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BIOETHICS AND THE LAW: MEDICAL, SOCIO-LEGAL AND PHILOSOPHICAL DIRECTIONS FOR A BRAVE NEW WORLD. By George P. Smith, II. New York and London: University Press of America, Inc. 1993. 332 Pp. $56.00 (cloth); $29.50 (paperback).

*Reviewed by Patrick T. Clendenen**

> How many good creatures are there here! How beauteous mankind is! O brave new world, That has such people in't![1]

Until recently,[2] broad-based bioethical and biotechnological discourse in contemporary public America was noticeably absent in this age of health care reform,[3] and the lack of any serious discussion whatsoever is attributable in part to ignorance.[4] Knee-jerk sentimentality, emotion-fil-

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1. WILLIAM SHAKESPEARE, THE TEMPEST act 5, sc. 1. *See generally* William Domnarski, *Shakespeare in the Law*, 67 CONN. B.J. 317 (1993).

2. *See, e.g.*, Sharon Begley, *One Pill Makes You Larger, And One Pill Makes You Small . . .* , NEWSWEEK, Feb. 7, 1994, at 37; Philip Elmer-Dewitt, *The Genetic Revolution*, TIME, Jan. 17, 1994, at 46.

3. *See, e.g.*, President's Address to the Joint Session of Congress on Health Care Reform, 84 Health Care Facility Mgmt. (CCH) 1, 3 (Sept. 22, 1993) ("Millions of Americans are just a pink slip away from losing their health insurance and one serious illness away from losing all their savings."); Health Care Reform Proposal and Health Security Act, 87 Health Care Facility Mgmt. (CCH) 1 (Nov. 1, 1993); Peter D. Fox, *Foreword* to THE INSIDER'S GUIDE TO MANAGED CARE: A LEGAL AND OPERATIONAL ROADMAP 11 (Douglas A. Hastings et al. eds., 1990)("Imposing an economic discipline on the health care system is essential, but society needs to assure that its most vulnerable members are protected in the process."); *Reforming Health Care: The Patient's-Eye View*, ECONOMIST, Dec. 18, 1993, at 24.

4. *See* DIANA B. DUTTON, WORSE THAN THE DISEASE: PITFALLS OF MEDICAL PROGRESS 350 (1988) ("[W]e who use medicine's innovations, who bear their risks, and who, both as taxpayers and as consumers, pay for the products and the research that made them possible, have little if anything to say about the nature and pace of medical progress."); *The Gene Jury*, ECONOMIST, Dec. 18, 1993, at 79 ("Biotechnology is a subject which most people feel neither enlightened about nor in control of."). This criticism has even been made of the very purveyors of bioethical wisdom. *See* SHERMAN ELIAS & GEORGE J. ANNAS, REPRODUCTIVE GENETICS AND THE LAW xi (1987)("Medical and scientific writers tend to ignore social policy issues, and lawyers and ethicists tend to misunderstand or ignore medical and scientific facts.").

led responses, and division, rather than deliberation and balancing, are the more common phenomena in national bioethical and biotechnological disputes.[5] In this political landscape and for those who see the prospect of a brave new world as "a mysterious mixture of promise and threat, probably important but fatefully ill-defined,"[6] George P. Smith's *Bioethics and the Law* provides a welcome reminder that not only the legal but also the medical and scientific communities[7] as a whole should deliberate and "consider anew the extent to which the plethora of medical, legal, scientific and technological considerations of [today] would either challenge or complement both the traditional rights of humanity and those being redefined according to contemporary values and standards."[8]

In Smith's view, the contemporary discourse on bioethics and the law needs to be more proactive[9] in

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5. *See* GEORGE P. SMITH, II, BIOETHICS AND THE LAW: MEDICAL, SOCIO-LEGAL AND PHILOSOPHICAL DIRECTIONS FOR A BRAVE NEW WORLD 197 (1993) (In the realm of surrogation, "law must operate within a rational structure and not a vortex of sentimentality.") (endnote omitted); *id.* at 186 (In the sterilization decision, "[r]easoned analysis, not emotional passion should be the watchword for action."); *id.* at 202 (In the surrogation decision, "[w]hile it may well be 'desirable for the child to have contact with both parents' the issue must be settled by application of the standard of reasonableness — and not a 'standard' of emotionalism.") (endnote omitted).

6. *The Gene Jury*, *supra* note 4, at 79; *see also* William Miller, *British Debate: Does Fertility Science Break "Natural Law"?*, BOSTON GLOBE, Jan. 9, 1994, at A2 ("The public may still be alarmed that the frontiers of medical science are being pushed forward too far and too fast.").

