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IS LAW THE PRESCRIPTION THAT CAN CURE MEDICINE?¹

SAMUEL GOROVITZ²

It is a pleasure and a privilege to have this opportunity for endless learning in an environment so rich and so different from my own. I am grateful to Mr. Drinko, to the firm he represents, to Dean Steinglass, and to the faculty of the Cleveland-Marshall College of Law for the honor of being the first non-lawyer to occupy this chair. Not only am I not a lawyer, it is even worse. My training is as a philosopher.

When asked to pick a topic, I first considered two that I had independent reasons to be working on. One was the Food and Drug Administration's regulation of tobacco, a subject I was to address in November. The other was physician assisted suicide, an issue on which I have been working for the New York State Task Force on Life and the Law. I tried to decide between these two issues, and then realized that I ought to address what they have in common. They both raise the question of the role of law in health-related decision making. Thus, I titled this lecture, "Is Law the Prescription that Can Cure Medicine?"

Why even ask such a question? What ails medicine that I should suggest that it is in need of a cure? To answer that question, I have to make a brief historical comment about the development of health care capacities.

Medicine as a human social enterprise is old. It has probably gone on in one form or another for tens of thousands of years. For most of its history, until extremely recently, medical intervention had no significant capacity to achieve its objectives. It is only very recently, primarily in our time—or if one wants to take the long view, since the 19th century, which is just a couple of minutes ago in terms of the development of human history and human social institutions—that medical intervention has had the capacity to achieve a significant proportion of its objectives.

Physicians used to attend to the ailing and the dying with a repertoire of interventions which, viewed in retrospect, we understand ranged primarily from the innocuous to the lethal. Some have claimed, with considerable credibility, that only in our time has medicine on balance done more good than harm. A few even argue that it has not quite gotten there yet. Most acknowledge that in times past some medical interventions did help but that much of that help was simply the effectiveness of a caring presence, of the physiological consequences for the patient of trusting in a figure presumed to have powers

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²Joseph C. Hostetler - Baker-Hostetler Endowed Professor of Law, Cleveland State University, Cleveland-Marshall College of Law (Fall 1996); Professor of Philosophy and of Public Affairs, Syracuse University; Ph.D. Philosophy, Stanford University (1963); B.S. Humanities and Science, Massachusetts Institute of Technology (1960).

and authority. Here and there the odd herbal remedy had an active ingredient, some of which we are now identifying. Set against that was all the leeching, bleeding, and administration of toxic substances. It was all relatively simple.

Now medical care has been transformed. We recognize that the human organism is a complex interaction of many different systems—respiratory, circulatory, neurological, digestive, and so on. Some of them can fail and create both problems and opportunities we did not formerly have. One of the opportunities we now have is that we can keep people alive who in an earlier era would not have survived. And one of the problems we now have is also that we can keep people alive who in an earlier era would not have survived. Some of them are kept alive with such diminished capacity that we are not sure that on balance it is what we ought to do. Indeed, often we have the capacity to keep people alive who are sure themselves that it does them no benefit. That one possibility transforms the relationship between physicians and patients. Instead of patients hoping that medical intervention can do for them some part of what they want, patients now confront the question, "How much of what doctors can do do I want done?" That is a new kind of question, and it has changed the distribution of decisional authority. Some cases of physicians wanting to do more than the patients want done have even lead to litigation.

An evolution of models of clinical decision making parallels this transformation in the nature of health care. What I will say next is, as it must be in such a context, something of a cartoon. But, like any good cartoon, it captures a truth. In the olden days, meaning until relatively recently, medical decisions were made paternalistically by doctors. Hence the familiar expression, "doctor's orders." That's how it worked. The doctor decided, gave orders, and patients followed them. If they did not, they were accused of failure to be in compliance. It all had a militaristic gestalt. Also note the parallel with traditional family structure where the authority (the father, the male) gives the orders, which are then implemented by the woman (the wife, the nurse) for the dependent (the vulnerable, the patient or child). There is an intriguing isomorphism between these two traditional models.

