, and euthanasia do not *expressly* endorse the delivery of deadly poisons to love-lorn teenagers and patients suffering from emotional disorders. On their principles, however, it is hard to see what objection there could be if Jack Kevorkian's epigones went into the business of helping to deliver such people from life. See, e.g., EPSTEIN, *supra* note 34, at 306 (arguing that the principle of self-ownership, which authorizes suicide, entails the right to contract to have oneself killed).

death-dealing by doctors would remain confined to those who freely and knowingly elect it. But this clearly is not the case. The vast majority of patients whose lives seem worthless to outside observers cannot make informed requests for assistance with suicide. Persons in a so-called persistent vegetative state; those suffering from severe depression, senility, or mental illness; infants who are deformed; and retarded or dying children—all of these are incapable of consenting to death, but they are not likely to be denied the new humane aid-in-dying. Indeed, after a Canadian man was given a ten-year prison term for killing his daughter, who suffered from cerebral palsy, one leader in the assisted-suicide movement characterized the sentence as “quite unconscionable” because the parents had already served a twelve-year sentence during the child’s life.⁴⁵

Professor Richard Epstein contends that family members and legal guardians are generally more trustworthy than “the state” in making the necessarily difficult decisions about life or death for incompetent patients,⁴⁶ but even he acknowledges that the government must put limits on these decisions:

State intervention must be used to preserve lives known to be worth living, but it should be rejected as a tool to preserve lives haunted by pain or doomed to eerie silence. Imperfect utilitarian judgments as to the prospects and quality of life are inescapable whenever life and death decisions are made, for ourselves as well as for others. That issue cannot be glossed over with unthinking categorical rules that ignore evident, perceived differences in prognosis and expectations. When life is hopeless or inert, the guardian may not have the duty, but surely has the right, to see that the life ends; and if active euthanasia is the best means to achieve that end, so be it.⁴⁷

This attack on “unthinking categorical rules” is an arresting remark because it is offered by the legal academy’s leading advocate of imperfect categorical rules.⁴⁸ The categorical rule on which Professor Epstein him-

45. See Clyde H. Farnsworth, *Mercy Killing in Canada Stirs Calls for Change in Law*, NY TIMES, Nov. 22, 1994, at A6.

46. See EPSTEIN, *supra* note 34, at 353. (“Whenever the incompetent has not or could not have [chosen in advance what medical interventions should be provided or withheld], familial judgments are preferred to judgments by the state.”).

47. *Id.* at 358.

48. See RICHARD A. EPSTEIN, *SIMPLE RULES FOR A COMPLEX WORLD* (1995) (proposing that the entire legal system be based on six categorical rules: autonomy, first possession, voluntary exchange, protection against aggression, limited privilege for cases of necessity, and takings of property for public use on payment of just compensation). Professor Epstein acknowledges that this is not a recipe for Utopia:

I realize that no set of rules will be perfect in its application; indeed, knowing when to quit is one of the driving forces behind a set of simple rules. Nonetheless even though there are some daunting exceptions, these rules do have the virtue of offering solutions

self seems to settle is that non-voluntary euthanasia of incompetent patients should be confined to those "who are in a permanent vegetative state or who have slipped into a final coma."⁴⁹ Regrettably, this rule appears to have been advanced on the questionable and unsupported assumption that physicians can reliably determine when unconsciousness is "permanent" and when comas are "final."⁵⁰ More profoundly, Professor Epstein's proposal seems to be based entirely on a personal preference derived from personal intuitions about what makes life worth living. In light of the careful and elaborate reasoning that characterizes most of Professor Epstein's argument in favor of assisted suicide and euthanasia, it seems highly significant that he can do no better than to offer a personal intuition about this matter. Others will have different intuitions and preferences, especially when there is the opportunity to avoid large financial or emotional burdens associated with keeping an unwanted patient alive. The rules worked out in the Hippocratic tradition are certainly categorical, but they are not "unthinking." On the contrary, they have been thought about, and tested in practice, for a very long time. That gives them a real advantage over one person's intuitions about worthy and unworthy lives, especially when powerful forces will exert relentless pressure to carry euthanasia far beyond the seemingly narrow limits that Professor Epstein would personally prefer.⁵¹

for 90 to 95% of all possible situations. Never ask for more from a legal system. The effort to clean up the last 5% of the cases leads to an unraveling of the legal system insofar as it governs the previous 95%. No single, carefully constructed hypothetical case offers sufficient practical reason to overturn any rule that has stood the test of time.

Id. at 53. So far as I can tell, Professor Epstein has not brought this insight to bear on the time-tested rule against physician-assisted suicide and euthanasia.

49. See EPSTEIN, *supra* note 34, at 357.

50. Professor Epstein asserts:

The permanent vegetative state is so radically discontinuous from other ailments and maladies, and so irreversible, that it falls into a separate category governed by its own rules. A rule that said "allow death in a permanent vegetative state" could easily be adopted without sliding down some slippery slope, so close is the permanent vegetative state to clinical death.

Id. at 349. Professor Epstein provides no evidence to support either of these assertions. For evidence to the contrary, see *infra* notes 106-109 and accompanying text. Another puzzling aspect of Professor Epstein's proposed categorical rule is that it seems to be inconsistent with his claim, in the passage quoted in the text, that state intervention should be rejected to preserve "lives haunted by pain." Obviously, there are many incompetent patients (for example, children and the deranged) who endure lives haunted by pain although they are not in a "permanent vegetative state" or a "final coma."

51. These forces are explored in more detail in Part II below.

3. *The Dutch Experience and the Impossibility of Effective Regulation*

The specter of unauthorized euthanasia is not a figment conjured up by scare-mongers. Recent reports on the practice of euthanasia in Holland provide ample proof. Although assisted suicide and voluntary euthanasia by physicians are technically still against the law there, the practice has been tolerated and even encouraged for nearly twenty years, under guidelines established by the medical profession. Although the guidelines insist that choosing death must be informed and voluntary, a 1989 survey of 300 physicians conducted by the supporters of euthanasia disclosed that over 40 percent had performed *non*-voluntary euthanasia and over 10 percent had done so five times or more.⁵² An elaborate and carefully constructed study commissioned by the Dutch Government's Commission of Inquiry into the Medical Practice of Euthanasia provides even more striking data. Besides an estimated 2,300 cases of voluntary euthanasia and 400 cases of physician-assisted suicide per year, there are at least 1,000 cases of active *non*-voluntary euthanasia performed without the patient's knowledge or consent.⁵³

In some of the non-voluntary euthanasia cases, perhaps as many as 14 percent, the patients are totally competent.⁵⁴ In addition to these cases, more than 15 percent of all deaths in the Netherlands result from overdoses of pain-killing drugs; in some 36 percent of these cases, the overdose is given at least partly with the purpose of shortening the patient's life, and in 27 percent of the cases, the patient is competent but not consulted about the decision.⁵⁵ It is not entirely clear why all of the drug overdose cases were distinguished from the 1,000 cases classified as non-voluntary euthanasia, but the separate classification does make it clear that an estimate of 1,000 is extremely conservative. The authors estimate that as many as 2 percent of all deaths in the Netherlands may involve drug overdoses that might reasonably be classified as non-voluntary euthanasia.⁵⁶

52. See John Keown, *Some Reflections on Euthanasia in the Netherlands*, in EUTHANASIA, CLINICAL PRACTICE AND THE LAW 193, 209 (Luke Gormally ed., 1994) [hereinafter cited as Keown, *Some Reflections*] (citing F.C.B. van Wijmen, *Artsen en het Zelfgekozen Leven seinde (Doctors and the Self-Chosen Termination of Life)* 24, Table 18 (1989)). Keown does not describe the methodology used in this survey.

53. See van der Maas Report, *supra* note 44, at 193-94. Comparable rates of non-voluntary euthanasia for the United States would be roughly 20,000 cases per year. The methodology of the study, which included three distinct surveys, is described *id.* at 9-18.

54. See *id.* at 61 (Table 6.4). This figure emerged from one of the three constituent surveys in the van der Maas study, which the authors suggest may be unreliable. See *id.* at 57-58, 65-69.