7. Professor Smith may even wish to go so far, as the British Government apparently has, as to include "juries" of informed laymen to influence the course of biotechnological policy. Although the British experiment presently is limited to contemporary issues in plant biotechnology, the "discussion will be carefully watched by Britain's Medical Research Council, which is pondering whether to hold consensus conferences on medical biotechnology and genetic engineering." *The Gene Jury*, *supra* note 4, at 79; *see* SMITH, *supra* note 5, at 6 ("[T]he creation of ethical guidelines for the application of the New Biology [should draw] on the skills of lawyers, legislators, theologians, philosophers, humanists, social scientists, and laymen." (endnote omitted)); *see also* William Miller, *British Debate: Does Fertility Science Break "Natural Law"?*, BOSTON GLOBE, Jan. 9, 1994, at A2 (Britain's Human Fertilization and Embryology Authority "called on members of the public together with doctors, scientists, and theologians to present their views on the ethical, moral and legal implications" of using eggs and ovarian tissue taken from aborted fetuses and corpses "to create babies in infertile women.").

8. SMITH, *supra* note 5, at iii; *see also* George J. Annas, *Doctors and Lawyers and Wolves*, 29 JURIMETRICS J. 437, 449 (1989) ("Unless lawyers and doctors, ethicists and the public, can work together to constructively confront [today's] critical questions, we will wind up as King Lear did when he died.").

9. SMITH, *supra* note 5, at iv ("Law, science and medicine must become full, unlimited partners in the bioethical ventures of modern society.").

> the task of assuring the primary goal of society, itself: namely, that all citizens be provided with an equal opportunity to achieve their maximum potential for human growth, development, interpersonal relations, and intellectual fulfillment when it exists, within the economic market place as well as the market place of ideals and to have not only their physical suffering minimized and their spiritual tranquility assured, but their rights of autonomy and/or self-determination recognized.[10]

To achieve this goal, Smith utilizes a utilitarian construct for decisionmaking that is a recurring theme for his recommendations in the situational dilemmas of the day: that is, a balancing test that not only "seeks to yield a final action that minimizes human suffering and maximizes the social good"[11] but also utilizes "the new and startling discoveries of the twenty-first century with a spirit of beneficence, autonomy and distributive justice."[12] In this vein, Smith urges society to embrace, rather than shirk, both the possibilities and responsibilities of the brave new world.[13] As such, Smith has written a book not just for lawyers, judges, doctors, and nurses because its breadth and scope touch upon the totality of contemporary human relationships.[14]

Because *Bioethics and the Law* has at its core the laudable goal of facilitating a dialogue and creating a decisional construct that both underscores the enormous potential for social good (e.g., the relief of pain and suffering and the battle with disease) offered by recent advances in genetics and biotechnology and points to aspects of the new biology that could

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10. *Id.* (endnote omitted).

11. *Id.*

12. *Id.* Professor Smith is a case utilitarian rather than a rule utilitarian. *See* George P. Smith, II, *Biomedicine and Bioethics: De Lege Lata, De Lege Ferenda*, 9 J. CONTEMP. HEALTH L. & POL'Y 233, 239 (1993) ("Case utilitarians, on the other hand, would weigh the good that each separate case or situation would provide.").

13. "Society should encourage, not stifle, research; for a society unable to accept and encourage either current or future behavioral variations does not promote a hospitable environment for the free development and expression of ideas of any kind. Man cannot learn by merely thinking in this area." SMITH, *supra* note 5, at 6 (endnote omitted); *see also id.* at 126 ("The obvious implication of these restrictions on embryonic and fetal research is that the scientific pursuit of mankind is significantly handicapped."); *id.* at 259-60 ("The quest for maximum utilization of biological and medical knowledge represents but one of the tenets of modern 'evolutionary wisdom.'") (endnote omitted).

14. *See* George P. Smith, II, Book Review, 7 J. CONTEMP. HEALTH L. & POL'Y 443, 445-46 (1991) (reviewing IAN KENNEDY & ANDREW GRUBB, MEDICAL LAW: TEXT AND MATERIALS (1989)) ("Health Law exists because health care is not a thing so much as it is a relationship between individuals: doctors and patients, patients and families, health care providers and health care institutions.").

lead to abuse,[15] Smith, at first glance, takes on a remarkably broad agenda. Professor Smith does, however, provide the detail necessary to illustrate how his construct might work in practice. Indeed, by relying on both a descriptive and normative discussion of at least eleven major topics, Smith develops his conception of a utilitarian brave new world without failing to articulate his vision in the situational dilemmas of the day.