How many find equally familiar the expression, "lawyer's orders"? That is not so familiar. Yet, assuming your lawyer is competent, if you do not have adequate regard for the advice of your lawyer, bad things can happen. You can lose your property, respect, even your freedom. In the extreme case you can, in the United States, lose even your life. Yet we do not speak of "lawyer's orders." Lawyers just provide advice. There is something instructive in the juxtaposition of these two different professions in their relationship to those they serve.

Over the past three decades that paternalistic model of medical decision-making gave way to a preferred model of autonomous decision-making in which it was initially understood that physicians should provide patients with advice, enabling the competent patient to make the decision about what would then be done. The reasons for that change are multiple. It was partly a reaction to the possible divergence between the aspirations of the doctor and the aspirations of the patient. It is also related to the civil rights movement, the emerging women's rights movement, more aggressive consumerism, and other social phenomena. But physicians, in the face of this pressure to respect the autonomous decisions of their patients,

found it frustrating when their patients were not the idealized rational and intellectually deft patients. They were often dysfunctional in any one of a number of ways—perhaps racked with pain, incapacitated by terror, just irrational, or perhaps in various other ways not capable of being the decision makers. So there emerged a third phase in the evolution of medical decision-making: shared decision-making in which the decisional judgment of the physician was required as a supplement to the physician's medical advice. As much decisional authority was still vested in the patient as the patient was capable of handling—but not more than that. This model emerged as the preferred model of medical decision-making, probably within the last decade.

Then this hard won autonomy that the patient had in collaboration with the physician started to become unraveled by the relatively sudden and powerful emergence of third party constraints upon decision-making. I refer to health maintenance organizations, insurance companies, risk managers, and managed care managers, all of whom brought to bear on the health care context an independent voice saying, "We understand that the doctor and the patient have agreed that this is how they want it to be, but on advice of our statisticians, or accountants or lawyers, that is not what we will approve."

So, medical decision-making has gone through a complicated multi-layered evolution. Now, in addition to constraints that are internal to health care, there are also the constraints that are emerging from legally mandated or regulated policies.

As all of this was happening, medical progress proceeded apace. I have mentioned life sustaining treatment—the ability to keep a patient alive who otherwise would not be alive by using such devices as renal dialysis machines, respirators, and all the rest. We have genetic screening. We have the use of human genome information making possible the analysis of human functioning at the molecular level and allowing us to intervene in ways that were unimagined and perhaps unimaginable a decade or two ago. In this era of technologically aided reproduction we worry about the disposition of frozen embryos, and we have post-menopausal pregnancy resulting from in vitro fertilization. Organ transplantation is common. An ad shown locally on television in the Cleveland market likens the human being with a failed vital organ to an automobile that needs a replacement part.

All of these phenomena—which transform utterly our relationship to the medical sciences—glamorous and dramatic as they are, pale into insignificance by comparison with the cumulative impact of incremental improvement in the quality of geriatric medicine, which is demographic dynamite. We can sustain the lives of aging people remarkably well. There are 50,000 people in the United States today over the age of 100 years. That is just the nose-cone of the demographic missile. Right behind these elderly people are waves of nonagenarians and octogenarians who are doing very well. The number of 50,000 will, in just a few years, double to 100,000. Given this, it is not possible to saturate medical need. There comes a time when there are enough color television sets in the country to satisfy all the interests that people have in color television sets. They may want bigger or newer ones, but once there is one in every room, more of them become more a burden than a benefit.

Medical care does not have that characteristic. When you keep someone alive by virtue of sophisticated medical intervention, you have produced a continuing health care consumer. It is always simpler and cheaper to bury a corpse than to have a surviving patient. As we continue to develop new medical procedures and expand our capacity to treat the ailing and the elderly, we greatly expand the range of what we are able to do and therefore the demand increases and saturation of the demand seems not to be a possibility. That is especially so if we define medical needs so broadly as to include the desire for anything that can be medically helpful.