55. See *id.* at 72, 73 (Table 7.2), 75 (Table 7.7).

56. See *id.* at 183.

Because the usual name for euthanasia performed without the patient's request is "murder," the exact language of the survey report is worth quoting: "On an annual basis there are, in the Netherlands, some thousand cases (0.8% of all deaths) for which physicians prescribe, supply or administer a drug with the explicit purpose of hastening the end of life without an explicit request of the patient."⁵⁷

The authors of the study were at pains to emphasize the "suffering" that was avoided through these acts, and the fact that large numbers of doctors volunteered in a government-sponsored survey that they had committed murder speaks volumes about the level of tolerance for this practice.⁵⁸ And why are Dutch physicians doing this? The reasons given by physicians for killing patients without their request included: "low quality of life" (31 percent of the cases); "the relatives could no longer cope" (32 percent); "no chance of improvement" (60 percent); "futility" of medical therapy (39 percent); and the avoidance of "needless prolongation" (33 percent); pain or suffering was mentioned as a reason in only 30 percent of the cases.⁵⁹ The burden of proof, one would think, should be on those who believe that Dutch physicians are for some reason more prone than their American counterparts to convert a license for assisted suicide into the practice of institutionalized murder.

Even proponents of physician-assisted suicide concede that there are dangers of misuse and abuse.⁶⁰ But, they believe, physicians and state governments can establish guidelines and regulations that will prevent such

57. See *id.* at 182. This is a low estimate based on one of the three constituent surveys taken as part of the van der Maas study. One of the other surveys produced an estimate of 1.6%, or double the estimate adopted by the authors of the report. See *id.* at 181.

Professor Epstein, who concludes that "the difficulty in the Dutch experience does not lie in its outcomes, but in the clumsiness of their formal requirements," summarizes the results of the van der Maas Report *without mentioning these findings*; oddly, he does provide an elaborate critique of a much more limited study that was published *before* these survey results were reported. See EPSTEIN, *supra* note 34, at 320-24.

58. See van der Maas Report, *supra* note 44, at 182. The doctors who acknowledged practicing non-voluntary euthanasia must have assumed that they would not be regarded as murderers, and their confidence was rewarded. Van der Maas and his co-authors concluded that "[m]edical decision-making and medical acting concerning the end of life are of good quality in The Netherlands." *Id.* at 199. Similarly, the government commission that sponsored the van der Maas study concluded that the absence of a request "only serves to make the decision process more difficult" and rationalized the practice by saying that the "degrading condition the patient is in confronts the doctor with a case of force majeure." John Keown, *Further Reflections on Euthanasia in the Netherlands in the Light of the Remmelink Report and the Van Der Maas Survey* (hereinafter cited as Keown, *Further Reflections*), in EUTHANASIA, CLINICAL PRACTICE AND THE LAW 219, 229 (Luke Gormally, ed., 1994).

59. Van der Maas Report, *supra* note 44, at 64 (Table 6.7).

60. See, e.g., EPSTEIN, *supra* note 34, at 313-28.

abuses and curtail undesirable extensions of the practice.⁶¹ This confidence in regulation is a mere assertion. Indeed, it is nothing but a pious hope, and one that flies in the face of existing evidence and common sense.

The guidelines that have been proposed are, in fact, defective and ineffective. The evidence from Holland already shows that they are not being followed: the rather comprehensive regulations that include requirements of voluntariness, thoughtfully considered and persistent requests by the patient, unacceptable suffering, consultation with a second physician, and accurate reporting of the cause of death are all being ignored in many cases.⁶² There are many known cases of non-voluntary euthanasia, and no reason to doubt that many more go unreported. In the majority of cases, Dutch physicians illegally certify that death was due to natural causes.⁶³ Moreover, in several court cases where the guidelines were clearly ignored, the Dutch have been willing to set aside the established criteria and regulations, in the name of mercy and in the name of an alleged medical duty to relieve suffering that is said to outweigh the duty not to kill.⁶⁴

The problem is not peculiar to the Dutch regulations or to Dutch social prejudices and legal arrangements. As Daniel Callahan and Margot White have shown, *any* guidelines and regulations that have been or *could be* proposed are likely to be equally defective and ineffective.⁶⁵ Callahan and White analyze in considerable detail the Oregon law authorizing assisted suicide, as well as other state legislative proposals and some model guidelines proposed in the academic literature. They offer compelling arguments for concluding that the usually mentioned safeguards of consent, mental competence or capacity, voluntariness, limited or restricted eligibility, witnesses, clear definitions of what constitutes abuse, and specific requirements to report, investigate, and punish abuse are inadequate to the task.

61. See, e.g., *Compassion in Dying*, 79 F.3d at 832-33:

State laws or regulations governing physician-assisted suicide are both necessary and desirable to ensure against errors and abuse, and to protect legitimate state interests. Any of several model statutes might serve as an example of how these legitimate and important concerns can be addressed effectively. . . . [W]e believe that sufficient protections can and will be developed by the various states, with the assistance of the medical profession and health care industry, to insure that the possibility of error will be remote.

See also *Quill*, 80 F.3d at 730.

62. See HERBERT HENDIN, *SEDUCED BY DEATH: DOCTORS, PATIENTS, AND THE DUTCH CURE* (1996); Keown, *Some Reflections*, *supra* note 52; Keown, *Further Reflections*, *supra* note 58.

63. See Keown, *Further Reflections*, *supra* note 58, at 235-36.

64. See Callahan & White, *supra* note 36, at 15.

65. See Callahan & White, *supra* note 36.

The real difficulty does not lie in fashioning the right procedural rules, but in the impossibility of making any procedural rules effective. The practice of assisted-suicide is in principle unregulable, insofar as it will occur in the privacy of the doctor-patient relationship: “[M]aintaining the privacy of the physician-patient relationship and the confidentiality of these deliberations is fundamentally incompatible with meaningful oversight and adherence to any statutory regulations.”⁶⁶ Laws and regulations, moreover, cannot provide anything like a substitute for physicians’ judgment about relevant and subtle distinctions among particular patients (with respect, for example, to decisionmaking capacity) and particular illnesses (with respect, for example, to whether the disease is “terminal”). As Callahan and White show in detail, legalization of physician-assisted suicide will not lead to regulation of the practice, but to deregulation of the physicians, who will now have more power than ever over the life and death of their patients.⁶⁷

4. *The Future of Hippocratic Medicine*

The Hippocratic Oath is a valuable device, which was ratified by the market over the course of many centuries, at least in part because it reduces agency costs in transactions between physicians and patients. To the extent that physicians as a group credibly commit to obeying the tenets of the Oath, patients are saved from incurring considerable costs in monitoring their doctors to ensure that the doctor acts in the patient’s interest. Patients are also saved considerable costs that would otherwise result from physicians failing to act in their patients’ interests. The Oath’s ban on assisting patients to commit suicide is a crucial element in preserving an appropriate level of trust in the physician-patient relationship, and in preventing doctors from becoming the most dangerous thing that they are most tempted to be: euthanizers of unwilling victims.

66. *Id.* at 9. The text continues:

What if a physician decides not to come forward? A patient might want to keep his suicide private. Or the doctor may decide that the regulatory specifications have not been met, but nonetheless be sympathetic to the patient’s request. It is not difficult to imagine many circumstances in which either the physician or the patient, or both, would prefer to keep the agreement secret. How can that situation be monitored or regulated? How could abuses be detected if a physician wrongly decided to induce someone to consider, and then use, [physician-assisted suicide]? . . . Precisely the principle that allows doctors and patients to reach private agreements—doctor-patient confidentiality—no less assures them that [physician-assisted-suicide] decisions can continue to be effectively hidden. *Id.*

67. *Id.* at 64; see also Keown, *Further Reflection*, *supra* note 58, at 238-39.

