

THOU SHALT NOT KILL AS DEFEASIBLE HEURISTIC:

LAW AND ECONOMICS AND THE DEBATE OVER PHYSICIAN-ASSISTED SUICIDE*

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I. Introduction

Everybody dies. But if death is like taxation in being inevitable, it is also like taxation in that its most vexing questions are about how and when, rather than whether, it will occur. Nowadays, most people die in hospitals;¹ most people die of chronic illness;² and most people are subject to medical intervention that may postpone the time and alter the manner of their deaths.³ Not all such alteration is inevitably seen as salutary. Many terminally ill patients suffer, and they may see various medical interventions as prolonging, or even intensifying, that suffering. That such perceptions are commonplace has given rise to ample public concern about the role of the medical profession in alleviating the suffering of the dying and, incidentally, a vast body of literature on death and dying. Two of the most striking issues

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¹ See 2A NATIONAL CENTER FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, VITAL STATISTICS OF THE UNITED STATES: 1992, tbl.1-30, at 374-79 (1996), available at http://www.cdc.gov/nchs/data/vsus/mort92_2a.pdf (reporting places of death in the U.S. for 1992).

² See U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES: 1997, at 97 (1997) (representing deaths by age and leading cause for 1994), available at <http://www.census.gov/prod/3/97pubs/97statab/vitstat.pdf>.

³ See Louis Lasagna, *The Prognosis of Death*, in *THE DYING PATIENT*, at 68 (Orville G. Brim, Jr. et al., eds., 1970).

presented by the medicalization of death are those surrounding the refusal of life-sustaining treatment and physician-assisted suicide (PAS).

Attempts to establish a constitutional right to PAS on due process and equal protection grounds were repudiated by the Supreme Court in the last decade, casting the debate back into the states.⁴ There, the debate over PAS continues apace. Recently, for example, United States Attorney General John Ashcroft has been advocating that Oregon physicians practicing PAS pursuant to Oregon's "Death with Dignity Act" are in violation of the federal Controlled Substances Act.⁵ In May 2004, a divided panel of the United States Court of Appeals for the Ninth Circuit rejected the Attorney General's position as unenforceable.⁶ Further litigation regarding the Oregon Act is not unlikely.⁷

Although the literature addressing medical decisions at the end of life is vast, surprisingly little of that commentary has come from the perspective of law and economics. That is odd, both because of the large body of economic literature regarding health care generally and because of the stark costs and benefits entailed by any legal constraints on medical decisions at the end of life.⁸ At stake are, on the one hand, questions of individual autonomy with respect to some of life's most desperate and personal decisions and, on the

⁴ See *Washington v. Glucksberg*, 521 U.S. 702 (1997) and *Vacco v. Quill*, 521 U.S. 793 (1997).

⁵ See *Oregon v. Ashcroft*, 368 F.3d 1118, 1121-23 (9th Cir. 2004).

⁶ See *id.* at 1131.

⁷ Immediately following the panel ruling, the Justice Department reported that they were reviewing the ruling and that no determination had yet been made as to the government's next step. See Blaine Harden, *Court Rules on Aided Suicide*, WASH. POST, May 27, 2004, at A2.

⁸ See, e.g., Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AMER. ECON. REV. 941 (1963) (early discussion of economics and health care).

other hand, some of our most universal and well entrenched norms prohibiting the willful taking of human life, norms that surely represent at least useful heuristics for maximizing social welfare.⁹

Not all is silence, however. Notably, Judge Richard Posner has offered a sort of cost-benefit analysis favoring the legalization of PAS.¹⁰ Despite Posner's signal position of influence as a jurist and a scholar, his discussion has been substantially ignored in the ongoing PAS debate.¹¹ This is in some respects understandable. For one thing, Posner's critique of the extant policy literature tends to be broad but quick. In places, his analysis of

⁹ At least, but not at most. Such norms may be viewed variously, both with regard to their etiology and with regard to their generality. For example, on a Kantian scheme we might see them as necessary and exceptionless rules for rational human conduct. *See, e.g.*, IMMANUEL KANT, KANT'S GROUNDWORK OF THE METAPHYSICS OF MORALS (H.J. Paton trans, London 1948) (outlining Kant's moral theory). Nothing in the argument that follows depends on a very particular account of social or moral norms. How one counts norms here may be up for grabs as well. I'm considering at least two: the general norm against intentionally taking the life of another (save, perhaps, in self-defense or in wartime) and the more specific norm prevalent in the medical profession against a doctor's participation in PAS.

¹⁰ RICHARD A. POSNER, AGING AND OLD AGE (1995) (concentrating on the issue especially in Chapter 10, Euthanasia and Geronticide). Posner talks about balancing costs and benefits in the most general sense appropriate to social welfare analysis; that is, abstracting from particular methodological commitments that come with particular approaches to cost-benefit analysis as practiced in the agencies, he is interested in the most basic of economic questions we can ask of any policy: what will it get us and at what cost?

Of course, to argue the benefits of legalized PAS via costs and benefits might seem worse than a bad joke. It has often been observed that medical expenditures at the end of life are substantial, even as the economic implications of those expenditures have been found by many to be unclear. *See, e.g.*, Seanda Coppa, *Futile Care: Confronting the High Costs of Dying*, 26 J. NURSING ADMIN. 18 (1997) (discussing the great monetary costs of "futile care for the dying"). *But cf.* H.L. Lipton, *Medical Care in the Last Year of Life: A Review of Economic and Social Issues*, 1 COMPREHENSIVE GERONTOLOGY 89 (1987) (arguing that conclusions regarding overconsumption of medical care at the end of life may be at least premature). That it is likely cheaper to kill people than keep them alive—however one cabins the domain of terminally ill candidates for PAS—appears at once obvious and impertinent. But however obvious *that* calculus, it is not what Posner has in mind. On the other hand, this balance is not irrelevant to Posner's larger attempt at calculation. *See* POSNER, *supra*, at 244 (suggesting that the cost of keeping terminal patients alive is—to the extent borne by the public—a legitimate third-party cost in the larger analysis, although a cost made tentative by the question whether (and, presumably, to what extent) legalization of PAS might tend to promote or suppress the frequency of suicide).

¹¹ For a recent example of the debate in the courts, see *Oregon v. Ashcroft*. 368 F.3d 1118, 1121-23 (9th Cir. 2004).

topics already the loci of much debate may appear exceedingly casual.¹² But at bottom, I believe that Posner's discussion is often overlooked because of a mistake about the type of economic—or law-and-economic—explanation he has on offer. On its face, Posner's discussion seems to offer a broad—albeit not comprehensive—canvas of the various costs and benefits that the adoption of a particular legal regime permissive of PAS would, or should, entail. The ensuing social welfare calculus considers truly diverse phenomena in turn, without the benefit of a developed pragmatic means of limiting the cost-benefit problem space.

I believe that Posner has something more in mind. At the heart of his account is a model of PAS legalization as a sort of technological innovation. What this particular innovation brings is a radical reduction in certain critical information costs attending end-of-life decision making. In brief, the promise of assisted suicide is said to provide a wait-and-see window for desperate decision makers, a window in which critical uncertainties are likely to be resolved. To the extent that the information costs imposed by such uncertainties are the crux of the problem, the innovation represents a real breakthrough. More generally, Posner's is an account according to which a single, relatively simple economic aspect of some change in legal regime is held to be clear, univocal, and dominant. Posner's model of PAS thus looks—at least implicitly—to constitute a sort of end run around the messy business of assessing the very disparate costs and benefits many think to be implicated in the PAS debate. In brief, Posner thinks little of the oft-discussed social costs of PAS, so he does not need to count them against the benefits he anticipates; these are, that legalized PAS may: (a) reduce

¹² I shall argue some of these limitations below, although I am mostly concerned to discuss the model that seems to me to be at the heart of Posner's discussion.

the absolute number of suicides; (b) reduce (costly) uncertainty and anxiety regarding contemplated suicides; (c) improve the self-selection of suicides; and (d) reduce the costs entailed by those suicides that are carried out.

Posner's discussion is worth attention for several reasons. For one thing, Posner may be right, at least of some, that "the opponents of physician-assisted suicide underestimate the benefits and exaggerate the costs."¹³ Moreover, Posner's focus on information and uncertainty are well placed, as questions regarding decision making under uncertainty are central in end-of-life care generally. Posner's model—for all its limitations—does not obscure these issues; it helps to make them clear. More interesting still, I think, is the promise implicit in some of the conceptual tools Posner brings to bear on PAS, a promise only partly fulfilled in Posner's own discussion.

In this article, I want to take up three issues raised by Posner's discussion. First, I want to consider Posner's model of one particular legalization scheme seen as a sort of technological innovation. That model frames, in a useful way, some of the central problems posed by consideration of PAS as a case of decision making under conditions of radical uncertainty (for the individual at one level and for the state at another). I shall argue that Posner's model is incomplete. The problem is not that the information gains suggested by Posner's model are ephemeral. Rather, it is that for typical patients they are too small, and too incrementally realized, to make a critical difference. Legalization of PAS is not likely to remove the fundamental uncertainties attending end-of-life decision making and it is not likely to provide benefits adequate to offset the myriad costs considered in the familiar policy debate. Recasting the model, I shall argue that certain biases implicit in such decision making

¹³ See POSNER, *supra* note 10, at 243.

suggest an answer rather different from the one Posner advocates; that is, I have in mind an argument on behalf of what is, in almost all the states, the status quo.¹⁴

Second, I want to consider generally the question of applying some sort of bounded cost-benefit analysis to the deeply fragmented policy debate over PAS. I shall argue that a general solution to the problems posed by PAS is not forthcoming via cost-benefit analysis. Considering such analysis is useful, all the same, when applied to implementation-level problems within the PAS debate.¹⁵

Third, I want to discuss the normative framework within which the PAS debate does or ought to occur. That is, I want to consider the baseline assumptions against which we should evaluate arguments for redrawing the legal rules regarding PAS. To do so involves answering questions about both the substantive and epistemic standards requisite for certain sorts of legal norm reform. It will also raise a question about the default standards that should govern when the project of justifying a change in the *status quo* proves intractable.

Writ large, the point of this article is to consider, on the one hand, some of the light economic analysis may shed on the PAS debate and, on the other, certain aspects of the debate that may not prove amenable to economic solution. At a lower level I seek to do two things, apart from simple reconsideration of Posner's extant text. First, I mean to develop an

¹⁴ Prohibition of PAS takes different forms in the states. Famously, *Vacco v. Quill*, 521 U.S. 793 (1997), one of the two simultaneously decided Supreme Court cases repudiating claims to a Constitutional right to PAS, began with a challenge to New York State's explicit, criminal prohibition of PAS at N.Y. PENAL LAW § 125.15(3) (McKinney 1987). To date, only Oregon has enacted a statute permitting PAS; that is, Oregon's "Death with Dignity Act." OR. REV. STAT. §§ 127.800-.897 (1995).

¹⁵ Although the general notion of implementation may be ubiquitous in the law—consider, for example, the notion of a statute's implementing regulations—the theoretical topic of implementation has received little attention here. A general discussion of this topic would take us far from the subject of this paper. I refer, however, to the developed cognitive science literature on levels or hierarchies of explanation for complex systems for the sense of "implementation" I am after. See, e.g., DAVID MARR, *VISION* (1982); Daniel Gilman, *Optimization and Simplicity: Computational Vision and Biological Explanation*, 107 *SYNTHESE* 293 (1996).

argument against legalization of PAS that is not predicated on the general notion that suicide, assisted or otherwise, should be viewed as anathema. There are serious general arguments against suicide, just as there are serious general arguments for its decriminalization.¹⁶ It will not be part of this article to reject those arguments. I am, simply, arguing to a particular conclusion based on more broadly acceptable premises; and those are that we should be extremely chary of state-sponsored killing. At the very least we ought in several respects to set the bar high when considering putative justifications for enlarging the scope of permissible killing beyond the established cases of defense, self-defense, and certain limited law enforcement contexts. In particular, we ought very carefully to scrutinize arguments on behalf of PAS predicated on the supposed consent of those who are to be killed.

Second, my argument against legalization will both depend on and inform aspects of the debates over commensurability and risk analysis. Special concerns about interpersonal valuations of life will lead to special concerns about how to evaluate the inevitable error rate that would be associated with any of the offered screening filters for PAS. In turn, the sorts of problems presented by decisions at the end of life may suggest an especially bad case—perhaps generalizable—about the familiar proxies offered to ground interpersonal valuations of life in the larger risk management debate.

The course of my discussion is to be as follows: Section II of this article offers a

¹⁶ See, e.g., PETER SINGER, PRACTICAL ETHICS 128-29, 140-47 (1979) (arguing that assisted suicide and “voluntary active euthanasia” are morally permissible under certain circumstances); James Rachels, *Active and Passive Euthanasia*, 292 NEW ENGLAND J. MED. 78, 78-80 (1975) (criticizing the familiar distinction between active and passive euthanasia and arguing that active euthanasia may sometimes be morally preferable to passive euthanasia). But see, e.g., Thomas D. Sullivan, *Active and Passive Euthanasia: An Impertinent Distinction?*, 3 HUMAN LIFE REV. 40 (1977) (defending the “traditional position” on euthanasia and criticizing Rachels); Daniel Callahan, *When Self-Determination Runs Amok*, HASTINGS CENTER REP., Mar./Apr. 1992, at 52, 52-55 (contra euthanasia generally).

critical analysis of Posner's general overview of the PAS policy and ethics literature. Elements of that discussion surface later in the article, but it is not critical to understanding Posner's formal model of his legalization scheme, and readers chiefly interested in that scheme may wish to skip to section II. Section II considers Posner's model of a proposed change in legal regime with respect to PAS and his analysis of that model. The model is found problematic in various regards. Because the benefits to PAS modeled by Posner do not dominate the costs familiar from the literature, we are left with the question how to account for those costs in a systematic fashion. I consider one family of such costs, those entailed by informed consent requirements generally and by ineffective or mistaken consents in particular. Posner appears to suppose that the problem of devising institutional structures to guarantee effective consent is trivial. I do not think any such thing, and Section IV discusses certain biomedical impediments to consent (and to ascertaining consent) among the terminal elderly, raising a question about inevitable error rates for any contemplated screening procedure for PAS (including the abridged procedure offered by Posner). Section V then considers how to figure a cost for such errors in light of the risk management literature regarding the valuation of human lives. Despite the positive literature regarding risk management, the project is found to be very likely intractable. Section V also considers other special categories of third-party costs that might be entailed by the legalization of PAS. Finally, Section VI concludes by offering a positive account of why difficulties in completing a social welfare analysis of PAS ought to leave us with something other than just a puzzle. Considering the general (heuristic) utility of certain moral norms, together with the degree to which such norms tend to be embedded and the consequent costs of attempting their modification by legal fiat, it is argued that what is generally the legal *status quo* should be

regarded as a strong default position at the least.