These issues are at the intersection of law and the most fundamental human activities and values. What kinds of issues are we talking about? Birth, reproduction, suffering, death—issues that we approach with anxiety, hope, terror, trust, frustration, confidence, and sometimes despair. Surely these issues require a larger perspective than that of law.

At this point, I will make a brief detour into legal education. Being a non-lawyer in a law school has consequences. My course here is not primarily about learning health related statutes or case law, nor is it about developing legal skills, except in a broad sense. I told my students at the beginning that it is not my role here to help them to learn to think like a lawyer. Enough other people are doing that to them! My objective is to help them to learn to think like a reflective, analytic, rigorous human being. That is a different matter. I submit, however, that it is related to what is involved in being a genuinely good lawyer. Paul Brest, the Dean at Stanford Law School, has been devoting considerable effort lately to expressing some of his discontent with legal education, which he submits is not producing good lawyers.³ Its training and focus are too narrow. It helps people to learn case law and to master the statutes, but is not good at all at developing three specific values that he argues are crucial to being an effective lawyer: common sense, creativity and good judgment. He proposes substantial reformation of the curriculum designed specifically to address these areas.

That is part of my objective, too. I see that as part of liberal education. If more of this were infused into law schools it would enhance the quality of legal training, just as it would in medical school. Let me illustrate with a specific example.

I asked my students at the beginning of the semester to write a short paper in which they did two things: First, describe some action they considered to have been wrong, either their own or someone else's. Second, explain why it was wrong. This, I learned, was an extremely difficult assignment for law students because they did not know what cites were appropriate. They wanted to know, and some of them verbalized this concern explicitly: "What

³Mary Crystal Cage, *Stanford Law School Experiments with a Course that Teaches Students to Think Like Lawyers*, CHRON. HIGHER EDUC., Sept. 13, 1996, at A16; Paul Brest, *The Responsibility of Law Schools: Educating Lawyers as Counselors and Problem Solvers*, 58 LAW & CONTEMP. PROBS. 5 (1995); Paul Brest, *Plus Ca Change*, 91 MICH. L. REV. 1945 (1993) (Response to Judge Harry T. Edwards).

authorities are we to cite?" I said, "How about the authority of your own capacity for sophisticated moral reasoning?" The answer was, "But that would be an opinion. We're not allowed to have opinions." Later we talked about what goes on in the courts as they read the second and ninth circuit federal appeals court opinions on physician assisted suicide.⁴ I raised the question, "Why do you think these are called opinions?"

The point is that extra-legal judgment is important even in the context of law school. Lawyers and law students need to understand that the important social issues that confound us, including but not limited to issues in health care, cannot be resolved simply by recourse to the law. The law itself is something we evaluate in terms of broader concerns and more fundamental values even than those reflected in the law. The law is a mechanism of social choice and also a reflection of social choice. To maximize the law's value as a social enterprise, we need to evaluate its operation both within and from outside of its internal legal parameters.

The new possibilities in health care present new decisional challenges and new realities. What do we want from health care? In an ideal world, what would health care be like? We would like access to it. We would like it to be of good quality and we would like it to be affordable. But access is ambiguous. We have to ask, "Access for whom, and access to what?" The easy answer to access for whom is access for everyone. It is a remarkable and shameful fact about the United States that we, uniquely among the industrialized nations, do not provide access for everyone. But the "Access to what?" question is harder. Does this mean, for example, that anyone regardless of age or condition who wants organ transplantation—say, a heart-lung transplant—should be entitled to it even if the person has already had a few which have failed because of the person's self-destructive lifestyle?

We have to address difficult questions of limitation. Central to the new reality of health care is that it is just not possible to have access to everything for everyone who might want it, plus quality with affordability. Most commentators understand that it is comparatively easy to have any two of the three. If you do not care what you spend you can have good access for everybody at a high level of quality. But we do care what we spend. If we do not mind the basic American approach of excluding fifteen percent of the population from access to health care, then we can have good quality and reasonable affordability. If we are unconcerned about the quality then we can have broad access and affordability.