Although the Hippocratic Oath helped professionalize medicine in a way that survived a very extended market test, it is no longer the profession's principal organizing force. In its place, we have substituted legal regulation. In some respects, the legal rules we have adopted reinforce Hippocratic principles, as with the laws forbidding assisted suicide. In other respects, the law is now simply inconsistent with those principles, as in the case of abortion. In still other respects, the legal regulations are different, but not starkly inconsistent. In place of the Hippocratics' private efforts to withhold medical training from persons unwilling to subscribe to the Oath, for example, we now have government rules that dictate who can be licensed to practice medicine and how those licenses can be revoked.⁶⁸

To the extent that government licensing agencies adopt and enforce the principles of the Hippocratic Oath, they strengthen the bonding mechanism that the Oath provided under conditions of free competition. With Hippocratic principles thus tied to an indispensable government license, a physician who violates the Oath is risking a very high penalty if he is caught, and the promises contained in the Oath therefore become highly credible.⁶⁹ If, however, government legalizes practices that the Oath forbids, it becomes extremely costly for physicians to commit themselves credibly to the Hippocratic bargain. An individual doctor could hang up a sign in his waiting room announcing that he practices Hippocratic medicine and spelling out the tenets of the Oath.⁷⁰ But why should the patient believe the promises? There would be no sanction from the outside on violators, and it is difficult to imagine how the parties could contract for meaningful sanctions to be applied. Furthermore, we already know that obstetricians who do not themselves practice abortion are forced to facilitate abortion lest they be subjected to "wrongful birth" suits.⁷¹ Physicians who refused to practice assisted suicide would be forced to violate the Oath's proscription against "making a suggestion to this effect" for exactly analogous reasons, and patients would of course come to know this. As various forms of euthanasia became legally acceptable, they would inevitably fall within the scope of medically appropriate care, and tort law would almost certainly impose liability for failure to deliver such care. Hippocratic physicians would thus be forced at the very least to call in

68. See 61 AM. JUR. 2D §§ 51-68 ("Qualifications of Applicants for License").

69. This does not mean that enforcement would or could be perfect. But if physicians had to risk professional ruin and possibly prison when they bent or broke the rules—for example, by helping a patient commit suicide—it is unlikely that many would do so casually.

70. Cf. EPSTEIN, *supra* note 34, at 324-25 (noting that Dutch hospitals and nursing homes commonly advertise whether they practice euthanasia or not).

71. See *supra* note 39 and accompanying text.

other doctors to perform euthanasia, and the Hippocratic bargain would unravel completely.

While medical licensing exists, the law must perforce either strengthen or completely undermine the Hippocratic bargain. For the reasons set out above, I contend that changing the law in a way that undermines the Hippocratic ethic would be a mistake.⁷² Agency costs in the doctor-patient relationship would rise, possibly by an enormous amount, and the offsetting benefits would likely prove trivial or illusory. This does not imply, however, that a refusal to legalize assisted suicide is adequate protection against the dangers that such a step would bring. On the contrary, government's involvement in the medical marketplace goes far beyond the licensing of doctors, and this involvement may be the greatest obstacle of all to preserving the benefits of the Hippocratic bargain.

72. The laws against assisted suicide apply generally, not just to assistance by physicians, and it is possible to imagine a world in which we maintained the rule against physician-assisted suicide, while allowing non-physicians to go into business as suicide assisters. My arguments against physician-assisted suicide would not apply to such a proposal. So far as I know, however, proponents of assisted suicide do not advocate this approach and I do not believe it would have wide appeal.

To see why, it is helpful to distinguish two categories of potential customers. First, there are people who are not confined to hospitals, but who want to commit suicide. Very little now stands in their way apart from their own lack of resolve. For those who want a quick death, firearms, tall buildings, and high bridges are readily available. For those who want a quiet death, one can simply turn on a car in a closed garage or a gas oven in a closed room (a technique that differs little from Jack Kevorkian's), and the booming business in carbon monoxide detectors for the home is good evidence that this is no secret. If non-physician suicide assisters were licensed by the government to prescribe deadly drugs, it might become slightly more convenient for those who are not very resolute to kill themselves. But it is not obvious that this incremental increase in consumer convenience would be an unmixed blessing. Many people who attempt suicide later express gratitude that they failed, and many who succeed undoubtedly would regret it later if they could. Suicide attempts are often really cries for help in living, and it is hard to see why we should be eager to make it as easy as possible for such people to evade the natural revulsion against self-destruction.

The second category of potential customers for suicide assistance are those extremely ill patients who no longer have the physical strength and mobility to kill themselves without help. Some of these patients presumably would choose to purchase the services of non-physician suicide assisters. In order to retain a meaningful ban on assistance by physicians, however, physicians should be forbidden to refer patients to suicide specialists. Physicians should be allowed to use their persuasive powers to discourage their patients from contracting with such people, and should also be allowed to force would-be suicides to leave the hospital in order to get help in killing themselves. Although it is conceivable that suicide clinics might spring up under these conditions, it hardly seems likely that there is really a lot of unsatisfied demand for this sort of thing.

The absence of a clamor for legalized suicide-assistance outside the medical setting reflects, I believe, the fact that the real demand is for *physician*-assisted suicide, both by those whose true goal is promoting euthanasia and by those who mistakenly believe that assisted-suicide is a sensible alternative to degrading and excessive medical interference with the natural process of dying.

In recent decades government has increasingly disrupted and displaced the fundamental economic relationship between patients and their doctors. I will suggest in Part II of this Article that refusing to legalize assisted suicide, while prudent in itself, may do little to prevent euthanasia from becoming a common practice. This analysis should disquiet those who are skeptical—even in the face of the evidence from the Netherlands—about the slippery slope argument presented above. They should ask themselves why it is that after so many centuries the Hippocratic ban on assisted suicide has only now come under serious attack. The answer, I suggest, is not that people are slapping their foreheads as they suddenly wake up to an obvious implication of the ideal of patient autonomy. Nor is it simply a matter of a natural revulsion to the over-medicalized deaths that new technologies have made possible. The most significant new development has been that large numbers of people have acquired strong, new material interests in preventing other people from running up large health care bills. Those material interests, which are largely the result of identifiable government policies, would be served at least as well by coerced euthanasia as by assisted suicide or voluntary euthanasia.

II. Managed Care and Euthanasia

All forms of euthanasia are inconsistent with traditional Hippocratic medical ethics, under which physicians are required to apply their expertise solely to restoring their patients' health and to providing comfort when efforts to restore health become futile. Doctors are permitted, indeed required, to refrain from treating patients without their consent.⁷³ Further, they are permitted, and even required, to refrain from subjecting consenting patients to useless treatments, whether because such treatments are financially profitable to the doctor or in order to satisfy some other personal motive such as an urge to avoid being "defeated" by the patient's disease. For all its virtues, however, the Hippocratic Oath never did, and never could, prevent physicians from having and acting on personal motives. The Hippocratic tradition lowers agency costs in the doctor-patient relationship, but it does not reduce them to zero.

One obvious stubborn temptation that doctors face is to increase their income by overtreating their patients. This temptation has particular relevance to the debate over assisted suicide because so many people fear that they will be overtreated at the end of their lives. For the reasons set out in

73. For obvious reasons, physicians are permitted to give emergency treatments until the patient becomes capable of giving or withholding consent.

Part I above, legalizing assisted suicide is not an auspicious device for addressing the problem.⁷⁴ The problem, however, is a real one and it deserves careful consideration. A recent study, for example, has shown that people are much more likely to die in a hospital, and much more likely to undergo intensive-care treatment, in some geographic locations than in others.⁷⁵ This pattern strongly suggests that economic considerations, such as a desire to keep hospitals operating at optimal capacity, are driving decisions about the care of patients at the end of life.⁷⁶ People justifiably find it highly objectionable that they and their loved ones should be subjected to highly medicalized deaths in order to enrich the medical profession, and it is likely that this often occurs.