II. The (Selected) Costs and Benefits of PAS

Posner's analysis comes in two parts. First, he proposes a balancing of costs and benefits meant to favor the legalization of PAS. Second, he offers a quasi-formal, quasi-empirical argument on behalf of the suggestion that legalization of PAS may actually serve to decrease the incidence of PAS. The first analysis is framed by a particular utilitarian commitment as well as a stipulated restriction on the domain of discourse. That is, Posner—following J.S. Mill—will count only “tangible harms” to third parties as third party costs.¹⁷ As well, Posner's argument is to apply only to “physician-assisted suicide in cases of severely disabling and debilitating, usually though not always terminal, illness.”¹⁸

Within this framework, Posner considers five factors: (1) the extent to which suicides may be impulsive;¹⁹ (2) the option value of a legal right to PAS;²⁰ (3) the competing (third-party?) wishes of family members;²¹ (4) emotional or psychological illness as distorting patient volition;²² and (5) the putative social harms entailed by blurring the mission of

¹⁷ See POSNER, *supra* note 10, at 238. This is both a defensible and problematic restriction. For now, we'll note that, however broad the support for utilitarian theory more generally, this is but one possible version of utilitarian accounting. Below, we'll consider how well or poorly Posner cabins “tangible” from intangible third party harms. See *infra* pp. 48-57.

¹⁸ See POSNER, *supra* note 10, at 237-38.

¹⁹ See *id.* at 238.

²⁰ See *id.* at 239-40.

²¹ See *id.* at 240.

²² See *id.* at 240.

physicians.²³

I'll begin with the second factor, as Posner's argument here makes a straightforward and worthwhile economic point.²⁴ Posner suggests that the right to PAS has a sort of option value for seriously ill patients, whether they choose to exercise the right or not.²⁵ I think that this is correct as far as it goes. That is, I think it likely that there is a non-trivial class of patients who would derive some positive utility if U.S. law (or the law of their particular jurisdictions) were to provide legal access to PAS. And I think it psychologically plausible that some patients would enjoy such a "right" independent of any choice to exercise it.

Reports from Oregon seem to indicate that there are at least some patients who appreciate the "option value" of the form of PAS available under law there.²⁶ Thus, I think Posner is right to suggest that legalization of PAS would provide some positive option value that: (a) ought to be considered in any complete tally of costs and benefits for PAS; and (b) ought to some non-zero extent offset any costs legalization would impose.²⁷ But that is as far as Posner takes it. There is no attempt to specify the scope of the class of patients for whom some substantial option value might obtain. And no case is made—*à la* cost-benefit analysis in the agencies—for some particular assignment of interpersonal value to that option for that class. Thus,

²³ See *id.* at 241-43.

²⁴ I leave aside the third argument altogether as it seems insubstantial at best.

²⁵ See POSNER, *supra* note 10, at 239.

²⁶ See Linda Ganzini, et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 NEW ENG. J. MED. 557 (2000) (surveying Oregon doctors regarding the practice of PAS, and regarding their own observations of patient reports); Susan Okie, *'I Should Die the Way I Want To': Ore. Doctors, Patients Defend Threatened Assisted Suicide Law*, WASH. POST, Jan. 1, 2002, at A1, A6 (reporting interviews with several Oregon physicians and patients).

²⁷ See POSNER, *supra* note 10, at 240.

although Posner has raised an issue worth consideration, he has not begun to answer the question of how much this limited option value might offset any costs at issue.

Next, I'll take factors one and four together, as they overlap in Posner's analysis as well as my own. According to Posner:

[t]he main nonreligious objection to *generally* making suicide easier than it is ... is that many suicides are impulsive, the product of a bout of depression, intense grief or shame, bad news that may be wrong ... or other transient causes that, *ex ante*, the affected individual might want to prevent from affecting him. Efforts to discourage such suicides, as by making them more costly by punishing people who assist in them, can be loosely analogized to the prohibition of extortion ... in which a class of transactions yielding a short-term gain ... is denied legal sanction because the vast majority of people would consider themselves better off if the occasion for such a transaction never arose.²⁸

Posner, here, appears to signal a complex of concerns about competence and consent, uncertainty, and the stability of preferences underlying choices to commit suicide. What's useful is the straightforward observation—oft ignored in analyses not grounded in economic concepts—that legal sanction, however stringent, imposes a cost on a given form of conduct, a cost that has predictable effects on consumption of that conduct and substitutes for that conduct.²⁹ Few sanctions are so stringent as to drive consumption to zero.³⁰

In addition, the focus on the putatively transient nature of expressed preferences for PAS brings together both: (a) concerns about the stability of expressed preferences under conditions of cognitive and affective impairment; and (b) concerns about the relationship

²⁸ *See id.* at 238.

²⁹ Of course, this observation has been made elsewhere, not least by Posner himself. RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 4-5 (3rd ed. 1986); GUIDO CALABRESI, *THE COSTS OF ACCIDENTS* (1970); Neal Kumar Katyal, *Deterrence's Difficulty*, 95 MICH. L. REV. 2385 (1997); Darryl K. Brown, *Cost-Benefit Analysis in Criminal Law*, 92 CAL. L. REV. 323, 344-45 (2004).

³⁰ Murder rates do not tend to be null in the face of even the harshest penalties. And trivially, few legal rights come with such lavish subsidies as to impose zero costs on consumers of the behaviors those rights guarantee.

between expressed preferences in the strained and unusual domain of PAS (and end-of-life decision making generally) and the causal reach of any sort of stable underlying preference function that is to provide a foundation for such expressed preferences.

What is striking about Posner's response to these concerns is that it consists of two wholly analytic arguments. There is no empirical ground, no attempt to assess and balance actual costs and benefits. The first pass is brief:

A prohibition against assisting suicide cannot be persuasively defended on this ground in cases in which the person who wants to end his life is incapable of doing so. The condition that makes it infeasible for the individual to take his own life furnishes a rational motivation for suicide.³¹

Indeed, that may be correct. At the same time, the mere possibility that some level of serious physical incapacity might, for some persons, under some circumstances, constitute some part of the basis of a rational choice to commit suicide tells us rather little. Posner elaborates on this argument by considering the plaintiffs in *Compassion in Dying v. Washington*, the trial court case that gave rise to *Washington v. Glucksberg*.³² There, as he says, the court's description of the plaintiffs—that is, those of the plaintiffs suffering from terminal illness—is indeed “harrowing.”³³ And perhaps Posner is right that “[i]t is easy to see that an individual who is soon to die anyway may have a negative expected utility of

³¹ See POSNER, *supra* note 10, at 238.

³² 521 U.S. 702 (1997). *Glucksberg* is, of course, the companion case to *Vacco v. Quill*. 521 U.S. 793 (1997). *Glucksberg* and *Quill*, famously, were decided unanimously by the Court on the same day in 1997. Together, the cases firmly and unanimously reject a constitutional right to access to PAS. In *Glucksberg*, action commenced when three, anonymous, terminal patients, five physicians, and the nonprofit organization Compassion in Dying, brought suit challenging the Constitutional permissibility of a Washington state statute banning PAS. We may, of course, acknowledge the plight of those anonymous patients without acceding to their legal brief.

³³ See POSNER, *supra* note 10, at 239.

living.”³⁴ But that such a negative assessment is possible does not make it—to any particular degree—likely, much less necessary. And even in the face of a negative expected utility, assessed in the face of extreme suffering, a patient might rationally prefer any number of substitutes to PAS. For one thing, the patient might simply prefer adequate pain medication, a generally feasible and entirely lawful alternative, which unfortunately many terminal patients are denied.³⁵

What then, is there, beyond the claim that it is not merely analytic that a request for PAS is pathological? Regarding emotional and cognitive disorders among the terminal elderly, Posner argues that:

Anyone who decides to kill himself must find his life depressing, and, with “suicidal ideation” and the like used to diagnose depression, it is apparent that one would have to assume that suicide is irrational in order to be justified in declaring suicide irrational *because* the person who committed suicide was depressed. The argument is circular.³⁶

Indeed, *that* argument is circular. And that argument does exist in the literature, and does reflect an ongoing tendency on the part of some mental health professionals to

³⁴ See *id.* at 239. A recent interview with Judge Posner may be instructive here. Reflecting on his father’s last years, Judge Posner is quoted as saying “[b]ecause my father was more or less compos mentis and wanted treatment, you couldn’t deny it. . . . [T]he notion of giving up, not fighting to the end, was anathema to him. I hope my generation can be a little more rational about this. I’d like to choose my own time of exit.” Larissa MacFarquhar, *The Bench Burner*, NEW YORKER, Dec. 10, 2001, at 78, 83.

³⁵ See generally Council on Scientific Affairs, Am. Med. Ass’n, *Good Care of the Dying Patient*, 275 JAMA 474, 475 (1996) (noting that in hospice care only two percent of dying patients suffer pain that is difficult for the treatment team to manage); Robert McCann et al., *Comfort Care for Terminally Ill Patients: The Appropriate Use of Nutrition and Hydration*, 272 JAMA 1263, 1263-65 (1994) (monitoring thirty-two consecutively admitted, terminally ill patients in a comfort care setting, none of whom reported “much discomfort”; especially striking indications of the potential of palliative care were that, of the patients reporting “some discomfort,” two suffered from metastases of cancer to bone and liver, one was an eighty-three year-old woman with lung cancer and chronic obstructive pulmonary disease, and one began his stay with significant bony pain from multiple myeloma). Cf. Charles S. Cleeland et al., *Pain and its Treatment in Outpatients with Metastatic Cancer*, 300 NEW ENG. J. MED. 592 (1994) (reporting that forty-two percent of its sample of 597 cancer patients were not given adequate analgesic therapy).

³⁶ See POSNER, *supra* note 10, at 240.

see the contemplation of suicide as itself psychological pathology.³⁷ But if that argument is something more than a straw horse, it is something rather less than the typical concern about depression and volition. In brief, it does not reflect the dominant contemporary view of depression and suicide and it is not the typical argument.

It is generally true that “suicidal ideation” is used to diagnose depression. It is not generally true that suicidal ideation is itself a mood disorder or that it is sufficient, as a symptom, to justify diagnosis of a mood disorder.³⁸ For example, the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) lists suicidal ideation as but one of nine criteria for a Major Depressive Episode.³⁹ And the DSM-IV requires that five or more of the nine symptoms be present during a given two-week period for a positive diagnosis.⁴⁰

That is not to say that suicidal ideation is not legitimate grounds for therapeutic concern. Of course it is. But the general psychiatric concern with suicidal patients is more complex than is captured in Posner’s argument and does not logically preclude a rational choice to seek PAS. Posner’s circle is not closed, much less vicious.

It is surprising that Posner’s treatment of emotional and cognitive disorders among

³⁷ See, e.g., Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 AM. J. PSYCHIATRY 595, 595 (2000) (reporting the results of a survey of 456 board-certified forensic psychiatrists). Posner cites Thomas J. Marzen, “*Out, Out Brief Candle*”: *Constitutionally Prescribed Suicide for the Terminally Ill*, 24 J. GERIATRIC PSYCHIATRY 261, 274 (1991).

³⁸ AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 317-444 (4th ed. 1994) [hereinafter DSM-IV] (reviewing various classes of mood disorders and anxiety disorders); see also Ganzini, et al., *supra* note 37, at 595-96.

³⁹ See DSM-IV, *supra* note 38, at 327.

⁴⁰ See *id.*

elderly terminal patients is so superficial. Much of Posner’s “theory” of old age can be read as a morbid meditation on the worst forms of decline that old age may have to offer.⁴¹ Indeed, Posner himself recognizes—then glosses—the issue in his chapter on Euthanasia and Geronticide.⁴² But despite his substantial preoccupation with the cognitive and emotional impairment that aging may bring, Posner does not seem interested in the question whether legalization of PAS will in fact offer a *bona fide* option for many patients who are not well placed to engage in the ordinary life practice of choosing, much less that of choosing between possible “arms length” transactions with doctors who are their caregivers and, not incidentally, state-appointed gatekeepers to regulated narcotic painkillers.⁴³

In fact, there is a complex relationship between pain, depression, and requests for PAS. For example, it has been observed that under-medication of pain symptoms can promote or aggravate depression in the terminal elderly, and can otherwise prompt requests for PAS, requests that often disappear in the face of adequate pain medication.⁴⁴ And several authors have expressed special concern about the relationship between depression and PAS in women patients.⁴⁵ For example, Lynn Kohm and Britney Brigner have observed that women are twice as likely as men to suffer from major depression, and that such depression, and its

⁴¹ “Aging is most usefully viewed as a process one element of which is an inexorable decline across a broad range of bodily (including both physical and mental) capabilities: call this ‘bodily decline.’” *See id.* at 18.

⁴² *See* POSNER, *supra* note 10, at 236.

⁴³ And, at least in the case of Medicare patients, gatekeeper to hospice care, as coverage depends on the attending physician’s certification that the patient is both terminal and likely to die within six months. *See, e.g.*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEP’T OF HEALTH AND HUMAN SERVICES, YOUR MEDICARE BENEFITS 28 (revised July 2004), at <http://www.medicare.gov/Publications/Pubs/pdf/10116.pdf>.

⁴⁴ *See* BERNARD GERT ET AL., *BIOETHICS: A RETURN TO FUNDAMENTALS* (1997).

⁴⁵ *See, e.g.*, Lynne Marie Kohm & Britney N. Brigner, *Women and Assisted Suicide: Exposing the Gender Vulnerability to Acquiescent Death*, 4 *CARDOZO WOMEN’S L.J.* 241(1998).

underlying causes, make women more likely both to request PAS and to acquiesce to external pressures to seek PAS.⁴⁶

Especially troubling is the observation that “[w]hile far fewer women than men kill themselves, three times as many women as men try to kill themselves.”⁴⁷ To the extent that this disparity reflects a large number of women trying not to end their lives but to seek help,⁴⁸ we ought to be concerned that legalized PAS might well lower an important threshold for emotionally troubled women who are not beyond psychological assistance and whose lives might otherwise be significantly extended in ways valuable to themselves and others. The case for PAS as an alternative to irremediable suffering might appear compelling,⁴⁹ but the brief for PAS as a low-cost substitute for adequate psychiatric treatment does not.⁵⁰

This is, of course, a telegraphic discussion of the thorny problems of depression among the terminal patients Posner addresses. I am not arguing that such cases of depression exhaust the domain. I am not arguing that all cases of depression or any other form of suffering can be adequately treated, much less that they all necessarily obviate the possibility of rational choice. I am not arguing that there are no rational exercises of genuine volition in requesting PAS. I am suggesting: (1) that our ordinary assumptions about the stability of

⁴⁶ See *id.* at 260-64.

⁴⁷ See *id.* at 266 (quoting Bard Lindeman, *Deal with Suicide Realities, But Discard the Myths*, RECORD (Northern New Jersey), Apr. 11 1996, at H6).