Now, not just in the United States, but throughout the developed world, people are trying to cope with these realities and the attendant tensions are of a new kind. Health maintenance organizations and other structures of the delivery of health care now focus on cost containment and outcomes research. In the old days—and again when I talk about the old days, that means within

⁴Quill v. Vacco, 80 F.3d 716 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996); Compassion in Dying v. State of Wash., 79 F.3d 790 (9th Cir.) (en banc), *cert. granted*, Washington v. Gluckberg, 117 S. Ct. 37 (1996), consolidated and argued on January 8, 1997.

my lifetime and most of yours—the relationship between a doctor and a patient was a caring relationship that had continuity. You had your doctor, who had a continuing relationship with you. Medicine was a calling, and patients' interests were the highest value.

In these new days, the language in which health care is discussed is completely different. One hears—and you can hear this eavesdropping in medical environments and other places as well—the new vocabulary of through-put rates, downsizing, mergers and acquisitions. It is the language of corporate industry, with health care CEOs who have multi-million dollar annual salaries, spending tens of millions of dollars on advertising, and sending hundreds of millions of dollars out of the health care system as returns to investors. Yet, tens of millions of Americans still go without any coverage for health care.

In this changed environment of physician-patient autonomy, the doctor and patient often must seek permission to proceed in accordance with their joint decision. Sometimes, the doctor has to defend the patient against deprivations imposed by the doctor's employer, not just the patient's insurer. With the mergers and acquisitions, increasingly the insurance company is buying the hospital and the hospital is employing the doctor. This often occurs through a complicated, multi-layered network of corporations so that the ownership line is elaborate. But, it is all one interrelated complex of organizations.

What is the consequence of this for the character of medical practice and of medical care? I submit, and this is not a dazzling insight, that the changes in the structure and financing of medical care in the last decade do not just change the way it is paid for and delivered, they are changing what it is that is delivered.

What is the proper role of the law in such matters? I will cite some examples both of litigation and of legislation. First some cases. *Scheer v. Entel Radiological Association*.⁵ Alan Scheer, a clinical radiologist, left the Georgetown University Medical School and joined a practice group in Florida where he was providing clinical treatment in a private corporation. Although he was not an equity partner, he was a high ranking and well-paid employee. One day he was summarily fired—simply told by an officer of the corporation, essentially, "Clean out your desk. Don't come back tomorrow." There was never any allegation of discontent with the quality of his clinical service.

Scheer sued the corporation which had been his employer. In the trial it came out that the firing was strictly a business decision. The powers in that corporation decided that Scheer was not the rainmaker they had hoped he would be. He had declined to join the local country club and to do various other things to help promote the image of the clinic. They wanted to replace him with a younger and less expensive clinical radiologist. Much of the discussion in the trial focused on his relationship with his patients, some of whom had shown

⁵No. 86-14316-14 (Fla. Cir. Ct., Pinellas County Nov. 2, 1989), *aff'd*, 592 So. 2d 684 (Fla. Ct. App. 1992).

up for appointments only to be told that Scheer was gone and that they had been reassigned to another doctor.

These patients had no information about ownership, corporate structures, or employer-employee relationships. Their position was, "I have a medical need. I am a patient. He is my doctor. What do you mean, I am now the patient of some stranger with whom I have no relationship? I am not the patient of some corporate entity. I am the patient of a physician, a specific human being with whom I have a relationship." But the clinic claimed that the patients were theirs, and that they had the right to reassign patients to other physician employees at their option.

So a question arose that was essentially new. If I am a physician and you are my patient, what is the operational significance of that fact? We have a sense of what it means to say, "That is my car." I can give it away or sell it. I can do with it as I please. We know what it means to say "That is my student." I have certain responsibilities and certain entitlements. Similarly, if I say "That is my son," I have certain entitlements and responsibilities. But what does it mean to say "That is my patient?" What are the associated entitlements and responsibilities on both sides? This question has not been adequately addressed.