The best way to begin thinking about this problem, and about how to address it, is not in isolation but as part of a larger picture of health care financing. Until fairly recently, patients had much the same *economic* relationship with their doctors that they have with most others from whom they purchase personal services: individual patients and individual physicians bargained with each other, either explicitly or implicitly, until they reached an agreement as to what services the patient would purchase and at what price. As doctors became politically organized, they acquired and exercised the ability to raise prices through the usual means, such as price fixing and the creation of governmentally enforced barriers to entry into the profession.⁷⁷ Indeed, there is good reason to regard the American medical profession as one of the most spectacularly successful cartels in history.⁷⁸ Whatever inefficiencies resulted from this success, however, it

74. As Professor Hendin points out, the same desire to "defeat the disease" that sometimes leads physicians to overtreat dying patients might well also lead them to use assisted-suicide and euthanasia as a substitute way of coping with the sense of despair they naturally feel in the face of death. See Herbert Hendin, *Suicide and the Request for Assisted Suicide: Meaning and Motivation*, 35 DUQ. L. REV. 285, 291 n.42 (1996).

75. DARTMOUTH ATLAS OF HEALTH CARE 1998 84-87 (1997).

76. John E. Wennberg, the principal author of the Dartmouth Atlas, concludes that the geographic differences in where people die reflect "the characteristics of the health care system and not what patients want or what is best for them." Amy Goldstein, *Dying Patients' Care Varies Widely by Place, Study Says*, WASH. POST, Oct. 15, 1997, at A1, A8.

77. Price-fixing, typically adopted under the guise of professional ethics, goes back at least to 1766 in this country, and was endorsed in the first code of ethics promulgated by the American Medical Association in 1847. See FRECH, *supra* note 20, at 65. Although this practice is now clearly illegal under the antitrust laws, government regulations continue to restrict the supply of medical services by erecting artificial barriers to entering the profession. The picture has been complicated in recent decades by government subsidies for medical education, which have artificially inflated the supply of trained doctors in some specialty fields, and for hospital construction.

78. Consider, for example, the fact that the number of doctors per capita in the United States in 1965 was precisely the same as it had been in 1870, despite enormous improvements in the useful services that doctors could provide and enormous increases in the amount of disposable

did not fundamentally alter the economic relationship between doctors and patients. On the whole, patients still decided what medical services to purchase, from whom, and at what price. Because the economic relationship between doctors and patients was fundamentally controlled by the price mechanism, albeit under conditions of imperfect competition, medical care was rationed in basically the same way that other goods and services are rationed: customers got about as much of what they wanted as they were willing and able to pay for.

One obvious difference between medical care and most other goods and services is that strict allocation by the price mechanism can have particularly harsh effects on impoverished individuals. Medical care, however, is not unique in this respect, for the same is true of other goods, such as food and housing. Traditionally, the problem was addressed in the same way for all such goods: through charity. That approach obviously did not provide poor people with the level of medical care they wanted. Nor did it provide them with the same level of medical care as richer people were able to purchase. But the same can be said about food and housing, and it would be equally foolish in all these cases to condemn a system because it failed to provide some with everything they wanted or because it failed to provide everyone with an equal share of what they wanted. If one believes, for whatever reason, that the amount of medical care provided to the poor through charity is going to be intolerably inadequate, the obvious alternative would be to have the government provide supplements to the poor. That is what we have done with food and housing, and there is no immediately obvious reason why medical care should be treated differently.

We have in fact treated medical care very differently. Except for education, it is difficult to think of an important consumer service in which the operation of the price mechanism has been more thoroughly disrupted. In recent decades, three enormously influential government policies have transformed the economics of the medical industry. First, large government subsidies have promoted a dramatic increase in the types and quantities of medical care that can be produced.⁷⁹ Second, the government has

income available for expenditures on health care. See Cotton M. Lindsay and James M. Buchanan, *The Organization and Financing of Medical Care in the United States*, in HEALTH SERVICES FINANCING 538 (Table 1) (1970). As one would expect, physicians' incomes have skyrocketed. In the mid-nineteenth century, the income of doctors was about twice the average nonfarm income, and less than the income of skilled manual laborers and craftsmen; in 1991, the average physician earned \$170,600 while average annual income was \$32,649. See FRECH, *supra* note 20, at 51.

79. Government funding, of course, has not been solely responsible for recent advances in medicine. Nevertheless, even those developments that seem to have come primarily from the private sector (in pharmaceutical research, for example) have presumably been stimulated in part by

begun paying the medical bills for a much larger portion of the population than it does with respect to other basic requirements of life, such as food and shelter. Third, the government has promoted and regulated group health care insurance so as to create incentives for consumers that are very different than would otherwise exist.

The most obvious and immediate effect of these policies was to *reduce* the incentives for physicians and families to hasten the deaths of their patients and loved ones, just at the time when technological developments were offering increasingly elaborate ways of keeping very sick people alive. To the extent that doctors get paid more for providing more treatment, they will not have a financial motive to look for ways of getting rid of the person who is causing the money to flow in, especially when the appearance of undertreatment may trigger liability in tort. Similarly, when family members do not have to foot the bills, they need not cope with the insidious conflicts of interest that would otherwise exist. It is very likely true that many patients have been and still are being subjected to painful, degrading and pointless medical treatments near the end of life as a direct result of perverse incentives created by government's heavy involvement in health care financing. It should be no surprise that rational people, many of whom have witnessed this phenomenon in their own families, should believe that patients and families should be given the power to stop this sort of thing from happening.

Were this the end of the story, it might be difficult to defend the continuing usefulness of the Hippocratic ethic's ban on assisted suicide and voluntary euthanasia. The initial and obvious effects of government's new role in medicine, however, are merely part of a larger phenomenon in which the general problem of overtreatment is rapidly causing its opposite: problems of selective *undertreatment*. The current "crisis" in medical costs is largely a result of government policies, as is the resulting search (in both the private and public sectors) for ways to cut costs. There is now a gigantic literature on the subject of a health care financing, along with a myriad of contending theories and proposals for reform. Two relatively narrow aspects of the subject are particularly germane to the assisted suicide debate: first, the nature and effect of the changes that have occurred in the physician-patient relationship; and second, the increased politicization of decisions about the allocation of medical resources. Before turning to those questions, however, a brief description of the rise of government involvement is in order.

government programs that inflated demand by funding the purchase of products that would otherwise not have found a market sufficient to pay the costs of development.

A. The Invasion of Government

For most of history, medicine was a relatively insignificant portion of the economy because the providers of medical services did not really have very much to offer. As the Hippocratic Oath suggests with its reference to "dietetic measures," the distinction between professional medicine on one hand and common sense and folk remedies on the other would for a long time have been difficult to draw on technical grounds. In fact, what we think of as scientific medicine is a recent development. Less than two centuries ago, standard treatments prescribed by orthodox medicine for most maladies included bleeding patients until they lost consciousness, purging the digestive system with laxatives, and administering powerful poisons such as mercury.⁸⁰

As a more scientific basis for medicine began to develop, a new kind of professionalism—one distinct from the ethical professionalism symbolized by the Hippocratic Oath—became possible. This new professionalism was based largely on high levels of formal education, and it thus became important for physicians who made a large investment in education to distinguish themselves in the marketplace from "quacks" (i.e., medical practitioners who had not made the same investment). If these investments had all the value customarily attributed to them by doctors, scientifically educated physicians should have driven their competitors out of business simply by virtue of the superiority of their services. That did not happen.⁸¹ Instead, doctors organized politically and induced state governments to impose licensing requirements that excluded their competitors from medical practice, and they used this power to restrict entry into the guild by "raising standards" at the medical schools.⁸² By 1930, the medical guild had achieved dominance.⁸³

Although this system might not have proved durable unless the education provided by medical colleges enabled physicians to provide significant benefits to their patients, the system also enables physicians to charge

80. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 42 (1982).

81. Formal education, it should be emphasized, does not necessarily imply that what is learned is valid. Scientific progress has not prevented scientifically unverified theories like phrenology and Freudian psychotherapy from becoming popular among orthodox medical practitioners. This suggests a possible alternative definition of "quacks:" medical practitioners who find more favor with their patients than they do with their competitors.

82. For a detailed study of this process, see STARR, *supra* note 80, at 79-144. High standards for those actually practicing have apparently been of less concern. See, e.g., Reuben A. Kessel, *The A.M.A. and the Supply of Physicians*, 35 *LAW & CONTEMP. PROBS.* 267, 275 (1970) ("Once a doctor wins a license to practice, it is almost never revoked unless he is convicted of law-breaking").