⁴⁸ See *id.* at 241-42.

⁴⁹ See, e.g., Brief for Respondents, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858).

⁵⁰ Of course, that is not a logically impossible argument. Part of a cost-benefit analysis of PAS must be an analysis of substitution effects that ought to attend various policy options. And things get thorny when one contemplates these costs through the lens of Medicare and Medicaid subsidies. Where PAS comes cheap and psychiatric treatment—at least for a certain class of patients—comes dear, PAS might look that much more attractive as a substitute locus of public subsidy. But that is surely an unhappy argument. As far as I know, it has not been advanced by any contemporary proponent of PAS.

preferences and the autonomy of choice are—as matters of empirical fact—complicated when we consider depression among elderly medical patients suffering some terminal disease; (2) that these complications raise serious concerns for any analysis of costs and benefits of the legalization of PAS;⁵¹ and (3) that Posner’s argument about depression cannot possibly settle the matter. In Section IV, below, I shall more thoroughly examine the problem of consent with regard to cognitive—rather than affective—disorders among terminal, elderly medical patients. That will serve both to push Posner’s analysis further into the red and to illustrate just one of the kinds of independent empirical analyses that need to underlie this sort of economic discussion.

Before turning to Posner’s model of legalization as a sort of technological innovation, I should briefly consider Posner’s discussion of medical norms and his argument that concerns about confounding the role of the physician via change in legal regime are misplaced.⁵² Here, he makes a conceptual point and an empirical one. In the first case, he argues that tolerating the spectacle of ghastly pain “can also create ambivalence about healing.”⁵³ Thus, presumably, PAS prohibitions may blur the mission, confound the psychology, and create competing pressures on the reputational assets of physicians as easily as would their repeal. Second, he suggests that the Dutch experience with euthanasia, from

⁵¹ For example, these complications about the sort of institutional arrangements that might mitigate fears of involuntary—or at least nonvoluntary—euthanasia. One large scale survey revealed that most forensic psychologists are not confident that they could—in the course of a single examination—determine whether depression or cognitive deficit were responsible for a patient request for PAS. *See Ganzini, et al., supra* note 37, at 595 (reporting that 51% were “not at all confident” they could make the diagnosis; 43% were only “somewhat confident”; and only 6% were “very confident”).

⁵² *See POSNER, supra* note 10, at 241.

⁵³ *See id.*

the 1970s through much of the 1990s, under conditions of relatively light legal prohibition and weak enforcement, signals that more widespread practice of PAS in the United States would not lead to any sort of general decline in respect for life, either within the medical profession or without. To that end, Posner takes issue with one of the chief, then-current, English-language sources alleging that PAS is not always performed with patient consent in the Netherlands.⁵⁴

A detailed sociological assessment of the Dutch experience with PAS will not be found in Posner's discussion and I do not mean to offer a substitute here; it is beyond both the scope of this article and my own expertise. But because the specter of Dutch euthanasia looms so large in the greater policy debate, I should raise a few points on the way to bracketing this discussion. First, Posner's critique of Carlos Gomez's account of Euthanasia in the Netherlands is at least contentious, and is based on no independent empirical ground.⁵⁵ Second—more important and perhaps no surprise here—the character and effects of Dutch practice of PAS remain a source of controversy, as have reports of numerous instances of non-voluntary euthanasia in the Netherlands;⁵⁶ certainly, and at least, the intervening years

⁵⁴ See *id.* at 241. (critiquing CARLOS F. GOMEZ, *REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS* (1991)).

⁵⁵ See, e.g., Cass R. Sunstein, *The Laws of Fear*, 115 HARV. L. REV. 1119, 1143-44 (2002) (reviewing PAUL SLOVIC, *THE PERCEPTION OF RISK* (2000)).

⁵⁶ See, e.g., Richard Fenigsen, *The Report of the Dutch Governmental Committee on Euthanasia*, 7 ISSUES L. & MED. 339 (1991); John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?*, in *EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES* 261 (John Keown ed. 1995); Loes Pijnenborg et al., *Life-terminating Acts Without Explicit Request of Patient*, 341 LANCET 1196, 1197 (1993); Herbert Hendin et al., *Physician-Assisted Suicide and Euthanasia in the Netherlands: Lessons from the Dutch*, 277 JAMA 1720 (1997); Raphael Cohen-Almagor, *An Outsider's View of Dutch Euthanasia Policy and Practice*, 17 ISSUES L. & MED. 35 (2001); Bregje D. Onwuteaka-Philipsen, et al., *Consultants in Cases of Intended Euthanasia or Assisted Suicide in the Netherlands*, 170 MED. J. AUSTRALIA 360, 360-63 (1999). *But see* Jocelyn Downie, *The Contested Lessons of Euthanasia in the Netherlands*, 8 HEALTH L.J. 119 (2000) (arguing not that Dutch practice is unproblematic, but that many reports on Dutch PAS are significantly flawed).

have not rendered the international medical community sanguine about PAS in the Netherlands. Third, as others have observed, observations drawn from a small, ethnically homogeneous nation—one with vastly different norms and market conditions surrounding medical practice—may be of limited value in generating predictions about U.S. medical practice.⁵⁷ Fourth, the period of Dutch practice Posner considers does not quite mirror his contemplated legal change in any case; the Netherlands has only very recently decriminalized PAS (under certain conditions), so whatever we make of Posner’s quarrel with Gomez, et al., we might well reserve judgment on what legalization holds even within the Netherlands.

Observations from Oregon might further support Posner’s claim against a slippery slope. Certainly wholesale adoption of PAS by the medical community has not obtained in Oregon.⁵⁸ Surveys of physician practice indicate that most patient requests for PAS are rejected.⁵⁹ Indeed, several large medical centers and about one-third of Oregon physicians reject the practice of PAS outright, on religious, moral, or philosophical grounds.⁶⁰

At least the most pessimistic predictions about PAS have not come to fruition. But we do not yet know much about Oregon itself, after a few short years of legal sanction for one form of PAS. Apart from the questions whether and to what extent Oregon may be a useful model for those considering the rest of the United States, we might well wonder about the

⁵⁷ See, e.g., Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?*, 35 DUQ. L. REV. 159, 172-73 (1996) (discussing doctors’ and nurses’ tendencies to inaccurately assess the decision making competence of the dying).

⁵⁸ See Okie, *supra* note 26, at A6 (suggesting that predicted dire consequences have not obtained in Oregon).

⁵⁹ See Ganzini et al., *supra* note 26, at 557 (reporting that physicians grant one in six requests for a prescription for lethal medication).

⁶⁰ See *id.* at 559 tbl.1 (thirty-seven percent of physicians reported they were unwilling to prescribe lethal medication and 12% were uncertain whether they were willing to do so); Okie, *supra* note 26, at A6 (reporting

relevant time scale at which to evaluate Oregon practice. Given widespread entrenchment of social norms generally, and physician norms in particular, a few years period of observation is likely far too brief.⁶¹ Deeply entrenched mores do not tend to shift so quickly in the face of policy innovations.⁶² What's less clear is how long we have to wait for change to verify the null hypothesis.

Again, we have an argument from Posner—this time quasi-empirical—that the putative costs for PAS may not be so great as some contend. Again, we lack both a value and a methodology for fixing that value for this component of our analysis. But perhaps we may forgive an uncertain and contentious intuition about familiar elements of the PAS policy debate, if Posner's model of regime change, and the likely effects of change on consumption, proves fruitful.

III. A Model of Consumption

The centerpiece of Posner's PAS discussion is his formal model of PAS legalization as a sort of information-bearing technology. Here, Posner leaves behind the complex, perhaps fractional, policy debate for the question whether legalization would, in fact, prompt

that one Catholic health care organization operating three large hospitals in Portland prohibits doctors from participating in PAS).

⁶¹ See *supra* note 14 (regarding the Oregon statute). Although initially approved by citizens' initiative in November, 1994, implementation of the statute was delayed by injunction until 1997. See *Lee v. Oregon*, 107 F.3d 1382, 1386 (9th Cir. 1997) (vacating the permanent injunction ordered by the lower court at 869 F. Supp. 1491 (D.Or. 1994)).

⁶² Eric Posner, for example, has suggested reason to be chary of, e.g., attempted government engineering of social norms, as "social norms are complex, poorly understood, and sensitive to factors that are difficult to control." ERIC A. POSNER, *LAW AND SOCIAL NORMS* 8 (2000).

more or fewer cases of suicide.⁶³ That is, he describes the semantics for a formal inequality that would model a decrease in the rational consumption of suicide under certain conditions.⁶⁴ The gist of Posner's argument is this: rational (utility maximizing) consumers of a good—suicide—might decrease consumption of that good, in the face of lowered price, under certain conditions; that is, briefly, where neither the demand for the good nor the cost of the good remains constant.⁶⁵

Posner sees the choice between his proposed legal regime and the status quo as, essentially, the choice between static and dynamic decision procedures under conditions of uncertainty. That is, under the present legal regime, one chooses between committing suicide now or not at all, whereas under the contemplated legal regime one chooses between committing suicide now, later, or not at all. Under the present regime, an individual will commit suicide if:

$$pU_d > (1 - p) U_h + c$$

where p is the relevant probability, c is the total cost (financial, pain, suffering, anxiety, etc.) of committing suicide, U_d is the utility to be derived from living in the “doomed state,” and U_h is the utility to be derived from living in the healthy state.⁶⁶ That is just a way of saying that one will commit suicide just in case the expected utility of present suicide (as potential

⁶³ Of course, from a strict cost-benefit perspective the two questions cannot be taken as independent. There is some ambiguity whether Posner is arguing that legalization of PAS will reduce the overall number of suicides or that it will reduce the number of suicides among those persons he considers the best candidates for legalized PAS. The points are, of course, consistent but different. See *supra* note 10 and accompanying text.

⁶⁴ See POSNER, *supra* note 10, at 245-48. The argument itself has the form of a *sorites*, as, in fact, every stage of formal analysis, but for the statement of the conclusions, is left to the reader.

⁶⁵ *Id.*

⁶⁶ *Id.* at 245-46.

pain or suffering avoided) exceeds the expected utility of continued life plus the costs entailed by the act of suicide.⁶⁷

Given a pessimistic prognosis, it is presumed that p is relatively small. To the extent U_d and U_h have like values, the decision to commit suicide will hinge on c . Because c —seen as a sort of transaction cost—is substantial under the present legal regime, many will avoid suicide altogether precisely because of that transaction cost, not because of any great utility to continued life (or delta in utilities between living and dying). Moreover, where a prognosis is bleak, many will choose to commit suicide—despite some non-trivial degree of doubt regarding the prognosis—because to delay the choice risks incapacity which, under the present legal regime, will remove the choice.⁶⁸

Remove the now-or-never dilemma by introducing a new information-bearing technology—PAS—and that latter class of suicides disappears. That is, when, upon grim but uncertain prognosis, the patient may easily postpone the decision whether to commit suicide because suicide assistance may be obtained later, a rational choice to commit suicide will obtain only when $-U_h > c$.⁶⁹ But as it is supposed that both U_h and c are positive, this class of preemptive suicides disappears; and the class disappears independent of the fact that we have reduced the value of c (the cost). That is, to the extent that life in the present has some

⁶⁷ *Id.* at 246.

⁶⁸ This is, of course, not quite true. First, although physical incapacity may greatly add to the cost of suicide under the present legal regime, it is simply not true that it renders the cost either actually or practically infinite. Posner himself recognizes that there is a non-zero supply of unlawful and *sub rosa* PAS available even outside the state of Oregon. Hence, at least the generality of a now or never dilemma may be limited, even under the present legal regime. Second, we might note that the dynamics are artificially restrictive under Posner's model in any case. There is no way to account for, e.g., the perceived rate of change in circumstances and the effect that such perceptions may play decision making.

⁶⁹ See POSNER, *supra* note 10, at 247.

positive value, one could not rationally trade that value against a state of affairs that is presumed to have no value, either positive or negative, in and of itself, but the achievement of which entails some positive cost.

Think of Posner's story this way: Under the first regime (a model of the general prohibition), a terminally ill patient (or anyone else) must, at time T_1 , decide whether to commit suicide. The price of the undertaking is held to be relatively high, partly because the patient lacks expertise (and—presumably—experience) in the successful commission of suicide, partly because there is some cost to violating the law, and partly because committing suicide at time T_1 involves a substantial opportunity cost in the face of incomplete medical information and positively valued life foregone.⁷⁰ If one's health is seriously declining at T_1 , waiting until a subsequent time T_2 —for better information, closer proximity to the threshold between positive and negative utility for existence, etc.—promises benefits, but benefits bought at the following price: by the time things are truly awful, and more certainly bleak, the would-be suicide may no longer be capable of ending her own life. Absent the availability of lawful PAS, the price of suicide skyrockets simultaneously with the patient's incapacity. Committing suicide at time T_1 is a sort of hedge against both that skyrocketing cost and anticipated horror. In the limit, the possibility of obtaining such a hedge may be seen as a now-or-never dilemma.

Under Posner's alternative regime—legal PAS—the patient at time T_1 will very likely wait until *some* subsequent time T_2 for at least two reasons: first, because there is, at least initially, supposed to be a positive value to continued life (and because costs remain high at T_1 under both regimes), there is some impetus to wait; second, because it is anticipated that

⁷⁰ *See id.*

the price of suicide will drop—not rise—sharply with the advent of the patient’s incapacity, as PAS under the contemplated regime is only permitted for those who cannot help themselves.

Several things differentiate T_2 , under the competing models. First, because PAS is lawfully available the technical impediments to suicide (the risk of pain, the risk of horrible, but not fatal, self-injury) drop even as information about the patient—and likely futures—becomes more readily available. Thus, costs drop. Second, because information becomes cheaper, doubts about the patient and her condition are, at the margin, likely reduced. And thus, the initial class of potential consumers is partitioned into several. Most crudely: for some demand increases, for some it remains constant, and for some it decreases. If demand drops enough—either because things are not as bad as originally feared or because one dies of natural causes (or medical error) in the meantime—one will not consume PAS despite the lower price.

This is a somewhat expanded consideration of Posner’s basic intuition; namely, that where the price of present, unassisted suicide is greater than the utility of “the dying state,” suicide consumption will be suppressed, and that the utility of the dying state might actually be increased via the law’s permission of PAS.⁷¹ Of course, Posner is aware that a drop in consumption is not logically inevitable with a shift from the first regime (no legal PAS) to the second (legal PAS).⁷² But Posner suggests that the model has general plausibility and that there are reasons for optimism:

⁷¹ *Id.* at 248.

⁷² *See id.* at 248-49 (contemplating the cost of suicide as an important factor in the suicide rate and the possibility that persons might systematically underestimate either the likelihood or severity of the doomed state).