At the trial court there was a judgment in Scheer's favor of \$1.85 million, subsequently reduced on appeal to about a quarter of a million dollars. Central to this case was what these business practices did in rending the fabric of the relationship between doctors and patients.

In another Florida case,⁶ a Dr. Cutler had a patient in the hospital who had several problems including a suborbital fracture of the right eye. The care manager—in a different state with a fax machine, a telephone, and some papers on the desk—ordered the discharge of the patient. Dr. Cutler refused on the grounds that in his medical judgment the patient was not ready to be discharged. The company was Prucare, an insurer of employees of Eastern Airlines for whom this patient had worked for decades. Prucare informed the patient that further coverage was not authorized. Dr. Cutler was then dropped from the roster of approved physicians. He sued the insurance company that had cut him from its provider list. That case settled out of court with terms undisclosed.

One more case:⁷ In Kalamazoo, Michigan, a Dr. H. brought suit against a medical corporation which had approached him when he was in private practice and said, "We like your practice, we like your style. You're just the kind of physician we want associated with our health care enterprises." They made a deal with him according to which they would invest in his practice, which he wanted to expand. They brought in a computerized information system, more sophisticated office management, and some staff. He added some new clinical specialties to the practice and remained the medical director. He was medically

⁶No. 89-09164 CA 17 (Fla. Cir. Ct., Dade County).

⁷No. A90-0098-CK (Mich. Cir. Ct., Kalamazoo County).

sophisticated and talented, but was naive—culpably so—with respect to the agreements that were crossing his desk. Dr. H. either did not have, or else did not follow, good legal advice. He learned one day, to his complete surprise, that he had become just an employee of the organization. He had built the practice. It was his practice. He had many patients who saw him as their doctor. Like Dr. Scheer, he was told one day, "You're finished. You're no longer an employee of this corporation." They just threw him out. There, too, the patients said, "But he's our doctor, not some corporation." That case also settled out of court—another example of how the structures of financing and the management imperative have resulted in a radical change in the nature of the clinical transactions. These were not malpractice litigations. Doctors were the plaintiffs.

What about the legislative side? One of the early major pieces of legislation was Medicare's establishment of an end-stage renal disease program in the United States. According to this program⁸ the federal government provides funding for the treatment of kidney disease. If you want federal funding, make sure that is the disease you have, because it is the only one for which you have an entitlement to treatment by virtue of your medical need. There are also state laws about contracts regarding surrogate motherhood, legislation with respect to health care proxies and do not resuscitate orders, and federal legislation that bans a commercial market in transplantable kidneys. The recent Kennedy-Kassebaum Bill,⁹ signed in August, provides certain constraints on what insurers may do and exclude. A 1996 amendment to the Veterans Affairs Bill prohibits "drive-through deliveries," that is, the practice of requiring mothers who have just delivered a child to be out of the hospital within 24 hours after birth.¹⁰

There is also legislation, pending or enacted, in many states, and some federal bills, having to do with gag rules. Some health maintenance organizations have had the physicians who work in their employ sign employment agreements which limit what the physicians can say to their patients about various matters. Such matters include alternate modes of treatment that might benefit the patient but are not offered by that health plan, the structure of incentives which give the physician bonuses at the end of the year for under-utilizing treatments as compared with statistical projections, and comparative discussion of different health plans that might reflect badly on the health maintenance organization. Many people have observed a kind of irony in this attempt to limit free exchange of speech between physicians and patients, precisely because patients, we have long been told, must confidently rely upon and trust their physicians.

⁸42 U.S.C.A. § 1395rr (1996) (End Stage Renal Disease Program).

⁹Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-91, 110 Stat. 1936 (1996).

¹⁰6 U.S.C. § 601 et al. (1996).