83. See FRECH, *supra* note 20, at 53-54; see also STARR, *supra* note 80, at 127.

higher prices than they could if they were subjected to unregulated competition from uncredentialed medical practitioners. Although medicine is not a monopoly in the strictest sense (because individual physicians compete against one another), competition is imperfect because entry into the competitive arena is artificially restricted by the government. Whatever the magnitude of the inefficiencies created by these licensing requirements may be, however, they did not by themselves fundamentally alter the basic market system for allocating medical care through the price mechanism. In recent decades that basic system has finally begun to change: at least three large and essentially different kinds of government influence have now caused fundamental alterations in the practice of medicine.

1. *Government-Funded Research*

Although it may seem churlish even to mention the fact, the federal government has interfered significantly with market forces since World War II by injecting large quantities of tax dollars into medical research.⁸⁴ To whatever extent this money has simply been wasted—by overpaying medical researchers, for example, or by pursuing frivolous or ill-conceived research projects—one might say that this is an unfortunate but acceptable tradeoff for the advances in medical knowledge and technique that the funding has produced. But this is not the only obvious tradeoff. The same expanded body of knowledge and technique that seems unambiguously beneficial to a patient who finds himself cured of an illness from which he might well have died during his grandparents' time has also created many of the dilemmas about terminating treatment that form the backdrop to the debate about assisted suicide and euthanasia. Where one's parent may have seen his own father die quietly and naturally of pneumonia, one may now have to face agonizing questions about whether and when to have that same parent disconnected from an artificial ventilator. The pain caused by such questions has to count as a cost—though perhaps we should regard it as a small cost—of medical progress.

A more complicated side effect of the large infusion of federal funding in the post-war era has to do with the institutions of medical education. Much of this money has been funneled through medical schools and the "teaching hospitals" with which they are associated.⁸⁵ The sums of money

84. See, e.g., Helen Leskovic, *Academic Freedom and the Quality of Sponsored Research on Campus*, 13 REV. LITIG. 401, 404-05 (1994).

85. See, e.g., Ernest Moy et al., *Relationship Between National Institutes of Health Research Awards to US Medical Schools and Managed Care Market Penetration*, 278 JAMA 217, 218 (July 16, 1997) ("Approximately 80% of federal support for health-related research and development is distributed by the NIH [National Institutes for Health]. Medical schools receive the

that flowed into academic medicine were sufficiently large to make everyone involved quite happy. Clinical faculty were paid high salaries to do interesting work. Students received subsidized educations leading to extremely lucrative careers in which they could regard themselves, largely without fear of contradiction, as noble humanitarians. And indigent patients served by the hospitals began receiving a level of care that many wealthy people might have envied only a short time earlier. When the flow of money contracted in the 1970's, however, underlying problems began to come to light.⁸⁶ Institutions that had grown rich on government grants had predictably failed to discipline themselves as participants in markets must. Many apparently did not even use accurate accounting systems, and were ignorant of the costs of the services they provided. By producing a steady stream of highly trained specialists, moreover, they fostered the creation of sophisticated medical centers where there had once been only community medical hospitals; and the federal government aggravated this phenomenon by funding a massive program of hospital construction. Because the market for many specialized services is inherently limited, significant competition for patients among geographically dispersed medical centers arose. When the federal government began imposing cost-control measures in the Medicare and Medicaid programs in the 1980's, and private insurers began to do the same, even the most prestigious medical centers were forced into the real world of scarce resources and hard choices.

The intrusion of reality into academic medicine has not, or at least not yet, produced a simple reversal of the artificial institutional growth that federal funding had caused. Instead, existing institutions have attempted to cope with the reduction in resources primarily by cutting costs. This cost-cutting could in theory be accomplished by reducing the compensation of the doctors and administrators who run these institutions or by reducing the level of care provided to patients. It is a safe bet that academic medicine is insufficiently populated with genuine humanitarians to make the first option the first and only choice.

2. *Medicare and Medicaid*

If government had merely created a temporary spike in the level of medical care available to indigent patients who had the good luck to live near teaching hospitals, a subsequent reduction in that level of care might

majority of their sponsored research funding from NIH, and about 50% of all NIH research grants are awarded to medical schools." (footnotes omitted)).

86. For the more detailed discussion on which this summary is based, see Bruce A. Barron, *The Price of Managed Care*, COMMENTARY, May 1997, at 49.

have had relatively limited effects. More profound changes in the medical system during the post-war period, however, have produced similar patterns on a larger scale. With the rise of the Medicare and Medicaid systems, government has assumed responsibility for providing medical services to a very large fraction of the population, far beyond the class of persons who could be considered indigent.⁸⁷

For the truly indigent, it may be safe to assume that these government programs will finance a higher level of care than patients would receive if they had to depend on charity. If that assumption is correct, there is no obvious reason to suppose that the very poor have been made worse off in any way by the programs' growth. For the rest of the population, however, the case for government financing is less clear. Most obviously, patients lose a significant amount of autonomy when they send their health care dollars to the government, which in turn pays doctors and hospitals for their medical care. Patients who are not responsible for paying their own medical bills have a strong incentive to demand much more expensive medical care than they would demand if they were paying for the services directly; or, to put the same point differently, patients have little incentive to resist "buying" the most expensive treatments doctors have to sell. The government, in turn, is inevitably forced to devise mechanisms for frustrating these demands. Today, those mechanisms go by the names of cost containment and managed care. In individual cases, some patients no doubt receive a higher level of care than they would if the market were rationing medical services through the price mechanism. But in other cases, patients will be worse off because they could have spent the money that the government takes away in taxes more effectively than it is spent under the government's rationing system. And all these patients have lost an important source of power over their doctors, for whom the government rather than the patient has now become the paying customer.

3. *Private Insurance and the Tax System*

Federal intervention in the doctor-patient relationship has not been confined to those programs in which the government itself takes on the role of paying customer. Perhaps even more important, federal policies have created irresistible incentives for a dramatic growth in certain forms of pri-

87. See Stephen Wood et al., *Planning Strategy for Managed Care in Medicare, Medicaid, MANAGED MEDICARE & MEDICAID*, Dec. 1996, at 1996 WL 15558265 ("the percentage of the population covered by government medical programs now stands at 29% and will continue to grow").

vate group insurance plans.⁸⁸ This development should be considered particularly questionable because it was probably the result, at least in part, of inadvertence.

Health insurance, like many other forms of insurance, has double-edged effects. The principal purpose of most insurance is to benefit consumers through risk-spreading. If, for example, there is a small but non-negligible chance that my house will be struck by lightning and destroyed, a group insurance policy enables me and others to exchange a small annual fee in return for the assurance that none of us will be wiped out financially by a catastrophic lightning strike. Similarly, health insurance can spread the risk of relatively rare but costly illnesses. Unlike lightning insurance, however, excessive health insurance creates significant moral hazards. If, for example, I were the beneficiary of a policy that provided 100 percent coverage for any available medical service, an incentive would be created for me and all the other policyholders to consume medical services far in excess of what we would be willing to pay for ourselves. Because doctors can now supply a tremendous range of diagnostic and therapeutic services, the operation of these incentives would quickly make the policy so expensive that it would become unsaleable.⁸⁹ Where a significant potential for moral hazard exists, insurance companies try to compensate with devices such as deductibles and coinsurance. There is, however, no general formula that dictates where to find the most efficient tradeoffs between these devices and the underlying risk-spreading purpose of the insurance. Those insurance products that survive in a freely competitive market presumably represent the best approximation of whatever the ideal tradeoff may be.

Prior to government intervention, medical insurance policies did exist, but they did not dominate the market as they do now. The first modern group health plan, offered in 1910, paid benefits directly to disabled employees as a percentage of salary.⁹⁰ In 1929, only 12 percent of health care bills were paid by public or private insurers,⁹¹ and plans including direct payments to health-care providers apparently arose only in response to economic dislocations caused by the Great Depression.⁹² Today, of course,

88. For the sake of simplicity, the following brief summary ignores the effects of state regulation on private health insurance. This phenomenon is discussed in JOHN C. GOODMAN & GERALD L. MUSGRAVE, *PATIENT POWER: SOLVING AMERICA'S HEALTH CARE CRISIS* 323-53 (1992).