The general point—that the availability of a service can reduce rather than, as one might expect, increase the utilization of a service—is neither inconsistent with assuming rational behavior by persons facing horrific choices nor limited to suicide. Suppose that you get a sharp pain in your abdomen on Friday afternoon. If your physician’s office is closed on weekends, you may rush to the office on Friday, lest your condition worsen during the weekend. But if the office is open on weekends you may decide to wait and see whether the pain gets better or worse. In most cases it will get better, so there will be fewer total visits, in the class of cases represented by the example, if the physician is more available.⁷³

Indeed one may do just that. But there are many yarns we can spin, and not all are consistent with the claim that increased office hours results in decreased visits to the office, a claim that—taken most generally—is paradoxical on its face. Here is a tale that bears the distinction of being true, however it might, as a model, prove or fail at universality. That is, I’ve heard this tale as an historical report rather than imagined it as a counterfactual. While serving as a physician on a reservation, under the aegis of the United States Public Health Service, my acquaintance “Dr. J” saw patients without charge at all hours of the day and night. Readers may be somewhat (or not at all) surprised to learn that patients consulted Dr. J on all manner of affliction—including boredom, loneliness, minor gastro-intestinal irritation, headache, nausea, and intoxication—at all hours. They did not necessarily wait until Monday—or even Saturday morning—just because they knew they could be seen over the weekend or after. This is not to cast aspersions on the residents of any particular unnamed reservation. Faced with an available (read: less expensive) good—free weekend visits, day or night—persons consumed more than they would otherwise have done. That is normal market behavior, *ceteris paribus*. Indeed, such behavior is “normal” in the deepest sense of the word: it is not merely typical but paradigmatic—even nomological—market behavior.

⁷³ *Id.* at 248.

Greater convenience appeared to raise consumption. Feel a sharp pain on Friday and you may or may not wait to see a doctor. Feel a sharp pain on Saturday and you may fail to wait until Monday, if the doctor will see you Saturday or Sunday. That is true even if your condition is one that would, known or unbeknownst to you, resolve itself by Monday. And that is true despite the fact that present—rather than postponed—medical intervention carries its own risks.

Here's the rub: Posner supposes that demand will generally decrease because, just as with tummy aches, "[i]n most cases it will get better."⁷⁴ But that's not necessarily so, even for ailments that typically get better. Moreover, although it is true that doctors make mistakes—in diagnoses and otherwise—it is not obvious that patients diagnosed with terminal, debilitating disease typically "get better." And the difference between the two legal regimes is not just that "the availability of physician-assisted suicide increases the option value of continued living."⁷⁵ For under the second regime (Posner's version of permissible PAS), the price of the good decreases substantially at T_2 —relative to T_1 under the second regime and relative to *any time* under the first regime. Trivially, lowering the price of a good may increase consumption even if demand remains constant; depending on what drops at what rate, it may increase consumption even if demand decreases.

Posner is right when he argues that lowering the price of a substitute for a good will tend to reduce the demand for that good. And he's technically right that, "nothing in economics teaches that this reduction must be fully offset by the increased demand for the

⁷⁴ *Id.*

⁷⁵ *Id.*

...[substitute] good.”⁷⁶ Very generally, we do not suppose that the simplest snapshot characterization of the relationship between price and demand must hold across markets and time. Still, I believe that Posner is wrong to suggest that there is no tension between his projection and the law of demand; roughly, the utility of the snapshot model exceeds its boundary conditions, strictly conceived. That is a good thing generally. And in this particular case, I suspect that the fact of reduced cost is not likely to be swamped by other changes in the relevant market.⁷⁷ To make the case otherwise, at the very least, Posner ought to have done more work to close the problem space, and to show why alternative models are not likely applicable to *this good*, for *these consumers*, under *these conditions*. Rules that hold *ceteris paribus* may not hold where all is not equal. But assuming that they function in inverse cannot be as trivial as Posner appears to suppose.

In fairness, we may note again that Posner does not take it to be certain that legalized PAS will suppress suicide consumption. Rather, he argues at length that legalization of PAS “might ... *reduce* the number of suicides and *postpone* the suicides that occur.”⁷⁸ Bracketing the qualification, we note that there is a sort of double gap in the analysis here. Posner rightly spends a great portion of his chapter trying to tease out the implications of legalization on demand for and consumption of PAS. Surely we cannot begin to tally costs and benefits

⁷⁶ *Id.* at 250.

⁷⁷ In part, it depends how you measure the units of consumption. Introduce a generic—and much cheaper—form of Prozac, and consumption of name-brand Prozac will likely drop. Should the generic Prozac be packaged in a form that lasts longer (a stronger dose, or a timed-release dose), the number of pills sold may drop, even in the face of a lower average cost per pill for that form of serotonin re-uptake inhibitor. We do not need anyone to bother with the proof. Likewise, we do not need anyone to bother with proving that the number of persons consuming that form of anti-depressant may increase, even with fewer pills, or that the number of person/days on serotonin re-uptake inhibitor may increase, etc., as it becomes cheaper to medicate oneself against depression.

⁷⁸ POSNER, *supra* note 10, at 244.

attending some change in the law before we have at least a general sense of the consequences of that change.

Critically, we need to know more systematically—ideally with some precision—which and how many persons will bear the first-party costs and enjoy (although “enjoy” is surely the wrong word) the first-party benefits of legalized PAS, if we are to begin to develop some sense of the utility of the proposed policy change. To that end, being unclear about both the ordinal and the magnitude of change in consumption attending legalization cannot be regarded as a minor imprecision of argument.

Before moving on to the question of third-party costs, I think it important to consider another aspect of Posner’s model; that is, the fundamental question of uncertainty as regards decision making under either extant or contemplated legal regimes. To that end, I want to consider both the empirical question of the extent to which such decision making is likely to be impaired and the conceptual question how to conceive of possible errors in decision making.

IV. Cognitive Impairment In Hospitalized Elderly Patients

Robert A. Burt has suggested that communication problems may arise due to various “confusional states” that may be prevalent in the elderly.⁷⁹ And this is a point well worth examination. For Burt’s brief discussion raises a concern that, if borne out, does more than cast the terminal elderly as a vulnerable population; it casts in doubt the promise of PAS for the largest, and socially the broadest, population of possible candidates. Communication problems raise questions of information costs and, possibly, information asymmetries for

⁷⁹ Burt, *supra* note 57, at 172-73.

those who would participate in a PAS transaction. Perhaps more difficult, they raise questions about our ordinary assumptions about consent and contractual competence, assumptions that may not be tenable—at least as default assumptions—in this odd and particular case.

The term “confusional states” has fallen into disuse. It was widely considered ambiguous and does not describe a category of mental impairment in the DSM-IV.⁸⁰ Nonetheless, Burt’s point remains important, for the pieces of research he discussed offered systematic accounts of *bona fide* cognitive impairments in the elderly; this is a case of revised taxonomy, not null reference. Recast, the general observations remain: (1) cognitive impairments are common among the elderly, terminal patients that constitute the largest body of candidates for PAS;⁸¹ (2) such impairments are often difficult to detect and in many cases are not detected by the physicians and nurses caring for impaired patients;⁸² and (3) because of such impairments, “obtaining a truly informed consent is problematic.”⁸³

Here, we are chiefly concerned with certain cognitive—as opposed to affective—disorders, with impairments to reasoning and memory classified as delirium, dementia, and

⁸⁰ See Z.J. Lipowski, *Transient Cognitive Disorders (Delirium, Acute Confusional States) in the Elderly*, 140 AM. J. PSYCHIATRY 1426, 1427 (1983) (proposing the abandonment of the term “acute confusional states” as partial solution to the “semantic muddle”); see also DSM-IV, *supra* note 38, at 123-63 (discussing delirium, dementia, and amnesic and other cognitive disorders).

⁸¹ See Burt, *supra* note 57, at 172 (citing Eduardo Bruera, *Issues of Symptom Control in Patients with Advanced Cancer*, AM. J. HOSPICE & PALLIATIVE CARE, Mar./Apr. 1993, at 12, 13, which observed impairments in 83% of its patients before death).

⁸² See Burt, *supra* note 57, at 172 n.58 (citing J. Francis et al., *A Prospective Study of Delirium in Hospitalized Elderly*, 263 JAMA 1097, 1098, 1100 (1990), which suggested that physicians frequently fail to recognize cognitive impairment because of its fluctuating features and subtle presentation).

⁸³ See Burt, *supra* note 56, at 172 (quoting Francis et al., *supra* note 82). See RUTH R. FADDEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* (1986), for a substantial general discussion of the topic of informed consent.

amnesic and other cognitive disorders.⁸⁴ This is in contrast with the mood disorders and anxiety disorders that were Kohm and Brigner’s focus, though in many cases such conditions may similarly confound the problem of *bona fide* volitional choice, may well appear as comorbid, and indeed may interact with cognitive impairments.⁸⁵

In brief, “[a] delirium is characterized by a disturbance of consciousness and a change in cognition that develop over a short period of time,”⁸⁶ not typically longer than one month.⁸⁷ “A dementia is characterized by multiple cognitive deficits that include impairment in memory.”⁸⁸ Dementia may, like delirium, be remitting, or it may have a static or progressive course, often being associated with other diseases and fatality.⁸⁹ Amnesic disorders are “characterized by memory impairment in the absence of other significant cognitive impairments.”⁹⁰ Like dementia, amnesic disorders present a highly variable course, depending on the underlying etiology of the impairment.⁹¹ Finally, “confusional states” may fit the catch-all category of “cognitive disorder not otherwise specified.”⁹² Note that any of these impairments has the potential to disturb effective decision making on the part of the patient, as they may impair (1) gathering information, in dialogue with a physician or

⁸⁴ See DSM-IV, *supra* note 38, at 124-126.

⁸⁵ See Susan M. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 DUQ. L. REV. 455 (1996) (also considering the special problems raised by the role of depression in requests for PAS, considering the disparate incidence of depression among elderly women).

⁸⁶ See DSM-IV, *supra* note 38, at 123.

⁸⁷ See *id.* at 126; Lipowski, *supra* note 80, at 1427.

⁸⁸ DSM-IV, *supra* note 38, at 123.

⁸⁹ See *id.* at 137-138.

⁹⁰ *Id.* at 123.

⁹¹ See *id.* at 156-57 (reporting significant variation holding etiology constant, as well).

otherwise; (2) retaining information critical to decision making; (3) having all the relevant information “present” (cognitively accessible) during decision making; (4) formulating a sound decision based on the limited information at hand; (5) formulating a decision that is stable rather than transitory; and (6) communicating a stable decision to caregivers.

Again, Burt’s observation that cognitive deficits—“confusional states”—are common among the dying is borne out by diverse research. Indeed, his cited figure seems low.⁹³ This is likely due, in part, to the difficulty of detecting various deficits and, in part, to the higher incidence of delirium among the elderly.⁹⁴ “[B]etween one-third and one-half of the hospitalized elderly are likely to be delirious at some point.”⁹⁵ And this does not nearly exhaust the range of relevant cognitive and affective deficits. The observation that cognitive impairment is often—in fact, typically—undetected likewise enjoys diverse support.⁹⁶ Here we are concerned not just with inadequacies in the process of obtaining informed consent, but with impairments to competence itself, one of the fundamental prerequisites to informed

⁹² See *id.* at 163.

⁹³ See Francis et al., *supra* note 82, at 1098, 1100 (suggesting that “delirium occurred in over one-fifth of subjects”).

⁹⁴ See Lipowski, *supra* note 80, at 1427 (citing studies reporting that incidence is up to four times higher over the age of 40, and highest still over the age of 70); F.J. Flint & Shelagh M. Richards, *Organic Basis of Confusional States in the Elderly*, BRIT. MED. J. 1537 (1956) (suggesting that “[m]ental confusion is a relatively common feature of illness in old people”).

⁹⁵ See Lipowski, *supra* note 80, at 1427 (citing H.M. Hodkinson, *Mental Impairments in the Elderly*, 7 J. ROYAL C. PHYSICIANS 305 (1973) (finding an incidence of 35% in a geriatric multi-center British study of patients over 65 years old), and P.D. Bedford, *General Medical Aspects of Confusional States in Elderly People*, 2 BRIT. MED. J. 185 (1959) (finding an incidence of 80% among 5,000 patients of at least 65 years admitted to the Oxford Geriatric Unit).

⁹⁶ See, e.g., Rogelio I. Thomas et al., *A Prospective Study of Delirium and Prolonged Hospital Stay*, 45 ARCHIVES GENERAL PSYCHIATRY 937 (1988) (reporting that in a study of 133 hospitalized patients, only one in 20 delirious patients was diagnosed as such by the attending staff); Eduardo Bruera et al., *Cognitive Failure in Cancer Patients in Clinical Trials*, 341 LANCET 247, 248 (1993) (reporting detection, by specific assessment tools, of moderate to severe cognitive failure that had not been noticed by both the principal investigator and the research nurse involved in the study).

consent. All of this may obtain in patients well able to read and sign a consent form.⁹⁷ More generally, we are concerned with whether our default assumptions about contractual competence in the most general sense can be maintained in a particular medical setting.

Clinical difficulties in identifying cognitive impairment are likely to be to some degree intransigent. For example, they are not eliminated in palliative care settings, where “doctors and nurses spend more time talking to patients than the average physician and nurse.”⁹⁸ And such clinical failures can arise under standards of practice that are unlikely to appear defective in standard quality-of-care metrics.⁹⁹ This is the biomedical foundation or baseline from which we might begin to ask whether effective consent procedures might plausibly be constructed. And it is atop this foundation that we might consider further confounding factors such as susceptibility to coercion and the general tendency towards some degree of failure in the implementation of facially plausible legal safeguards.¹⁰⁰

That is not to say that problems of competence and consent need be fundamentally intractable. But it is to raise a very serious question about our standard assumptions concerning the utility of additional “choices.” Absent such assumptions, we face a difficult task in specifying the sort of institutional structures that might set the cost-benefit balancing

⁹⁷ See Burt, *supra* note 57, at 173 (citing Bruera, *supra* note 81).

⁹⁸ See Burt, *supra* note 57, at 173 (quoting Bruera, *supra* note 81, at 12).

⁹⁹ See text accompanying note 51 and n., *supra*. To the extent that such measures tend to be based either on outcomes or on ex post surveys of patient satisfaction, it is difficult to envision how they might reveal cases of failed consent. Auditing of consent forms might reveal certain forms of egregious procedure, but would not provide independent evidence of suitability for consent procedures that are typically legitimate.

¹⁰⁰ See *Vacco v. Quill*, 521 U.S. 793, 795 (recognizing “the real risk of subtle coercion and undue influence in end-of-life situations”); Callahan, *supra* note 16, at 52-55 (regarding both a general tendency to imperfect implementation of and adherence to legal standards and observing casual Dutch attitudes toward euthanasia and the law in particular).

right again. Posner suggests that fears of involuntary euthanasia “can be minimized by relatively simple regulations, such as a requirement that the patient’s consent ... be witnessed or in writing, that the physician report ... to a hospital committee, and that ... he consult with a duly certified specialist in the ethics of dealing with dying patients.”¹⁰¹ This suggestion appears optimistic, to say the least.