If a physician is to be therapeutically effective, that physician must have access to full disclosure by the patient. But how can the physician expect the patient to be completely trusting in a climate in which what the physician can say to the patient is constrained by business considerations imposed by the employing organization? So the American Medical Association has come out, guns ablaze, against gag rules or restrictive clauses in employment contracts with physicians. State legislatures are also beginning to pick that up, just as they did before Congress addressed the question of how much hospitalization a woman should be entitled to following a normal delivery.

How should such issues be resolved? To what extent do we want to turn to the law, through litigation or legislation, to resolve these various and diverse problems? Let me cite one example. I mentioned the prohibition of a commercial market in kidneys. In the early 1980s a physician in Virginia named Barry Jacobs sought to go to third world countries, find relatively healthy, but very poor people, and explain to them that their lives could be transformed for the better if they would relinquish one kidney to be transplanted into an affluent American. The recipient, by paying for the kidney, would be able to jump the queue and have the transplant. Jacobs would ensure the quality control and he would, of course, earn a fee for the transaction. The argument was that everybody would benefit. The wealthy American would have the organ he needed for his transplantation. It would be an economically advantageous transaction for Jacobs' company. The peasant, instead of facing grinding poverty and limited life expectancy, would be lifted up out of poverty by the provision of enough money to establish him in some kind of self-sustaining way. To be sure, his health would be slightly diminished by relinquishing one of his kidneys, but that would be more than compensated for by the countervailing benefits of being freed from intractable and relentless poverty.

The argument did not prevail. Federal legislation prohibits a commercial market in transplantable organs.¹¹ No one said there can not be three people—a recipient, a donor, and a physician—all of whom would benefit from such a transaction. The argument failed because of much broader considerations about what it says of a society which would address the problems of medical need and poverty in such a way. It failed because of our desire not to create a commercial market in body parts, but to think of the world of medical care as different in important ways from the normal domains of commerce.

These are global considerations of societal values, of what kinds of precedents seem to make sense and what kinds seem dangerous. At issue are questions of liberty, individualism, responsibility, and community, and therefore they are very much questions of the fundamental political structure within which we operate. One can imagine a society, one can even see examples of it, in which patient autonomy and individual choice are not respected. Imagine a soldier in the Army, for example, who says "I would rather not have

¹¹Organ Procurement and Transplantation Act, Pub. L. No. 98-507, 98 Stat. 2343 (1984) (codified at 42 U.S.C.A. § 274e (West 1996)).

first-aid for this minor wound because if you patch me up I may get sent back to the front and I prefer to be a little uncomfortable back here where it is safer." In a situation like that, patient consent is not at issue. One can imagine an entire political environment in which medical decisions are imposed. In our environment, informed consent is required because we respect individual autonomy and we believe that people have a right not to have bodily intrusions imposed on them which they do not themselves sanction. These deeply political values underlie clinical transactions.

Are litigation and legislation the way to resolve such matters? At what level of detail? What kinds of issues require and invite legal remedies when we talk about problems in health care? These are extremely difficult questions. Certainly the fact that fifteen percent of the American population lacks health care coverage requires a legislative remedy. Consider these brief excerpts from a wonderful and important book on this point. First, from the preface:

This is a book which will step on a great many toes, including those of some physicians and of the large industries which derive their income from the manufacture or distribution of products which directly affect public health.

Then, from the book itself:

The Committee on the Costs of Medical Care showed conclusively that the American people need insurance against the costs of medical care. A hundred other studies, before and after that Committee have shown the same need....

There has been enough of surveys and studies. The facts are at hand. What is needed now is not further meditating over statistics but hard-headed work to devise practical solutions.

Finally, from a hundred and fifty pages further in the book:

There will still be large problems to be solved and strong opposition to overcome. Constant vigilance will be needed against obstructive tactics and against the efforts of unfriendly interests to seize control. The legislative progress of the National Health Bill must be watched closely to see that it is not crippled by compromises.