89. Even lightning insurance presumably creates incentives for policyholders to skimp on precautions like lightning rods, but the magnitude of the economic effects is probably quite small.

90. See Laura A. Scofea, *The Development and Growth of Employer-Provided Health Insurance*, MONTHLY LAB. REV., Mar. 1994, at 3, 4.

91. See FRECH, *supra* note 20, at 9. The comparable figure for 1991 is 78%. *Id.*

92. See Scofea, *supra* note 90, at 5.

third-party payment systems are completely dominant. This has not, however, occurred through the operation of market forces.

On the contrary, the dramatic growth in the medical insurance industry owes its origins largely to a 1942 statute that tried to restrain normal wartime inflation by limiting the freedom of employers to grant wage increases to their employees.⁹³ Because Congress is a mere legislature, without the power to alter the laws of supply and demand, this statute simply created an incentive for employers to compete for workers by increasing the non-wage compensation of their employees. And the 1942 statute was helpfully interpreted to exempt health-care coverage from the wage controls; such coverage was then quickly adopted on a large scale in collective bargaining agreements.⁹⁴ The removal of the wartime wage control rules might have permitted a return to more normal compensation arrangements except that employers had treated medical payments as exempt from the withholding tax.⁹⁵ By the time the IRS finally objected, the tax subsidy for employer-provided health insurance had become so popular that Congress was forced to grant it a statutory tax exemption.⁹⁶ The result was inevitable. Because this kind of health insurance system was subsidized, excessive amounts of insurance were demanded and serious moral hazard problems were created. Eventually, the costs became intolerably high, and cost controls began being imposed. Just as in programs that involve direct government payment, the patient is no longer the paying customer, and physicians are increasingly responsive to the cost-cutting demands of the paying customer rather than to the patient. We encounter the result as "managed care," which might be better called "not-managed-by-us-care."⁹⁷

93. See Scofea, *supra* note 90, at 6. Another factor, though one that has less continuing relevance today, was political manipulation at the state level by organized medicine. See GOODMAN & MUSGRAVE, *supra* note 88, at 153-55, 158-61.

94. See Scofea, *supra* note 90, at 6. See also Paul J. Donahue, *Federal Tax Treatment of Health Care Expenditures: Is It Part of the Health Care Problem?*, 46 WASH. U.J. URB. & CONTEMP. L. 141, 142-43 (1994).

95. See Milton Friedman, *A Way Out of Soviet-Style Health Care*, WALL ST. J., Apr. 17, 1996, at A20.

96. See *id.* See also Peter J. Wiedenbeck, *Nondiscrimination in Employee Benefits: False Starts and Future Trends*, 52 TENN. L. REV. 167, 169 n.5 (1985) ("The exclusion of employer-provided medical insurance and amounts received thereunder was enacted with the Internal Revenue Code of 1954. I.R.C. §§ 105(b), 106 (1954) (current version at I.R.C. §§ 105(b), 106 (1982 & West 1985))."); H. Rep. 83-1337, 83rd Cong. 2nd Sess. (1954), 1954 U.S.C.C.A.N. 4017, 4039-40, 4169-71; S. Rep. 83-1622, 83rd Cong., 2nd Sess. (1954), 1954 U.S.C.C.A.N. 4621, 4645-46, 4817-20.

97. As of 1993, only 4% of the health insurance market involved unmanaged fee-for-service coverage. See American Medical Association, *TRENDS IN US HEALTH CARE* 95 (4th ed. 1995).

B. Managed Care at the End of Life

The public debate is awash in proposals for dealing with the escalation in health care costs that has resulted largely from the government policies briefly described above. Most of these proposals entail more government regulation of the market for medical services. With respect to the issues of assisted suicide and euthanasia, this is an unsettling prospect because the only real alternative to allocating medical care through the price mechanism is to allocate it by political criteria. Whether those criteria are applied directly through law and regulation, or through the development of a sort of customary law by proxies in the health care industry, they are likely to produce significant new pressures for withholding care from patients whose lives are deemed insufficiently worthy of continuation.

The increasingly political nature of health care rationing is the inevitable result of displacing the price mechanism. Recent instances of the direct politicization of medical decisionmaking are not hard to find. Congress, for example, has now decreed that insurers must allow women to stay in a hospital for at least 48 hours after giving birth.⁹⁸ This statute was a reaction to a clever slogan—Stop “drive-by deliveries”!—that subtly likened cost-conscious insurance companies to the gangsters who commit “drive-by shootings.” What politician could resist the urge to defend motherhood itself from such murderous depredations?⁹⁹ But the inevitable result of the statute, in a world of limited medical resources, is to deprive other patients of resources that must now be committed to newborn children and their mothers. Nothing in the statute ensures that these resources will be diverted from patients who need care less than the politically appealing women and children who are its beneficiaries.

Similarly, the state of Oregon adopted a Medicaid rationing plan that ranked several hundred different medical treatments; funds for lower ranking treatments are withheld so that everyone needing one of the higher ranking treatments can be served with available funds.¹⁰⁰ When the plan was first proposed, treatments meant to attempt a cure for patients in the late stages of AIDS were given a low ranking because such treatments were expensive and largely unsuccessful. In response, the AIDS lobby mounted a successful political campaign to get the plan amended so as to

98. Pub. L. 104-204 § 602 (1996) (codified at 42 U.S.C. § 300gg-4) (Sup. 1997).

99. See, e.g., Barbara Vobejda, “Moms and Babies” Prove to be Irresistible Force on Capitol Hill, WASH. POST, Sept. 20, 1996, at A17.

100. See OR. REV. STAT. § 414.705 to .750 (1991). See also Nancy K. Stade, *The Use of Quality-of-Life Measures to Ration Health Care: Reviving a Rejected Proposal*, 93 COLUM. L. REV. 1985 (1993).

protect the interests of these patients.¹⁰¹ Analogous groups of patients for whom expensive but largely unsuccessful treatments are available, such as low birth weight babies and advanced cancer patients, continue to have funds withheld under the Oregon plan for the simple reason that they are politically less powerful.¹⁰²

Examples like these are bound to multiply as access to medical care becomes the subject of explicit bargaining in the political arena. And it is not hard to imagine some of the outcomes that might result. The likely winners will include the most politically well-organized and appealing groups of patients. A campaign against "drive-by mastectomies" has already been mounted,¹⁰³ and it would be no surprise to see similar campaigns on behalf of patients suffering from diseases that disproportionately affect certain racial and ethnic groups.¹⁰⁴ Some occupations are also affected disproportionately by specific illnesses, and perhaps their unions might take up the cudgels for their members. Where campaigns like these produce winners, others must lose. Often, the losses will be distributed widely and invisibly, but the government is also capable of picking losers when the targets are sufficiently unpopular. Leading candidates might include those suffering from illnesses linked to cigarette smoking, illegal drugs, motorcycle riding, or liquor. Eventually, perhaps we might even consider curtailing health care to the obese, the sedentary, those with a taste for high-fat foods and red meat, or people who drive without seat belts or at speeds exceeding the legal limit. As the recent publicity about forced sterilization in Sweden suggests, even governments that fancy themselves paragons of enlightened humanitarianism are perfectly capable

101. See SMITH, *supra* note 34, at 87.

102. See *id.* For evidence that AIDS policies in general redistribute wealth from the general population to male homosexuals and medical professionals, see TOMAS J. PHILIPSON & RICHARD A. POSNER, *PRIVATE CHOICES AND PUBLIC HEALTH: THE AIDS EPIDEMIC IN AN ECONOMIC PERSPECTIVE* 199-206 (1993).

103. See, e.g., Sandra Sobieraj, *First Lady Pushes Ban on "Drive-by" Mastectomies*, ASSOCIATED PRESS POLITICAL SERVICE, Feb. 12, 1997; Charles Krauthammer, *Play Doctors on the Hill*, WASH. POST, Feb. 14, 1997, at A21; Lynn Lauerma, *Mandated 2-Day Stay after Mastectomy Debated; Committee Hears of No Rush Cases in Virginia*, RICHMOND TIMES DISPATCH, June 18, 1997, at B5; Amy Goldstein, *Under the Scalpel, then Out the Door; Rise in Outpatient Mastectomies Drives Legislation but Little Basic Research*, WASH. POST, Nov. 19, 1997, at A1.