Questions about what sort of certification is due are almost beside the point. Posner’s institutional suggestion cannot be adequate to the task. It might or might not be costly to implement—reflect on the burdens already faced by Institutional Review Boards for human subjects research—but it is unlikely to identify most of the problem cases whatever its cost.¹⁰² Again, those professionals best equipped to do the screening doubt their own ability to perform reliably in a single exam and there is no obvious form of outside consultation or documentation adequate to cure this fundamental defect.¹⁰³

One might, of course, design better institutional filters for problematic requests than those suggested by Posner’s “relatively simple regulations.” But the obvious questions remain: What would a reliable screening procedure entail? What would it cost? What sort of error rate would a “reliable” screen tolerate?¹⁰⁴ And what is the cost of a mistake? In

¹⁰¹ See POSNER, *supra* note 10, at 243.

¹⁰² See, e.g., Donald F. Phillips, *Institutional Review Boards Under Stress: Will They Explode or Change?*, 276 JAMA 1623 (1996); Hazel Glenn Beh, *The Role of Institutional Review Boards in Protecting Human Subjects: Are We Really Ready to Fix a Broken System?*, 26 LAW & PSYCHOL. REV. 1 (2002).

¹⁰³ See *supra* note 84.

¹⁰⁴ We might note that, better procedures or no, there exist no candidate screening procedures that can plausibly be advanced as either effective or semi-effective decision procedures for genuine consent. That is, at the very least, a blow to improving screening procedures sufficiently to satisfy a zero-tolerance (or near-zero-tolerance) standard for state-sponsored killing (or murders) absent proper consent. Note too, that there are at least several routes to a zero- (or near-zero) tolerance standard. Trivially, anyone who finds either suicide or assisted suicide generally to be *in principle* intolerable should hold to such a standard (this is to mention a widely held assessment, rather than to incorporate its foundations into my own argument). In addition, many might object

addition, we might well wonder whether implementation of a more rigorous screening procedure would shrink the market (and possible summed benefits) for PAS even as it implicated substantial process costs; to the extent that a screen entails additional testing, expert third-party evaluations, and delays (both for testing generally and to test the diachronic stability of expressed preferences in particular), the screen itself might well impugn the promise of PAS to allow terminal patients to choose the timing and manner of their deaths.¹⁰⁵

V. Tallying Death: The Interpersonal Value of Dying vs. the Interpersonal Cost

of Killing.

V(a). Cost-benefit Analysis and the Interpersonal Valuation of Lives.

I suggested early on that Posner seemed to have in mind the most general sort of balancing of costs and benefits for the PAS debate; that is, that his argument is not wedded to any particular technical scheme of the sorts implemented in cost-benefit analysis in the agencies.¹⁰⁶ To some extent, that is to Posner's advantage. For while the techniques of cost-benefit analysis become increasingly well entrenched, they are hardly uncontroversial in

fundamentally to state-sanctioned or state-sponsored suicide, even without adopting a more general objection to the act of suicide itself. Moreover, one might plausibly gauge the costs of implementing the sort of change in legal regime required for lawful PAS to be so great, even on behalf of ideal cases that, a very small number of inevitable errors would inevitably sink social welfare arguments on behalf of such a change. See, for example, the Court's opinions in *Washington v. Glucksberg*, 521 U.S. 702 (1997), and *Vacco v. Quill*, 521 U.S. 793 (1997), for a partial catalogue of relevant costs. See also, e.g., Brief for the American Medical Association, et al., as Amici Curiae in Support of Petitioners, *Washington v. Glucksberg* (No. 96-110).

¹⁰⁵ The Oregon statute itself imposes a waiting period of at least 15 days between a patient's initial request for PAS and the writing of a prescription for fatal medication. See OR. REV. STAT. ANN. § 127.850 (Supp. 1996). Similarly, Gert et al., argue that reasonable procedural safeguards for PAS would impose a delay of at least two weeks. See GERT ET AL., *supra* note 44, at 303.

¹⁰⁶ See *supra* note 10 and accompanying text.

either their particulars or their most general methodological commitments.¹⁰⁷ At the same time, Posner's informal approach may be seen as a limitation. Absent a problematic method for comparing our present legal state of affairs with the scheme he contemplates, Posner may be left with no systematic method at all. *Pace* Posner's very strong view of the information benefits implicit in PAS, common law and economics techniques, such as focusing on a salient, dominant, and univocal economic effect of some considered policy or other, simply do not appear to be available in this case.¹⁰⁸ I have already suggested that it is conspicuous that Posner's calculation is seriously incomplete. What is more, he has skirted entirely a raft of technical difficulties posed by questions he himself has recognized. What would a more complete analysis look like, supposing that such a thing is at all tractable?

The PAS question is in many ways the sort of question to which cost-benefit analysis is often applied.¹⁰⁹ Contemplating the costs and benefits of legalized PAS entails considering numerous non-market and quasi-market phenomena. This is true both within the health care arena and without. It also entails contemplating a policy change that is liable to be enmeshed in a significant regulatory environment itself. Moreover, one of the most striking issues in the

¹⁰⁷ See, e.g., COST-BENEFIT ANALYSIS: LEGAL, ECONOMIC, AND PHILOSOPHICAL PERSPECTIVES (Matthew D. Adler & Eric A. Posner eds., 2001) (offering a useful collection of essays discussing cost-benefit analysis). In an earlier article, Adler and Posner put it thus: "The reputation of cost-benefit analysis . . . among American academics has never been as poor as it is today, while its popularity among agencies in the United States government has never been greater." Matthew D. Adler & Eric A. Posner, *Rethinking Cost-Benefit Analysis*, 109 YALE L.J. 165, 167 (1999).

¹⁰⁸ See, e.g., *Chicago Bd. of Realtors v. City of Chicago*, 819 F.2d 732, 741-745 (1987) (Posner, J. separate opinion). In *Chicago Board of Realtors*, Judge Posner (joined by Judge Easterbrook) offers several straightforward economic arguments (together with perhaps one or more controversial ones) regarding certain Chicago housing regulations that would tend to prompt overlapping effects of increased rental prices and reduced supply of rental housing. The most straightforward and least controversial of these concerns the theoretical and empirical effects of rent control (not itself actually at issue in the decision), as it tends to suppress the supply of low-rent housing.

¹⁰⁹ See Paul Davidson, *The Valuation of Public Goods*, in *ECONOMICS OF THE ENVIRONMENT* 345 (Robert Dorfman & Nancy S. Dorfman eds., 1972), for a general discussion of cost-benefit methodology.

PAS debate is the question of how we attach value—either positive or negative—to certain sorts of lives. That is a question at the heart of much methodological debate about cost-benefit analysis more generally.¹¹⁰ For there we find ample disagreement about both the propriety and the particulars of fixing, as a policy matter, an interpersonal monetary value for human lives. I want to suggest that these issues should be especially salient in the present debate in at least two ways. First, standard valuations of statistical lives—especially monotonic valuations abstracted from age and health—appear to present an exceedingly poor fit for concerns about loss of life in end-of-life decision making generally. Second, as I have argued, any policy proposal for the legalization of PAS must, as a practical matter, contemplate a non-trivial error rate, delivering a “service” for which nobody properly contracts.¹¹¹ If that is right, then the cost of such errors themselves calls for valuation.

The literature on monetary valuations of human lives of the sorts contemplated by cost-benefit analysis is substantial. It is beyond the scope of this article to provide a thorough review of that literature, much less to settle the myriad issues raised there. Still, I think that

¹¹⁰ See, e.g., W. KIP VISCUSI, *FATAL TRADEOFFS: PUBLIC AND PRIVATE RESPONSIBILITIES FOR RISK* (1992), and W. Kip Viscusi, *Risk Equity*, 29 J. LEGAL STUD. 843 (2000) (discussing both the general notion of equalizing costs per life saved across policy initiatives and the particular values properly attributable to such savings). *But see, e.g.* John Broome, *Trying to Value a Life*, 9 J. PUB. ECON. 91 (1978); Frank Ackerman & Lisa Heinzerling, *The 6.1 Million Question*, Global Development and Environment Institute, G-DAE Working Paper No. 01-06 (2002), at http://ase.tufts.edu/gdae/publications/working_papers/0106%20revised6_1Million%20Question.pdf (discussing problems with homogenous valuation of lives of just this sort and, in the latter case, also questioning the particular values attached in the literature).

¹¹¹ Of course, on some views any intentional killing of the sort entailed by PAS is an error, perhaps a profound error. Without wishing to slight those views, what I have in mind here by “error” is the intentional killing of a medical patient who did not, in fact, make a competent and informed choice to be killed. Recall that under Posner’s policy recommendation, all cases of PAS are cases where the physician is directly involved in killing the patient, as Posner recommends legalization just in case the patient (appears to) wish it but suffers “severely disabling and debilitating . . . illness,” such that he or she “likely” is physically incapable of suicide him- or herself. POSNER, *supra* note 10, at 237-38.

the problem of PAS is relevant to this area of the cost-benefit literature for several reasons.¹¹²

Most generally, the details of the PAS debate make especially salient a significant problem with the interpersonal valuation of lives lost or saved for policy purposes: That is, (a) the entire debate over PAS would never get off the ground were it not for the fact that many people care very deeply about how they die and not just when they die; and (b) the variation in preferences and magnitudes of preference appears great, and appears to cross-cut familiar and accessible differences in income, wealth, and education.¹¹³ Consideration of PAS may then provide a useful domain in which to consider certain risk management questions in the alternative to the well-developed cases from the world of environmental regulation.

Moreover, to the extent that problems from the risk management literature are problems in assessing the costs of an intractable and non-trivial rate of error under any PAS scheme too, then we have a further hurdle for Posner's analysis and policy recommendation.

Cost-benefit analysis is often concerned to balance the policy costs and benefits attending some means of risk reduction.¹¹⁴ Commonly, the point of the risk reduction—say, through environmental regulation regarding a superfund site cleanup—is a statistical prediction of reduced deaths, according to some likelihood and degree of confidence.¹¹⁵

¹¹² Note that much of that literature concerns valuations of life from the particular perspective of environmental law, rather than health law. *See, e.g.*, Ackerman & Heinzerling, *supra* note 110; Lester B. Lave & Eugene P. Seskin, *Air Pollution and Human Health*, 169 *SCIENCE* 723 (1970) (both criticizing and utilizing, as a default, a forgone earnings valuation).

¹¹³ *See, e.g.*, Adler & Posner, *supra* note 107, at 174 (mentioning the distinction between cost-benefit analyses that attach a single value across all human lives and the common “textbook” technique of valuation that varies according to income or wealth).

¹¹⁴ *See, e.g.*, *supra* note 108.

¹¹⁵ *See generally* Richard L. Revesz, *Environmental Regulation, Cost-Benefit Analysis, and the Discounting of Human Lives*, 99 *COLUM. L. REV.* 941 (1999) (regarding the valuation of human lives in environmental regulation).

Because the assessment is fundamentally stochastic and predictive, we may know with greater or lesser precision the population from which the putative n lives are saved, but not the particular individuals who are actually to live or die under the policy initiative. Thus, we need an interpersonal value for each life (supposedly) saved if we are to balance benefits against costs.¹¹⁶

Perhaps the most commonly used method for fixing a value in the agencies is W. Kip Viscusi's "value-of-life" methodology, a valuation technique that derives its estimates from labor market data said to reflect willingness to pay to avoid risks.¹¹⁷ Based on his methodology, Viscusi has estimated the value of life at roughly \$ 5 million, in 1990 dollars.¹¹⁸

The motivation for a homogenous valuation ought to be conspicuous, especially from a policy perspective. As Viscusi puts it,

[o]ne quite reasonable notion of risk equity is that if society is homogenous in its attitudes towards risk, then agencies should equalize the marginal cost per life saved across regulatory programs. Doing so will maximize the number of lives saved for any given cost amount.¹¹⁹

This may serve not merely to maximize policy returns (and, not incidentally, to avoid some of the spectacular imbalances we have seen in public risk management

¹¹⁶ That is, we require such a value for any larger efficiency analysis of a contemplated or extant policy. At the simplest level, where no benefit other than saved-lives is contemplated, we can of course attribute ordinal efficiency values to competing policies without assigning any particular dollar value to each life saved.

¹¹⁷ See W. KIP VISCUSI, ANALYSIS OF OMB AND OSHA EVALUATIONS OF THE HAZARD COMMUNICATION PROPOSAL (report prepared for Secretary of Labor Raymond Donovan, March 15, 1982).

¹¹⁸ See *id.*

¹¹⁹ Viscusi, *supra* note 110 at 855. I would be remiss if I were to fail to point out that Viscusi himself does not regard this version of risk equity as the last word in refinement of risk equity measures. *Id.* at 857 (discussing "legitimate sources of heterogeneity").

efforts).¹²⁰ It may, as well, impose a certain version of equity on public policy regarding risk management.¹²¹

Nonetheless, there are good grounds to look for heterogeneity. The main approaches from cost-benefit analysis are either income (or wealth) invariant—fixing a unitary value for the society as a whole—or not.¹²² But in no case do we find a metric that even begins to grapple with the sorts of variation we see in common preferences regarding medical decisions at the end of life.¹²³ In that regard, we should consider that at least several authors have questioned whether risk valuations need to account for variations in types of deaths as opposed to deaths *simpliciter*. For example, instantaneous deaths may be valued differently from those that are prolonged,¹²⁴ deaths by voluntarily assumed risks may be valued differently from those by involuntary risks,¹²⁵ and, certainly, deaths that are qualitatively awful may be especially dreaded.¹²⁶ Cancer deaths, for example, may generally be considered

¹²⁰ Viscusi, for example, cites a figure of \$131.8 million per case of cancer averted for a particular 1989 EPA asbestos regulation, an overpayment by more than an order of magnitude relative to some of the EPA's other valuations. *See id.* at 855.

¹²¹ *See generally id.*

¹²² Cost benefit analysis as implemented by the Environmental Protection Agency has tended to employ valuations of life that are invariant across wealth or income, although other approaches commonly assign values that range proportionately with (at least categories of) income or wealth. *See, e.g.,* Adler & Posner, *supra* note 107, at 174.

¹²³ There has been some discussion of the general question how to parse “pure mortality risks” from those associated with morbidity preceding mortality. *See, e.g.,* George Tolley et al., *State-of-the-Art Health Values, in VALUING HEALTH FOR POLICY* 339 (George Tolley et al. eds., 1994). To some extent, common morbidity may be associated with disease-specific risk premiums. *See id.* at 340. At the same time, that one might, conceptually, parse conditions preceding death—or the environmental conditions of dying—is not necessarily helpful to the uniform valuation problem if one cannot in fact, physically, parse environment, cause, and effect.