The book, *Health in Handcuffs*, was written by John Kingsbury and published in 1939.¹² It ought to be reissued. That is depressing, but it is important to understand that debate about our inadequate public response to health care needs has gone on not merely for decades, but generations. Nothing short of a large-scale legislative remedy can address the embarrassing and long-standing lack of access in the United States.

¹²JOHN A. KINGSBURY, *HEALTH IN HANDCUFFS*, introduction, 42, 198 (1939).

In the *Matter of Quinlan*,¹³ the court finding was not a clinical decision but a finding about where decisional authority should reside. The decision was that the family should make the decision as a personal matter in consultation with physicians and clergy as they saw fit, but that this was not the kind of clinical decision that should be made by the court.

What do we get and what do we lose when we resort to the law in making health care decisions? Let me refer now to the infamous Baby Doe Hotline which in the early 1980s was set up by the federal government to protect newborn infants who had birth defects from being under-treated by those who were in a position to impose a clinical judgment that treatment was not warranted. I will quote three paragraphs I wrote in 1991:

Curious about how the Baby Doe Hotline was working, I had called it in April 1983. I was told that the line could only be used to report cases of suspected abuse, but that if I left my name and number, someone would return the call who could answer my questions. Within minutes, a member of the HHS staff did return the call. I learned that the hotline had received at that point about 500 calls. Most of them were about tax questions, veteran's benefits, social security, the national parks, and other matters unrelated to the purpose of the hotline. A free line to Washington, it seems, has broad appeal.

Only a handful of calls reported complaints of the appropriate type, and some of those were quickly found to be hoaxes. In four cases, the Department was able to confirm that the caller was lodging a serious complaint about a real infant. In one of those cases—but possibly just one—a neonatal intensive care unit was disrupted by the sudden arrival of a squad of federal marshals and local police. In the end, nothing inappropriate was found to have been happening in respect to the treatment of the infant. But the fact that the disruption occurred at all quickly emphasized in nursery units across the land that malpractice suits are not the only peril hanging over the heads of neonatologists.

One mistreated infant would be one too many; preventing one such abuse is an objective that must command respect. But one disrupted hospital unit is also a lot, for it is enough to demonstrate the reality of direct government involvement in particular patient care decisions, even when there is complete agreement among family and medical team members about what ought to be done.¹⁴

So, the law is a crude instrument for making specific clinical decisions. What are the alternatives? Market mechanisms can do some good, and have begun to illuminate inefficiencies in the health care system and some practices which

¹³In re Quinlan, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976).

¹⁴SAMUEL GOROVITZ, DRAWING THE LINE: LIFE, DEATH, AND ETHICAL CHOICES IN AN AMERICAN HOSPITAL, 45 (1993).

are contrary to patient interests. But market mechanisms always work to the detriment of the most disadvantaged except insofar as those market mechanisms are themselves constrained by an externally imposed commitment to social justice.

Now, because I am a philosopher rather than a jurist or lawyer, I can end with two related questions rather than an answer. Because I am a visitor, I can then just leave town. They are hard and complex questions, but important ones. I believe some good will have been done if I can induce you to take them seriously and begin to ponder and discuss them. They are just this: (1) What is the range of health related issues that it is appropriate to address through the mechanisms of law? (2) For those that are better addressed in other ways, what strategies are available for keeping them out of the courts and out of the legislatures?

These are not questions within the law. They are questions about the law and about its relationship to many of the most intimate and important dimensions of our personal lives. Their scope ranges from the degree of autonomy that families will enjoy to the allocation of social resources over the various different good purposes that we value. Ultimately, they are questions about the extent to which we will fashion a just, humane, and healthful society. The right doses of law, properly applied, can do health care some substantial good. But, just as a healthful life requires much more than just good medicine, curing what ails health care in the United States today—and that, I submit, is a lot—will require much more than just prudent legal intervention and the avoidance of imprudent legal intervention. Helping decide what else is possible, and what else is needed, is a challenge we should all accept as part of our responsibility as potential patients, as family members, as taxpayers, and as citizens.