104. This is not mere speculation. Medical criteria for the allocation of transplant organs have already begun to be displaced by rules based on theories of "racial justice." See Lloyd R. Cohen and Melisa Michelsen, *The Efficiency/Equity Puzzle and the Race Issue in Kidney Allocation: A Reply to Ayres, et al. and UNOS*, 4 ANNUAL REV. OF LAW AND ETHICS 137 (1996).

of adopting barbaric medical practices directed at the politically unpopular.¹⁰⁵

It is, of course, quite possible that legislatures will shrink from engaging in the sort of explicit rationing just suggested. If so, however, the difficult and essentially political decisions about allocating limited medical resources will simply be shifted to other decisionmakers. Doctors and health care administrators, provided with limited budgets and under constant pressure to keep within those budgets, will have virtually no choice except to withhold care from some people in order to conserve resources for other patients whom the decisionmakers regard as more "deserving" or more "promising." As these decisions are played out in practice, the line between withholding care and committing euthanasia is bound to blur, and perhaps ultimately to disappear.

Consider, for example, the phenomenon known as the persistent vegetative state, which is sometimes referred to as a permanent vegetative state when it is "deemed" irreversible. Leaving aside the odd fact that doctors now liken some of their patients to carrots and broccoli, one of the most striking characteristics of this condition is how poorly the medical profession understands it. The vegetative state has traditionally been defined as "the absence of any adaptive response to the external environment."¹⁰⁶ But patients diagnosed as persistently vegetative often regain consciousness.¹⁰⁷ Indeed, even patients in a permanent vegetative state

105. See, e.g., Dan Balz, *Sweden Sterilized Thousands of "Useless" Citizens for Decades*, WASH. POST, Aug. 29, 1997, at A1 (from 1934 to 1974, 62,000 Swedes were sterilized by the state, often against their will). Balz notes:

[T]here was nothing secret about the sterilization program. It was carried out in the light of public debate at a time when Swedes believed they were creating a society that would be the envy of the world. . . . Politicians in Sweden defended the program as a way to hold down the costs of the enlarging welfare state. They argued that it was important to limit the size of families, especially those with a history of antisocial behavior. [Researcher Maija] Runcis said the Social Democrats "argued that it was necessary to sterilize people who got a lot of benefits from the welfare state because the welfare state was only for people who behaved themselves.

106. See Brian Jennett and Fred Plum, *Persistent Vegetative State after Brain Damage*, 1 LANCET 734, 736 (1972).

107. See, e.g., Harvey S. Levin, Christy Saydjari, Howard M. Eisenberg, Mary Foulkes, Lawrence F. Marshall, Ronald M. Ruff, John A. Jane, and Anthony Marmarou, *Vegetative State after Closed-Head Injury: A Traumatic Coma Data Bank Report*, 48 ARCHIVES OF NEUROLOGY 580 (1991) ("Of 84 patients in a vegetative state who provided follow-up data, 41% became conscious by 6 months, 52% regained consciousness by 1 year, and 58% recovered consciousness within the 3-year follow-up interval."). For those inclined to put their faith in doctors who "deem" some comas irreversible, it is worth noting that the authors of this study report that "[a] logistic regression failed to identify predictors of recovery from the vegetative state." *Id.*

often experience periods of wakefulness.¹⁰⁸ Patients who have been unresponsive to external stimuli, moreover, frequently report upon recovery that they had in fact been conscious, even though they had been incapable of showing any signs of awareness.¹⁰⁹

As the controversy about *Cruzan* suggests,¹¹⁰ considerable sentiment exists for the practice of withholding food and water from patients suffering prolonged apparent unconsciousness.¹¹¹ This sentiment, moreover, is not confined to lay persons unfamiliar with the paucity of medical understanding about the condition. In 1994, for example, the executive editor of the prestigious *New England Journal of Medicine* published an editorial recommending that steps be taken to protect "demoralized" caregivers

108. See Marcia Angell, *After Quinlan: The Dilemma of the Persistent Vegetative State*, 330 NEW ENG. J. OF MED. 1524, 1525 (1994).

109. See, e.g., Madelaine Lawrence, *The Unconscious Experience*, 4 AM. J. OF CRITICAL CARE 227 (1995). At least 27% of the subjects in Dr. Lawrence's study "were able to hear, understand, and respond emotionally at some time to what was being said but were unable to respond physically or communicate." *Id.* at 229. Because amnesia is a well-documented occurrence among people who are unquestionably conscious, such statistics might radically underestimate the number of apparently unconscious people who are actually aware of their surroundings.

110. *Cruzan v. Director, Mo. Health Dept.*, 497 U.S. 261 (1990). In this case, the Court held that state governments are constitutionally permitted to require that life-sustaining treatment be withdrawn from an incompetent patient only upon proof, by clear and convincing evidence, that such withdrawal was consistent with the patient's previously expressed wishes. Four members of the Court, however, dissented. See *id.* at 302 (Brennan, J., dissenting) (contending that this procedural requirement imposes an unconstitutional burden on the patient's right to avoid unwanted medical treatment); *id.* at 356 (Stevens, J., dissenting) (arguing that the "meaning and completion of [an incompetent patient's] life should be controlled by persons who have her best interests at heart—not by a state legislature concerned only with the 'preservation of human life'"). Justice Brennan's dissent, which was joined by Justices Marshall and Blackmun, noted the results of a survey suggesting that a large majority of the population approved of withdrawing life-support systems "from *hopelessly ill* or irreversibly comatose patients if they *or their families* requested it." *Id.* at 312 n.11 (Brennan, J., dissenting) (emphasis added).

111. A considerable amount of confusion and sophistry has arisen in connection with discussions of the use of feeding tubes and intravenous hydration. To say that failing to provide artificial feeding and hydration to patients who cannot be fed orally always constitutes "murder by starvation" implies that physicians must always take every step possible to delay the moment at which every patient becomes technically dead, even when such steps can only impose pointless suffering on the patient. But to say that artificial feeding and hydration can be withheld at any time and for any reason, even when the patient can easily be restored to health, is no different from the ancient sophistry that allowed parents to expose unwanted infants to the elements on the rationale that they were being killed by the weather rather than by their parents. Under traditional medical ethics, artificial feeding—like other medical procedures—should be used when *medical* judgment indicates that it may help the patient, but not when it merely constitutes a burdensome interference with the natural process of dying. See Kass & Lund, *supra* note *, at 422 n.45. The fact that such judgments can be very difficult to make is not a sufficient reason to substitute non-medical criteria or to engage in sophistries meant to blur the distinction between choosing a patient's death and accepting the inevitability of a patient's death.

from having to provide wasteful treatment to such patients.¹¹² The editor, Dr. Marcia Angell, offered three options: 1) redefine death to include permanent vegetative states, and withhold food from the "dead" person until the heart and lungs stop; 2) enact legislation prohibiting the delivery of medical care (including food) to a person who has been unconscious for a specified period of time; 3) create a legal presumption that a person who remains unconscious for a specified period of time would refuse further treatment (including food). Dr. Angell personally recommended the third option, but all of the alternatives are clearly driven by the same impulse: to conserve resources (including the morale of overburdened caregivers) by denying medical treatment (now defined to include food) to patients whose quality of life appears insufficient to justify further expenditures.