¹²⁴ *See, e.g.,* Revesz, *supra* note 115, at 949, 955-56.

¹²⁵ *See id.* at 968; *see also, e.g.,* Cass R. Sunstein, *The Arithmetic of Arsenic*, 90 *Geo. L.J.* 2255, 2285 (2002); Lisa Heinzerling, *Markets for Arsenic*, 90 *GEO. L.J.* 2311, 2327 (2002).

¹²⁶ *See, e.g.,* Revesz, *supra* note 115, at 961.

worse than others, and some work has been done on risk premiums paid regarding cancer risks in particular.¹²⁷

If we return to the illustration of the patient plaintiffs in *Glucksberg*, *Quill*, and, for that matter, *Cruzan*, it takes little imagination to fix the variation in utility across something like means-of-dying as, first, spectacular and, second, exceeding the bounds of the normal distribution of revealed preferences in more typical markets.¹²⁸ For example, the pseudonymous plaintiff class in *Glucksberg* included (1) a sixty-nine-year-old retired pediatrician who suffered from cancer, which, by 1994, had metastasized. She was bedridden for more than a year before her case reached trial, and was constantly in pain during that time. In addition, she suffered from swollen legs, bed sores, poor appetite, nausea and vomiting, impaired vision, incontinence of bowel, and general weakness; (2) a forty-four-year-old artist dying of AIDS who had experienced bouts of pneumonia; chronic, severe skin and sinus infections; grand mal seizures; extreme fatigue; and suffered from cytomegalovirus retinitis, a degenerative disease, which robbed him of most of his sight; and (3) a sixty-nine-year-old retired sales representative who suffered from emphysema, which caused him a constant sensation of suffocating, and which required constant connection to oxygen, and who also suffered from heart failure.¹²⁹ Nancy Cruzan, by contrast, was, following an automobile

¹²⁷ See John R. Lott, Jr. & Richard L. Manning, *Have Changing Liability Rules Compensated Workers Twice for Occupational Hazards? Earnings Premiums and Cancer Risks*, 29 J. LEGAL STUD. 99, 118 (2000) (reporting, e.g., an estimated annual premium of \$2,983 for workers in industries with cancer exposure one standard deviation greater than the mean); see also Tolley et al., *supra* note 123 at 340-41. *But cf.* Sunstein, *supra* note 55, at 1141 (suggesting that willingness to pay to avoid cancer risk varies substantially with the description of the cancer).

¹²⁸ **Cite to the cases—maybe brief review of salient points. [drop fn?]**

¹²⁹ See *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1456-57 (1994).

accident, confined to a Missouri state hospital in a persistent vegetative state when the Court heard her (guardians’) appeal.¹³⁰ These cases are all pitiable. They are not, however, homogeneous.¹³¹ Neither are they typical.¹³² Contrast such cases—where either the patient or some putative advocate therefore has attached some negative value to continued life—with the myriad everyday cases in which patients seek some means to extend life (or, for example, in hospice cases, where they seek at least to live their remaining days under certain conditions). Together, such cases call into question whether any particular value might reasonably be applied here—across cases, patients, time, etc.—and, so, whether there is any particular “good” to be so valued.

Of course, any policy initiative can serve to impose a fixed valuation—whether market-based or not—on the unwilling. To that extent, there is nothing special about the problem of policy valuations of human lives or means to death and conditions of dying. What is more plausibly special is the degree to which preferences vary and, at least for many persons, the degree to which that variation involves or constitutes something deeply personal and crucially important.¹³³ There are two basic questions here, and the second may be regarded as a special case of the first. The first has to do with what sort of imagined end-of-

¹³⁰ *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261 (1990).

¹³¹ Plainly, they are similar in that each of the *Glucksberg* plaintiffs sought PAS. The point is that, symptomatically, the population of parties interested in PAS is diverse; indeed, it appears that several of the women assisted by the infamous Dr. Jack Kevorkian were not, in fact, suffering from a fatal illness when they were killed. *See, e.g.,* Kohm & Brigner, *supra* note 45 (offering a case-by-case analysis of 58 women “assisted” in committing suicide by Dr. Kevorkian). Equally plain is what, so far as I know, nobody in the pro-PAS camp denies; that is, that people under extremely similar symptoms express very different preferences with regards to end-of-life decisions generally, and PAS in particular.

¹³² *See generally* SHERWIN B. NULAND, *HOW WE DIE: REFLECTIONS ON LIFE’S FINAL CHAPTER* (1994).

¹³³ Even Chief Justice Rehnquist’s sharp anti-PAS opinion in *Glucksberg* recognized the concern with the preservation of “dignity and independence at the end of life” prompted by the myriad issues raised by contemporary medicine and medical technology. 521 U.S. at 785.

life market the usual value-of-life proxies are to substitute for: given the diversity of contexts in which end-of-life decisions are faced—and the diversity and instability of reported preferences across those contexts—is there some particular demand here to be charted? The second has to do with whether we conceive differently of state-sanctioned deaths according to whether they are accidental or not: how clear do we have to be on the “S” in PAS and how do we calculate the social cost when the attribution of consent is in error?

With regard to the first question, I want to suggest that the debate over PAS provides ample ground for the following conjecture: (1) any attempt to construct a monotonic interpersonal valuation for human life, ranging across the contexts seen in end-of-life decision making, is liable to be intractable; and (2) any attempt to construct a proxy market for the risks posed by end-of-life decision making under a PAS regime is liable to be equally intractable—the supposed relationship between the proxy and ideal markets being fatally unstable, if not simply question-begging. I would suggest, further, that the confounding factors in such a constructive project are liable to cross-cut the usual filters involved in multi-valued valuations of human life (income, wealth, education, etc.) and are liable to arise from factors central to the individual preference functions that an interpersonal valuation is supposed—somehow—to aggregate.

To put it another way, fixing an interpersonal valuation of life for regulatory purposes typically supposes that there is an adequate proxy market—say in certain aspects of the labor market—to stand for imagined, but nonexistent, markets in degrees of safety-by-regulation. If the proxy is to function as an analogue, or contingent valuation, for the salient but hypothetical market at issue, the proxy market must function as an adequate *model* of the

hypothetical market; if not, the proxy is only a proxy by fiat.¹³⁴ Thus, an adequate proxy market supposes that both the proxy and that for which the proxy plays stand-in have—or would have if realized—certain features in common.¹³⁵ At least with regard to basic market features, the two should be, in the ideal case, isomorphic. Some of these features may be thought of as substantive—for example, that the real and imagined markets appear to be driven by the same underlying preferences. Some of these features may be thought of as structural—for example, that real and imagined demand should have the same degree of diachronic stability or volatility and that, generally, the real and imagined demand should be formally similar—the demand curves should have the same form and similar variance, and that demand should partition the population (market) in the same way, etc. I believe that both the substantive and structural assumptions are dubious in this case.

Of course, significant interpersonal variation, on its own, might cut either way in the PAS debate; hence the very divergent majority opinions in *Cruzan*, on the one hand, and *Glucksberg*, on the other. Indeed, the argument of the plaintiffs in *Glucksberg* was precisely that the fundamental interests protected by the Court in *Cruzan* ought to be extended to those seeking legally sanctioned PAS precisely because of the intensely personal and highly varied preferences at stake.¹³⁶ If the Court was unanimous in rejecting that proposed extension, it

¹³⁴ See, e.g., Sunstein, *supra* note 125 at 2275 (noting that EPA had “somewhat astonishingly” assumed that chronic bronchitis might serve as an adequate analogue to non-fatal cancers for risk management purposes).

¹³⁵ The *empirical* connection between the proxy market and the ideal one it represents may be relatively strong or weak, ranging from the substitution of “shadow prices” through analogous markets or hypothetical valuation. Heinzerling, *supra* note 125, at 2314-5. Of course one must turn to a proxy market only when the ideal one does not exist in the marketplace and hence has no measurable attributes. But the best proxies suggest formal conditions that would be satisfied were imagined markets to come into being (say, by the lifting of a legal ban) and it is well to keep that in mind when considering various substitutes.

¹³⁶ See, e.g., Brief for Respondents, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110).

was nonetheless sensitive to the problems motivating the complaint.¹³⁷

The complexity of medical decisions at the end of life may highlight a methodological problem for cost-benefit analyses of a certain sort, but the complexity may speak in favor of protecting individual autonomy, rather than restricting it. And that would appear to favor Judge Posner's overall policy recommendation, if not a particular means of justification for it. That Posner took such pains to show that PAS could effectively reduce the incidence of suicide overall and focus remaining suicides on information-rich patients, makes even more sense if it supposes, rather than ignores, problems in valuing lives.

There is, however, another problem. Recall Section IV's discussion of cognitive impairments among the elderly and the attendant concern about diagnostic error. If those concerns are well founded, then any legalized form of PAS—and certainly the one contemplated by Posner—will do at least two things: (1) it will permit well-informed, freely choosing, terminal patients to elect physician assistance in hastening death; and (2) it will cause certain patients to be killed without those patients' having made such a choice. The question is not just one of how we value various sorts of lives, whether individual-by-individual or group-by-group. That question is difficult on its own, but it is not the whole of it. The question is rather how we begin to value the practice of a certain sort of killing. I suggest that that question involves difficult, if not intractable, issues of both first-person and third-person valuations of the costs of violating or suspending some of our most deeply entrenched moral norms.

It might, of course, be argued that we ought simply to look at wrongful death

¹³⁷ See, e.g., 521 U.S. at 735 (reflecting on the “earnest and profound debate” regarding PAS); see also *id.* at 797-98 (Justice O'Connor, concurring) (focusing the putative right on cases of “great suffering”) and 827 (Justice Souter, concurring) (“[T]he importance of the individual interest here . . . cannot be gainsaid.”).

settlements to fix a value for PAS errors (intentional killings under what would be legally sanctioned circumstances, but for the absence of the requisite proper consent). But that is variously unsatisfactory. For one thing, the cases are difficult to compare where the contemplated wrongful deaths may be exceedingly difficult to identify *post hoc*. For another, to look at wrongful death settlements (and verdicts) is to wander from the policy goal of a simple and consistent valuation across income, wealth, age, etc. Moreover—and critical here—is that a wrongful death proxy would not contemplate the social cost of policies that sanction wrongful *and intentional* killings above and beyond the costs to the particular victims killed.

I simply do not know how to complete the policy analysis Posner contemplates. Before closing, I do, however, want to do two things. First, I want to address the question I have raised regarding the costs of killing versus the costs of allowing to die. This is, of course, a disputed distinction in the PAS literature.¹³⁸ Still, I think it useful to trace at least some of the potential costs Posner has ignored and to further develop this category of costs. The conclusion of that discussion will not be a completed cost-benefit analysis for PAS, although it will imply that Posner omitted very substantial costs in his social welfare calculus for PAS. Second, I want to suggest, briefly, how one might proceed if the project of cost-benefit analysis proves intractable.

V(b). The Cost of Killing and a Third-party Cascade.

Earlier, I discussed Posner's claim that legalization of PAS would not likely serve to

¹³⁸ The respondents' brief in *Quill*, for example, termed New York's distinction between permissible and impermissible physician assistance in end-of-life treatment "irrational." Brief for Respondents at 44, *Quill* (No. 95-1858); *see also* Rachels, *supra* note 16 (questioning the integrity of the distinction generally).

diminish the entrenchment or appearance of norms of medical practice.¹³⁹ His argument turned, in part, on a contentious claim that such problems have not arisen in Dutch practice since the decriminalization in the Netherlands of what we would consider PAS.¹⁴⁰ I mentioned, among other problems, the familiar one regarding social differences between the Netherlands and the United States.¹⁴¹ Following that observation, I think it worthwhile to consider some of the potential first-party and third-party costs that might follow legalization, especially as they relate to medical care and the African-American population.

A great deal of ink has been spilled over the complicated and sometimes tragic history of the medical profession's treatment of various vulnerable populations.¹⁴² That history includes, among other things, such diverse problems as forced surgical experimentation on slaves,¹⁴³ variable diagnosis and treatment—despite consistent disease states—according to race and gender,¹⁴⁴ and communication gaps between medical professionals and various minority populations.¹⁴⁵ Even a cursory recapitulation of that history is well beyond the

¹³⁹ See text accompanying nn. 49-50, *supra*.

¹⁴⁰ See text accompanying n. 51, *supra*.

¹⁴¹ See text accompanying n. 54, *supra*.

¹⁴² See, e.g., SUSAN E. LEDERER, *SUBJECTED TO SCIENCE: HUMAN EXPERIMENTATION IN AMERICA BEFORE THE SECOND WORLD WAR* (1995); JAMES H. JONES, *BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT* (new & expanded ed. 1993).

¹⁴³ See LEDERER, *supra* note 142; David A. Richardson, *Ethics in Gynecologic Surgical Innovation*, 170 *AM. J. OBSTETRICS & GYNECOLOGY* 1 (1994).

¹⁴⁴ See, e.g., Robert M. Mayberry et al., *Racial and Ethnic Differences in Access to Medical Care*, 57 *MED. CARE RES. & REV.* 108 (Supp. 1 2000).

¹⁴⁵ See generally ANNE FADIMAN, *THE SPIRIT CATCHES YOU AND YOU FALL DOWN: A HMONG CHILD, HER AMERICAN DOCTORS, AND THE COLLISION OF TWO CULTURES* (1997); BONNIE BLAIR O'CONNOR, *HEALING TRADITIONS: ALTERNATIVE MEDICINE AND THE HEALTH PROFESSIONS* (1995).

scope of this paper.¹⁴⁶ But one general moral to be drawn from that history is that even seemingly minor issues can have very serious medical import. For example, miscommunication between American physicians and Asian immigrants has—although not necessarily borne of anything like the virulent, institutionalized racism that led to the abuse of slaves—nonetheless led to serious and sometimes fatal misdiagnoses and mistreatment.¹⁴⁷ And that—suboptimal communication with catastrophic consequences—may be a species of problem with special import for PAS.

Proponents of PAS typically frame their arguments in terms of patient autonomy.¹⁴⁸ In doing so, Posner is hardly unique. Legalized PAS is said to enhance or promote patient autonomy by providing suffering terminal patients with a means, first, to exert some control over the timing and manner of their deaths and, second, to end the suffering itself.¹⁴⁹ The argument from autonomy may—but need not—gloss the strong social and economic constraints on end-of-life decision making. In its most basic form, the argument is simply that legalization of PAS would provide, for some, a very welcome alternative in an array of already limited choices. Indeed, even the best placed of those terminal patients for whom PAS is an issue may face a very limited range of likely unhappy options in any case; discussions of a “good death” cannot obscure the fact that for many, *any* end-of-life medical decisions are decisions between very limited alternatives, under conditions of, in effect,

¹⁴⁶ For a useful, if necessarily abbreviated, survey focusing on African-Americans, see Patricia A. King & Leslie E. Wolf, *Empowering and Protecting Patients: Lessons for Physician-Assisted Suicide from the African-American Experience*, 82 MINN. L. REV. 1015 (1998).