This sort of quality-of-life calculus has already been applied in other contexts, such as that of disabled children,¹¹³ and there is nothing in principle to stop it from being used to deny expensive medical care to countless patients who are fully competent and unwilling to request a hastened death. Nor is it clear that the medical profession and its new overseers in the managed care industry necessarily need wait for express legal authorization to begin allocating care on the basis of such calculations. Instead, they may be able simply to redefine the concept of "futile care" so as to create opportunities for hastening the deaths of patients they do not want to treat.¹¹⁴

It is obviously appropriate, and perhaps even mandatory, for physicians to refuse to provide treatments that would be medically futile, even if the patient wants them. If, for example, a patient mistakenly believes that his insomnia would be cured by having his feet amputated, such a request should certainly be refused. Or, to take a less outlandish example, physicians are perfectly right when they refuse to prescribe antibiotics for patients with viral infections. Such refusals are based on *medical* judgments about futility. By expanding the concept of futility to cover treatments that are perfectly appropriate under normal medical standards, physicians could

112. See Angell, *supra* note 108. The editorial poses the question: "Do care givers—demoralized by providing limitless, expensive care in a hopeless case—have the right to stop treatment anyway, so that the patient will die?" *Id.* at 1524.

113. See, e.g., Nelson Lund, *Infanticide, Physicians, and the Law: The 'Baby Doe' Amendments to the Child Abuse Prevention and Treatment Act*, 11 AM. J. L. & MED. 1 (1985).

114. Even without a development like this, the legalization of assisted suicide may encourage managed care organizations to undertreat depression, which is a significant cause of requests for assisted suicide. Because depression (accompanied by suicidal wishes) often manifests itself relatively early in the course of diseases like cancer and AIDS, this could be a significant source of cost savings. See Susan M. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 DUQ. L. REV. 455 (1996).

institute a regime of de facto euthanasia governed by essentially political criteria. This possibility is not mere speculation. One of the nation's leading specialists in bioethics has proposed that medical treatments be stopped under the following circumstances:

- when there is a likely, though not necessarily certain, downward course of an illness, making death a strong possibility; failure of more than one organ is an obvious example in an older patient
- when the available treatments for a potentially fatal condition entail a significant likelihood of extended pain or suffering
- when successful treatment is more likely to bring extended unconsciousness or advanced dementia than cure or significant amelioration
- when, whatever the medical condition, the available treatments significantly increase the probability of a bad death, even if they also promise to extend life.¹¹⁵

Recall that medical treatment does not merely include the vast array of expensive procedures and mysterious machines that we often think of with dread under the rubric of "heroic measures." It also includes such simple things as antibiotics for infections, and even the provision of food and water to patients who cannot feed themselves. Euthanasia is truly a euphemism when used to describe the deliberate starvation or dehydration of infant children or extremely debilitated elderly people. Under guidelines like the first one on Dr. Callahan's list, the desired goal of hastened death could be achieved surely enough through dehydration, but its acceleration would not be matched by its mercifulness. Once doctors begin making choices like these for their patients, assisted suicide and deliberately administered doses of genuinely quick-acting poisons may well be preferable from the patients' point of view.

Dr. Callahan does not recommend that the medical profession begin to implement his proposed standards immediately or unilaterally.¹¹⁶ But he does believe that medical care should be withheld on the basis of quality-of-life criteria.¹¹⁷ Because the definition of appropriate medical standards is largely determined by the medical profession itself, the law may not impose insuperable obstacles to a gradual movement in the direction recommended by Dr. Callahan. And, as doctors increasingly come under various kinds of pressure to cut costs, there is little reason to believe that they will long resist the urge to move in that direction. Neither doctors nor families

115. See DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE: LIVING WITH MORTALITY* 201-02 (1993).

116. See *id.* at 215-17.

117. *Id.*

much enjoy caring for people whom no one expects to recover, especially when the patient inconsiderately takes a long time to succumb. "We can't afford to keep such cases alive" will be the irresistible rationale for not keeping them alive, even if decisions to hasten death are camouflaged with high-minded expressions of solicitude for the patient's dignity. By the time the rest of us notice what has happened, we may be ready to demand that the law actually *require* physicians to supply a "gentle, quick release," if the alternative is being abandoned to a miserable death by dehydration or starvation.¹¹⁸

Conclusion

Much of the current enthusiasm for legalizing assisted suicide is driven by a perfectly understandable yearning for patient autonomy and by an equally understandable reluctance to let the notoriously arrogant medical profession force us to endure degrading technologically-extended deaths. Unfortunately, the legalization of assisted suicide would be a big step down a road that will finally reduce patient autonomy rather than enhance it.

Doctors are uniquely empowered by their technical knowledge and by the nature of their work to kill their fellow citizens without getting caught. The principal check on that power has been the ancient and durable Hippocratic ethic, which strictly forbids physicians from ever playing any part in deliberately hastening the death of any patient. That ethic is now under serious attack, at the very moment when strong new financial incentives are being created for doctors to step out of the narrow role of healer and to take on a political function—deciding which lives are worth preserving and which are not—for which they are eminently ill-suited.

In the past, these decisions rarely had to be made either by doctors or by explicit political choice. The combined effects of the Hippocratic ethic, the impersonal operation of market forces, and the technical limitations of the medical art resulted in an allocation of medical care in which nature and chance dominated human choice. Almost no one would want to reverse or retard the progress of medical knowledge and technique. We can and should, however, reconsider the policies that have displaced the operation of the price mechanism, and give serious attention to the desirability of restoring, to the extent possible, the patient's role as the paying cus-

118. Only wishful thinking could lead one to assume that deliberate starvation and dehydration will be confined to those who are unconscious. For examples of well-documented cases involving conscious patients, see SMITH, *supra* note 34, at 39-42, 216-18.

tomers. Unless that is done, efforts to rescue the Hippocratic ethic from its present endangered condition may be a lost cause.

It is true, of course, that this may be a lost cause in any event. No matter what steps are taken with respect to health care financing, the irreversibility of medical technology and knowledge means that we will never return to the days when most people could afford to buy most of the genuinely useful services that doctors had to offer. Nor would it be easy to overstate the political obstacles confronting any effort to begin dismantling the huge and complex array of programs, institutions, and subsidies through which the government now dominates the various markets for medical services. Nevertheless, it is worth trying to imagine alternatives to the politicized system of health care rationing toward which we are quickly headed.

Without pretending to be able to predict exactly what solutions a freer market would produce, one can note some obvious possibilities that are more attractive than anything the government is likely to come up with. First, eliminating the tax subsidy for employer-provided health insurance and abolishing the various programs under which the government acts as payor for medical services would create the conditions for the creation of more efficient insurance products and, perhaps, the creation of health maintenance organizations that actually respond to consumer preferences. It might well be that many people would choose to cover routine medical expenses out of their own pockets, while maintaining insurance for carefully defined catastrophic illnesses. Others might prefer more costly products that cover more routine services. Some catastrophic policies might exclude certain very expensive treatments for some illnesses, and others might not. In general, wealthier people would no doubt buy more medical care (especially exotic or high-tech care), just as they now tend to buy larger (and thus safer) automobiles, more expensive (and perhaps healthier) "natural" foods, (more expensive) housing in low-crime neighborhoods, and better dental care. There is nothing obviously wrong with this outcome, especially in light of the alternative, which is politicized rationing.

What, then, of the truly indigent? Here, there may really be no alternative to government rationing, given the decline of charitable institutions. If, however, a functioning free market in medical care were to exist, it would provide some potentially very useful cues about the types and levels of care that people really consider minimally adequate when they have to reveal their true preferences by spending their own money. Health-care vouchers, along the lines of food stamps, are an obvious device that could be used to provide care for the poor without significant economic distur-

tions. That would be a great improvement over a system in which advocates for the poor can simply say that they, and everyone else, should get as much medical care as possible.

Free markets cannot solve every problem, in this context any more than in any other. They cannot, for example, eliminate conflicts of interest between doctors and patients, or between patients and their families, or between indigent patients and taxpayers. Nor can they ensure that everybody gets as much as he wants of everything he wants. What they can do, in this context as in most others, is allocate limited resources more efficiently than government, and in a way that will often avoid the need for explicit and costly battles over those resources.¹¹⁹ As one contemplates current trends in health care allocation, it is becoming more and more difficult to suppose that allocation by the government carries benefits that could outweigh, or even come close to matching, these advantages.

119. See Mark F. Grady, *Politicization of Commodities: The Case of Cadaveric Organs*, 20 J. CORP. L. 51, 61 (1995) ("One virtue of market-based systems of allocation is that they do not require much public discourse.").