¹⁴⁷ See FADIMAN, *supra* note 145.

¹⁴⁸ See generally, e.g., Brief for Respondents, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858).

¹⁴⁹ See *id.* at 1.

extreme scarcity. For some, the option to curtail the duration of a dying process that is fraught with suffering may be extremely valuable. For others, the choice may be more difficult. But *ceteris paribus*, an additional choice cannot have a value less than zero.

However, all things are not liable to be equal. I have already argued that concerns about the autonomy argument need not be driven by paternalism, benign or otherwise. That is, the problem is not that poor people, the elderly, or African-Americans, when faced with an additional unfortunate opportunity, will tend to choose the “wrong” option. Rather, it is that the notion of choice is especially complicated in the area of PAS, acutely so for a non-trivial segment of the elderly, terminal population. And the issue becomes further complicated when we consider the problem of special populations, a problem wholly ignored by Posner.

First, there is a serious question whether legalization of PAS would tend to diminish, rather than enhance, the likelihood of informed choice in an already compromised doctor/patient relationship. Extant biases in the delivery of medical care to vulnerable populations might further skew information costs for persons already ill placed to acquire reliable information about their conditions and care. Also, there is concern that legalization would tend to skew the cost of substitutes for PAS—for example, that of adequate palliative care—for persons already ill placed to pursue them. Finally, there are serious worries about coercion under a regime allowing for institutionalized PAS.¹⁵⁰

There is also concern that legalization would irremediably breach various elements of physician responsibility and the presumption of trust in the doctor/patient relationship.¹⁵¹ In social situations where that relationship is already significantly compromised, this could lead

¹⁵⁰ See *Vacco v. Quill*, *supra* note 100, at 795.

¹⁵¹ See, e.g., Brief for the American Medical Association, et al., as Amici Curiae in Support of Petitioners, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110).

to an extremely pernicious downward spiral, further compromising not just the ability of terminal patients to make informed, autonomous choices, but also the ability of the medical profession to deliver effective care to broader segments of vulnerable populations in diverse circumstances.¹⁵² This entails, at least, a significant spillover cost that needs to be addressed in this debate.

Concern for the import of PAS for variously vulnerable persons has been often mentioned,¹⁵³ but there has nonetheless been a dearth of in-depth analysis of this issue. Several exceptions are noteworthy, but I will focus on just one. Specifically, I'll look to several issues raised by Patricia King and Leslie Wolf concerning African-American patients and PAS.¹⁵⁴ Most generally, Professors King and Wolf express well founded concerns that legalization of PAS—typically advocated as critically enhancing patient autonomy—may actually serve as a new locus of coercion and social pressure for already vulnerable populations.

At the outset, we might do well to note a preliminary observation made by King and Wolf, applying in this context a point often made much more broadly in bioethics; that is, that attention to common (in statistical terms) characteristics of some minority group ought not to obscure the very real, and significant, heterogeneity within that group, and that useful

¹⁵² A similar point has already been made with respect to the diagnosis and treatment of HIV in the African-American community; that is, that public health efforts in the African-American community have been hampered by, e.g., the legacy of Tuskegee and that this compromised care has had spillover effects for the broader society in turn. See, e.g., James H. Jones, *The Tuskegee Legacy: AIDS and the Black Community*, HASTINGS CENTER REP., Nov./Dec. 1992, at 38.

¹⁵³ See *Washington v. Glucksberg*, 521 U.S. 702, 703, 704, and 730 (1997) (where the Court expresses concern about vulnerable groups in general) and at 785 (where the Court expresses concern for not-fully-competent patients, raising special concern about managed care); Burt, *supra* note 57.

¹⁵⁴ See King & Wolf, *supra* note 146.

generalities ought not to be reified into over rigid stereotypes.¹⁵⁵ The implication noted by the authors is that we need to develop “thick descriptions”—detailed, complex, individual descriptions—of patients to understand whether or to what extent they are vulnerable.¹⁵⁶ Failure to develop such descriptions can have disastrous consequences in the delivery of care to individual patients. And that is doubly problematic, given the general worries we have raised regarding difficult-to-detect, and difficult-to-assess, cognitive impairment among the more general population of elderly, terminal patients.¹⁵⁷

Bracketing the importance of individual assessment, there are several general observations of note. First, African-American patients are more likely than whites to express distrust of the medical establishment generally, and are, in particular, less likely than whites to support the legalization of PAS.¹⁵⁸ Second, African-American distrust of the medical establishment may be well founded, as it rests on a long history of mistreatment, which has run the gamut, from benign neglect to exploitation and outright abuse.¹⁵⁹ Indeed, abusive treatment includes not just the aforementioned nineteenth century victimization of slaves, but

¹⁵⁵ *See id.* at 1019. This is an extremely general point. The authors raise it with special concern to vulnerability to coercion in particular social contexts but it applies equally well across the continuum from characteristics that are ideally social, to mixed social-biological characteristics, to characteristics for which there is very strong, heritable coding, e.g., from communication problems, to differential risk of coronary disease, to risk of sickle-cell expression.

¹⁵⁶ *See id.* at 1020.

¹⁵⁷ *See supra* text accompanying notes 104-26.

¹⁵⁸ *See* Marsha Lillie-Blanton et al., *Race, Ethnicity, and the Health Care System: Public Perceptions and Experiences*, 57 MED. CARE RES. & REV. 218, 233 (Supp. 1 2000) (reporting that minority Americans generally, and African-Americans in particular, are more distrustful of the medical profession than whites); *see also* King & Wolf, *supra* note 146, at 1022-23 (citing, among other sources, Annette Dula, *African American Suspicion of the Healthcare System is Justified: What Do We Do About It?*, 3 CAMBRIDGE Q. HEALTHCARE ETHICS 347 (1994), P.V. Carliss et al., *The Influence of Ethnicity and Race on Attitudes Toward Advance Directives, Life-Prolonging Treatments, and Euthanasia*, 4 J. CLINICAL ETHICS 155 (1993) and Richard L. Lichtenstein et al., *Black/White Differences in Attitudes Toward PAS*, 89 J. NAT'L MED. ASS'N 125 (1997)).

recent and well-publicized activities. Probably most famous of these is the Tuskegee Syphilis Study, which the Public Health Service extended into the 1970s (and might well have extended rather longer if not for considerable external pressure to abandon it); that is, long past the Nazi War Crimes Trials and the adoption of the Nuremberg Code, long past the Declaration of Helsinki, and indeed some years past the passage of the Civil Rights Act of 1964.¹⁶⁰ And the Tuskegee Study was not the final scandal in that ongoing history.¹⁶¹

Leaving aside such stark cases of abuse, we note that the African-American community continues to suffer disparate—and disadvantaged—access to health care in several significant areas.¹⁶² For example, African-Americans are less likely than white Americans to receive pharmacological therapy, diagnostic angiography and catheterization, and invasive surgical

¹⁵⁹ See King & Wolf, *supra* note 146, at 1023.

¹⁶⁰ See JONES, *supra* note 142 (describing the several decades of comprehensive subject abuse in the study that examined untreated syphilis in African-American males exclusively) and Jones, *supra* note 152 (addressing some of Tuskegee's epistemic legacy in the African American Community).

¹⁶¹ See King & Wolf, *supra* note 146, at 1029 (citing Charles Marwick, *Questions Raised About Measles Vaccine Trial*, 276 JAMA 1288 (1996)).

¹⁶² See, e.g., Mayberry et al., *supra* note 144 (conducting a broad review of the health services literature since 1984 and reporting persistent disparities even after adjusting for socioeconomic status, insurance coverage, stage or severity of disease, comorbidities, type and availability of health care services and patient preference). Establishing disparate access and disparate outcomes according to race raises complex methodological issues well beyond the scope of this paper. Following Mayberry et al., I want to suggest that the findings of disparate access (and outcomes) are—at least in certain health areas—robust across diverse study populations and statistical methods. And although it is important to tease out those disparities that may be diminished adjusting for, e.g., income, education, or insurance status, we should not be too quick to dismiss the race problem as a specious correlation in those instances where, e.g., income effects appear to dominate, especially as race is not irrelevant to determining income. It should be noted that differential access has not been observed in all areas of health care. For example, several studies of access to medical care for diabetes have found no significant racial differences. Mayberry et al., *supra* note 144, at 123 (citing, e.g., C.C. Cowie and M.I. Harris, *Ambulatory Medical Care for Non-Hispanic Whites, African-Americans, and Mexican-Americans with NiDDM in the U.S.*, 20 DIABETES CARE 142 (1997)). For a discussion of the underlying causes of differential health outcomes, with at least one aspect of access (consistent coverage due to membership in a single HMO) held constant, compare Anthony S. Robbins et al., *Race, Prostate Cancer Survival, and Membership in a Large Health Maintenance Organization*, 90 J. NAT'L CANCER INST. 986 (1998), and Anthony S. Robbins et al., *Response*, 91 J. NAT'L CANCER INST. 802 (1999), with Mack Roach III et al., *Re: Race, Prostate Cancer Survival, and Membership in a Large Health Maintenance Organization*, 91 J. NAT'L CANCER INST. 801 (1999).

treatment for heart disease and stroke;¹⁶³ and African-Americans suffer disparate health outcomes, having higher death rates from coronary disease, breast cancer, colon cancer, diabetes, and infant mortality.¹⁶⁴ Third, in part because of this history, in part because of frequent social and economic differences between medical professionals and African-American patients, and in part because of the various gradations of racism—from the subtle and unintentional to the overt—to which African-American patients may be subjected, communication problems between medical professionals and their African-American patients are common and can be quite serious.¹⁶⁵

The communication problem is of special significance for our discussion, as it bears both on the particular concerns of African-Americans and on some of our most general concerns about PAS. Consider a cascade that miscommunication and mistrust might engender. African-American patients—as a group—may tend to downplay or fail to discuss

¹⁶³ *Id.* at 11; John G. Canto et al., *Relation of Race and Sex to the Use of Reperfusion Therapy in Medicare Beneficiaries with Acute Myocardial Infarction*, 342 *NEW ENG. J. MED.* 1094 (2000). Disparities in access to coronary care are especially significant as coronary artery disease is the leading cause of death in the United States. Lynne C. Einbinder & Kevin A. Schulman, *The Effect of Race on the Referral Process for Invasive Cardiac Procedures*, 57 *MED. CARE RES. & REV.* 162, 162 (2000 Supp. 1). At least with access to coronary-revascularization procedures, it does not appear that we can attribute disparate access to over-use by whites. See Eric D. Peterson et al., *Racial Variation in the Use of Coronary-Revascularization Procedures*, 336 *NEW ENG. J. MED.* 480, 480 (1997) (“The differences in treatment were most pronounced among those predicted to benefit most from revascularization. Since these differences also correlated with a lower survival rate in blacks, we conclude that coronary revascularization appears to be underused in blacks.”).

¹⁶⁴ See, e.g., Robin M. Weinick et al., *Racial and Ethnic Differences in Access to and Use of Health Care Services, 1977-1996*, 57 *MED. CARE RES. & REV.* 36, 37 (2000 Supp. 1); James J. Dignam et al., *Outcomes Among African-Americans and Caucasians in Colon Cancer Adjuvant Therapy Trials: Findings From the National Surgical Adjuvant Breast and Bowel Project*, 91 *J. NATL. CANCER INST.* 1933 (1999) (reporting lower survival rates from colon cancer for African-Americans generally, as well as the fact that the disparity may be diminished through early detection and adjuvant therapy).

¹⁶⁵ See, e.g., Einbinder & Schulman, *supra* note 163, at 168 (citing fear as the major legacy of Tuskegee); Cindy Brach & Irene Fraserirector, *Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model*, 57 *MED. CARE RES. & REV.* 181 (2000 Supp. 1).

their pain symptoms with physicians.¹⁶⁶ When they do discuss these symptoms, they may have their subjective reports of pain significantly downgraded by their caregivers.¹⁶⁷ Thus, reports of pain symptoms by African-American patients may be biased at both ends of the clinical encounter: Patients themselves may artificially depress both the frequency and urgency of their reporting while physicians—typically unconsciously—downgrade those reports further, reducing the magnitude of pain reports more than race-neutral error rates would suggest.¹⁶⁸ Moreover, such biases with respect to pain symptoms need to be considered against the backdrop of a general medical tendency to under-treat pain symptoms in terminal patients.¹⁶⁹ Straightforwardly, under-representation of pain symptoms can lead to under-medication of pain symptoms. And under-medication of pain symptoms can promote or aggravate depression in the terminal elderly, and can otherwise prompt requests for PAS, requests that often disappear in the face of adequate pain medication.¹⁷⁰

Such miscommunication and mistrust might prompt clinical errors in a variety of settings. But they may cause special—and especially hard to detect and document—problems in end-of-life care. Medical decisions at the end of life are, typically, acute versions of

¹⁶⁶ James M. Raczynski et al., *Diagnoses, Symptoms, and Attribution of Symptoms Among Black and White Inpatients Admitted for Coronary Heart Disease*, 84 AM. J. PUB. HEALTH 951 (1994).

¹⁶⁷ See King & Wolf, *supra* note 146, at 1039 (citing Herbert Nickens, *The Genome Project and Health Services for Minority Populations*, in THE HUMAN GENOME PROJECT AND THE FUTURE OF HEALTH CARE 58, 65 (Thomas H. Murray et al. eds. 1996) (who reports his impression of disparate pain relief treatment for African Americans and whites) and Vanessa Northington Gamble, *Under the Shadow of Tuskegee: African Americans and Health Care*, 87 AM. J. PUB. HEALTH 1773, 1774 (1997) (who reports an anecdotal illustration of such disparate treatment)).

¹⁶⁸ At one end of the spectrum, such recalibration of patient complaints can lead to the outright dismissal of bona fide symptom reports and hence the failure to explore the underlying causes of those symptoms.

¹⁶⁹ See generally Council on Scientific Affairs, Am. Med. Ass'n, *supra* note 35; see also Cleeland et al., *supra* note 35 (reporting that 42 % of its sample of 597 cancer patients were not given adequate analgesic therapy).

¹⁷⁰ See GERT ET AL., *supra* note 44.

complex decision making under uncertainty. These are frequently decisions that depend on hard-to-manage information about myriad technical and biomedical phenomena. Moreover, to the extent that relevant information is specialized to a given patient's complex disease state (and health history), sources of information independent from a given context of care may be either nonexistent or isolated from the patient by physical and social barriers, the removal of which may be impossibly costly.¹⁷¹ It is not clear that such decisions can be made consensually absent ongoing, effective patient/physician dialogue.¹⁷² But here we have described both a significant lever for increased demand for PAS (if not outright coercion) within a suspect class and a significant barrier to the sort of dialog that might mitigate such demand and that is, not incidentally, necessary to proper consent.

Of course, even the most ardent advocates of PAS do not argue that physicians should legally (or otherwise) be allowed to accede to requests for assisted suicide when more traditional treatment modalities would obviate the need for such requests; that is, when the requests are borne solely—or even substantially—of inadequate delivery of available and presently lawful medical care. That would indeed be inexpensive, and in some crude sense cost-justified, but neither Posner nor any other serious advocate of PAS sees that substitution

¹⁷¹ See Arrow, *supra* note 8, at 965-66.

¹⁷² In that respect, the disparate access to invasive cardiac procedures may be especially telling. The referral process for invasive cardiac procedures is similarly complex to end-of-life decision making, implicating both objective and subjective symptom assessment, patient and physician values, and complex patient/physician dialogue. Lynne C. Einbinder and Kevin A. Schulman have broken down the process of obtaining invasive cardiac care into eight steps, including (1) recognition of symptoms by the patient; (2) obtaining access to providers; (3) presentation and recognition of symptoms; (4) physician assessment and initial recommendation; (5) patient acceptance of physician recommendations; (6) referral for noninvasive diagnostic evaluation; (7) referral for cardiac catheterization; and (8) referral for coronary angioplasty. They conclude that “[r]ace can effect each of the steps in the referral process for invasive cardiac procedures.” Einbinder & Schulman, *supra* note 163, at 175. Taking this referral process as a model for the potential pitfalls surrounding end-of-life decision making should give further pause about the impact of PAS for the African-American community.

as framing a desirable policy initiative. But here we have described a social situation in which such requests are liable to be numerous, and where complex social and historical factors stand in the way of parsing those requests from “*bona fide*” requests for PAS.

Such problems require nothing like conscious or intentional racism. Notice, too, that the deepest sort of failure that might occur here hinges on aspects of medical care unlikely to be revealed in standard quality-of-care metrics, as these are typically narrow and outcome-based.¹⁷³ And where the upshot of various interactive failures is an unwanted and unnecessary death, it is not clear how standard morbidity and mortality review could categorically identify bad outcomes—as opposed to the most grossly deficient processes—after the fact; once we identify assisted suicide as a legitimate procedure, we create a category of therapy for which death is not necessarily—or even typically—a “bad outcome” subject to clinical scrutiny or blame.¹⁷⁴

As for process, consider the extent to which full and effective informed consent—problematic even in ideal practice situations, if an acknowledged benchmark of every serious brief for legalized PAS—is fundamentally compromised by such gaping failures of communication. Of course, not every doctor/patient encounter will exhibit such failures when the patient is African-American. And this is so quite independent of the identity of the physician. But we cannot be sanguine about giving license to PAS where such breakdowns

¹⁷³ See generally MARK B. MCCLELLAN & DOUGLAS STAIGER, THE QUALITY OF HEALTH CARE PROVIDERS (Nat’l Bureau of Econ. Research, Working Paper 7327, 1999), at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=196391 (offering a multi-dimensional, outcome-based quality of care assessment method and critiquing alternatives). It is not that outcome-based metrics are liable to miss disparate health outcomes in minority communities altogether. It is rather that they are unlikely to be sensitive to the sorts of communication failures at issue here, lumping them together with other demographic disadvantages rather than highlighting them.

¹⁷⁴ Similarly, Posner himself highlights the difficulty of identifying Dutch euthanasia cases, given their clinical taxonomy. See POSNER, *supra* note 10, at 252-53.

are liable to be common. As the Court has said, “death is different.”¹⁷⁵ And just as special constitutional concerns are implicated wherever the State wants to take a life,¹⁷⁶ and especially where such decisions impact differentially on members of “suspect classes,” so we are at least politically bound to subject to special scrutiny any practice whereby the State would provide legal sanction—and indeed likely direct or indirect funding—for the “private” taking of lives, where such practices may impact differentially on members of suspect classes.

How do we tally the costs and benefits of Posner’s putative policy initiative at this stage? The answer is unclear. We do know that Posner gave short shrift to the problem of verified, volitional election of PAS, despite the overwhelming evidence of cognition-related difficulties for the largest likely candidate population. A fair accounting would consider at least two additional sorts of costs: Those imposed in revising Posner’s very obviously inadequate psychological screening procedures and those imposed by the errors that any such revision would inevitably fail to avoid. Questions regarding those two sorts of costs are not unrelated, for questions about the efficiency of any particular screening procedure are, in part, questions about the costs of any given error rate. Moreover, I have suggested that the cost of error is confounded in that interpersonal valuations of human lives are inherently problematic, especially when we seek to balance lives lost versus persons killed. When we consider PAS and the African American population the calculus is further confounded. For there, we need to account for, among other things, what is liable to be a higher error rate. And we need to account for both first- and third-person costs, both *ex ante* and *ex post*.

¹⁷⁵ Ford v. Wainright, 477 U.S. 399, 411 (1986).

¹⁷⁶ See *id.*; Woodson v. North Carolina, 428 U.S. 280, 305 (1976).

There is an open and essentially unanalyzed question of how we might possibly fix the scope of third-party effects here. If we recall a broader distrust of the medical profession within the African-American community than in the population at large, and if we recall the broader range of public health problems conceivably implicated by that differential mistrust, then we might well wonder how to cabin the third-party costs—say, in terms of public health effects alone—of a largely unwanted legalization of PAS?

The point of all this is not to claim any particular cost to PAS. It is, rather, to highlight (1) that the costs of PAS would inevitably be greater than Posner has let on; and (2) that the job of counting—or even constraining the domain of significant factors to be counted—would inevitably be far more complicated than Posner suggests. That is simply to say that Posner’s apparently flawed balancing of costs and benefits raises interesting questions about whether a defensible, rigorous accounting of costs and benefits could be forthcoming.

VI. Conclusions: Embedded Norms and Transaction Costs

Posner’s analysis of PAS is in some ways fascinating. At the same time, it suffers from serious flaws. I have argued that his account suffers from both substantive and methodological problems. I have argued that some of the methodological problems may be intractable and that they suggest a special problem with certain assumptions underlying risk management and the valuation of life as it is sometimes practiced in the agencies. There remains the nontrivial normative question: what to do?

The answer, in briefest form, is nothing. I believe that we ought to be chary of proposals to legalize PAS in additional states. Perhaps it goes without saying that we ought

to avoid such a move in federal law. Given the current institutional framework in which medicine (and public health) is practiced, I believe that further legalization of PAS would be a mistake. Despite the copious academic literature on the subject and the plaintiffs' briefs—and amicus briefs—in the *Glucksberg* and *Quill* cases, I have seen no convincing case that accounts for the salient costs, as well as the putative benefits, of legally sanctioned PAS. For all its interest, I do not see that Posner's analysis has fundamentally altered the landscape. My position is, of course, suggested by my more substantive critique of Posner's account. There, I have argued that Posner greatly underestimated the costs associated with legal sanction for PAS. The informal—if not necessary—implications are that those costs are great and we ought to avoid implementing Posner's proposal or generalizing the initiatives of the Oregon legislature.

Behind this position is the question of what sort of explanation might be adequate; and the answer is not entirely clear. I have already suggested that implicit in the PAS debate are questions about risk management that are difficult in general and especially problematic when applied to consent issues for likely candidates for PAS. Moreover, I think that most extant arguments for legalization share with Posner's analysis an under-appreciation for the sort of sea change in moral norms that legalization would entail. This limitation applies equally to our most general moral norms against intentional killing and some of the difficult implementations of those norms we see embedded in contemporary medical practice, as it deals with difficult questions about treatment at the end of life. In brief, I see inadequate attention paid to the likely high transaction costs entailed by any attempt to remake such norms via legislative fiat.

As mirror to the old and indecisive argument over the efficiency of the common law is

a newer argument regarding the efficiency of social norms. Robert Ellickson, for example, has suggested that at least certain sorts of norms may tend to maximize social welfare, whereas Eric Posner has argued that norms are often “likely to be inefficient,” at least in a sense.¹⁷⁷ At the same time, Eric Posner has recognized the difficulty of answering the question whether norms are efficient (as well as the difficulty of reforming those which may not be so).¹⁷⁸

I have no general theory regarding the efficiency of social norms. Conspicuous here, however, is that the PAS debate implicates distinctive sorts of norms, including some of our most generally held—if not wholly universal—principles regarding the value of human life and the necessary prerequisites to the taking of human life. Moreover, we deal here not with social norms that—in Ellickson’s sense—float above law’s more formal social constraints.¹⁷⁹ Rather, we have a debate over the proper boundary conditions of these norms and the way that they are reinforced in the law. Even in this restricted domain, real optimization arguments are liable to be problematic—either too thin to be much more than question begging or too baroque to be significantly general. Still, I think it plain enough that we have good preliminary grounds for favoring these norms over many alternatives, and equally good grounds to set a rather high threshold of proof for candidate replacements. To return to Judge Posner’s source, J.S. Mill, we have “the whole of human history” to consult regarding the

¹⁷⁷ ROBERT C. ELICKSON, *ORDER WITHOUT LAW: HOW NEIGHBORS SETTLE DISPUTES* (1991). Compare Eric A. Posner, *Law, Economics, and Inefficient Norms*, 144 U. PA. L. REV. 1697, 1724 (1996).

¹⁷⁸ Posner, *supra* note 177, at 1705; POSNER, *supra* note 62, at 8 (regarding the difficulty of tuning or reforming such norms).

¹⁷⁹ See ELICKSON, *supra* note 177, ch. 7.

implications of various moral rules.¹⁸⁰ If that history provides something less than a definitive proof of welfare maximization, it provides nonetheless strong pre-theoretical grounds for caution in public rewriting of the sorts of standards at issue in the PAS debate. My suggestion is this: To first approximation, that subset of social norms consisting of fundamental moral rules represents an extremely useful set of heuristics for maximizing social welfare. As such, the criteria for the defeasibility of such norms—the grounds on which we might reasonably consider suspending or revising them—ought to be especially demanding.

We have a deeply entrenched and nearly universal norm against intentional killing.¹⁸¹ In typical implementations, the norm is defeasible; that is, it is suspended in certain, limited contexts.¹⁸² Suppose we think of that norm as a defeasible heuristic (at the most general level this is consistent with both sides of the act/rule divide in utilitarianism).¹⁸³ That is, suppose—as I think plausible—that our most general rule against intentional killing tends towards maximizing social welfare but cannot, in universal application, guarantee it. To unpack the assumption:

1. The rule is indeed a very good rule of thumb;
2. The rule tends to promote the social welfare in its frequency of observation or application; and

¹⁸⁰ See JOHN STEWART MILL, ON LIBERTY [] (David Spitz ed., Norton 1975) (1859).

¹⁸¹ See BERNARD GERT, MORALITY: A NEW JUSTIFICATION OF THE MORAL RULES 67-70 (1988).

¹⁸² See, e.g., Carlos Iván Chesñevar et al., *Logical Models of Argument*, 32 ACM COMPUTING SURVEYS 337 (2000) (regarding defeasible logics generally).

¹⁸³ See, e.g., Allen Newell & Herbert A. Simon, *Computer Science as Empirical Enquiry: Symbols and Search*, 19 COMM. ASS'N FOR COMPUTING MACHINERY 113 (1976) (discussing heuristic search generally).

3. The rule tends to promote the social welfare in its public aspects, in being predictable in both projection and application (clear, systematic, and forceful).

As corollary to these assumptions I offer:

4. Conditions for suspending the rule—or redrawing its scope—ought to be both formally and substantively demanding.¹⁸⁴

In their deservedly famous Turing Award lecture of 1975, Herb Simon and Allen Newell described heuristic search thusly: “The solutions to problems are represented as symbol structures. A physical-symbol system exercises its intelligence in problem-solving by search—that is, by generating and progressively modifying symbol structures until it produces a solution structure.”¹⁸⁵ For our purposes, two features of heuristic search are especially salient. First, Newell and Simon intended that intelligent search models meet a “strong” limitation criterion; that is, they need to recognize the bounds of limited processing resources in not just a logical or mathematical sense but in a “practical” one.¹⁸⁶ Second, they saw the difficulty of a problem (and “intelligence” or utility of a method of solution) as resting not so much in the complexity of search involved but in the amount of search “that would be required if a requisite level of intelligence were not applied.”¹⁸⁷

¹⁸⁴ Whether one takes this corollary as a first or second-order principle (or both) may hang on commitments to particular systematic approaches to morality I would hope to leave aside for purposes of this discussion. That is, the commitment to setting the bar high may be seen either as a principle governing an individual’s adherence to the more general rule in a particular case or as a principle governing the reform or qualification of that rule more generally.

¹⁸⁵ See Newell & Simon, *supra* note 183, at X.

¹⁸⁶ See *id.*

¹⁸⁷ *Id.* Hence their notion of “intelligence without much search.” *Id.*

Our conservative fallback to the familiar, if difficult, standards regarding end-of-life problems surely fulfills the practicality requirement proposed: compared to an unbounded social welfare analysis—much less an undeveloped cost-benefit analysis—the prohibition against PAS as a form of killing is *at least* tractable. Adopting constraint “4,” above, adds the further benefit of radically reducing the search: to the extent that the rule *tends* toward beneficial outcomes, it should be treated as an embedded rule—one defeasible only under very limited and carefully specified circumstances. To the extent that the rule is thus treated as an embedded rule, further evaluation and search are simply suspended in the typical case. That is, a second heuristic (roughly: stop looking) operates at the evaluation and search stages following the first (just follow the rule), which governs the symbol (solution) generation heuristic. This is a ubiquitous, if trivial, bounded search strategy.

My position regarding Posner’s under-accounting of the transaction costs in a change in legal regimes thus depends on a descriptive observation and a normative suggestion. The descriptive observation is that the relevant norms are in fact deeply embedded in the practice of medicine and in our larger society. Changing them is thus liable to be expensive because, in addition to the usual transaction costs associated with changes in legal rules, implementation of the change is liable to be especially difficult even as the consequences of such changes may be especially hard to predict.¹⁸⁸ My normative suggestion is that this heightened degree of entrenchment of the norms in question is very likely a good thing: *Prima facie*, we *ought* to respect the entrenchment and utility of the norm itself, and thus any efforts to affect the operation of the norm via the legal system ought to be efforts to shore it up rather than tear it down. My suggestion has both a substantive and an epistemic

¹⁸⁸ Indeed, to some extent, *because* the results will be difficult to predict.

component: justifying a legal attempt to modify the norm requires a significant (as opposed to marginal) improvement in social welfare and our confidence in the prediction of that margin needs to be correspondingly high. Observing that no one has met this burden is thus a positive argument, not a negative one: the right thing to do socially is to maintain the heuristic and the present legal regime; the right thing to do personally is to refrain from killing.

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