In chapter one, entitled "Ethical Challenges," Smith first critiques the contemporary debate over medical ethics and contends that, although "the most striking weakness found is the lack of a basic yardstick against which either the 'rightness' or 'wrongness' of a physician's actions may be measured,"[16] an interdependent framework for decisionmaking does exist, and, even though it fluctuates with the particulars of the situation,[17] it must be both competent and moral, combining the three keystones of Bioethics: Autonomy, Beneficence, and Justice.[18] Second, Smith critiques the societal urge to stop all research because "we lack total knowledge."[19] This view, Smith contends, not only forecloses opportunities "to grow in wisdom and use that wisdom to act with dignity and responsibility"[20] but also ignores societal responsibilities to serve mankind.[21]

Although his optimistic view of medical progress is not universally embraced,[22] Professor Smith, without ignoring the significant dangers that

15. *See, e.g.*, SMITH, *supra* note 5, at 97 ("[T]here is always a danger—real or implied—that the institutional review board system—as with all self-regulatory systems, will favor inherently (by virtue of their composition) the interests of researchers."); *id.* at 290 ("The biggest uncertainty surrounding living wills and their subsequent administration is related to whether health care providers are required — under pain of civil or criminal sanction — to execute the terms of the will.").

16. *Id.* at 1.

17. *Id.* at 260 ("A situation ethic considers the consequences of each proposed biomedical action, carefully weighs them and concludes with an ethical posture or the structuring of a penultimate standard of modus operandi.") (endnote omitted).

18. *Id.* at 6. The morality Professor Smith espouses is not a new one to fit his personal likes; rather, it is morality that is "'discovered' by an unpacking, explication and articulation of individual intuitions about what ought be undertaken and what ought not be done." *Id.* at 15.

19. *Id.* at 13.

20. *Id.*

21. *Id.* ("[M]an often chooses the path of ignorance to escape the burdens of responsibility that arise from new knowledge.").

22. DUTTON, *supra* note 4, at 350-51 ("[M]edical and scientific 'advances' can do harm as well as good, and . . . judgments about both risks and benefits are not automatic or absolute but are made by individuals and agencies acting in the context of particular social, political, and economic pressures."). *See generally* DANIEL CALLAHAN, WHAT KIND OF LIFE: THE LIMITS OF MEDICAL PROGRESS (1990) (analyzing the converging and conflicting forces of improved medical technology, cost-effective treatment, and health care for all citizens); MEDICAL INNOVATION AND BAD OUTCOMES: LEGAL, SOCIAL AND ETHICAL RE-

exist in conducting (and applying the fruits of) research,[23] crafts a persuasive argument to consider the benefits and dangers concurrently.[24] Only then, Smith contends, can a true balancing take place.

Central to Smith's construct for principled decisionmaking is an economic balancing test which weighs the costs and benefits of maintaining the status quo and undertaking new courses of action, with an emphasis on making informed, competent, and self-critical decisions. Ultimately, however, Smith contends that because bioethics deals fundamentally with human beings and medical technology, rather than, for example, pesticide technology, these decisions must be made with an overriding respect for, and appreciation of, the individual in a micro and macroeconomic sense.[25] The stuff of econometrics Smith's theory is not.

To elucidate his theory, Smith has collected, edited, revised, and rearranged a wealth of his previously published work and his lectures and papers delivered around the world, to set forth a comprehensive set of essays which comprise "the conundrums that beckon us into the new Millennium."[26] Moreover, the scope of *Bioethics and the Law* is remarkably ambitious, for it covers not only genetics, assisted suicide, informed con-

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SPONSES (Mark Siegler et al. eds., 1987) (noting and analyzing in a collection of essays the public's demand for continuing technological advancement in medicine and the pitfalls of innovation's mistakes).

23. Those dangers surround not only the present generation but also future generations. SMITH, *supra* note 5, at 14 ("The creed encompasses a corresponding commitment to live life and influence the lives of others to promote the evolution of a better world for future generations by avoiding actions that would detrimentally impact the future.") (endnote omitted).

24. For example, in discussing research on in vitro fertilization, Smith argues that "[r]esearch into the impact of biomedical technologies and consideration of the ethical dilemmas involved does not require a moratorium on human experimentation; the two can continue concurrently." *Id.* at 6. Similarly, in Chapter 10, entitled "Of Clones and Cryons," Smith notes that, although "the total cryonic suspension of an entire human body *and its revival* remains speculative at best, . . . scientific actions which hold the promise, no matter how remote, of increasing the quality of purposeful living and minimizing suffering must be pursued." *Id.* at 265; *see also id.* at 264 (Because it "is only by continued effort that real progress through education can be achieved" in the field of asexual reproduction, "[i]mpatience with the unknown and terror over spontaneity must be conquered.").

25. *Id.* at iii ("The legal and ethical evaluations and constructions of law, medicine, biotechnology and genetic engineering need to be set within a continuing dialogue that is tied to a basic understanding of and respect for human rights and human dignity.").

26. *Id.* at back bookcover (as described by The Honorable Michael Kirby, President, Court of Appeal, Sydney, Australia). The titles to the chapters of Smith's book are as follows: Ch. 1, Ethical Challenges; Ch. 2, Rationing Health Care; Ch. 3, Ethics Committees; Ch. 4, Informed Decisionmaking; Ch. 5, Embryonic and Fetal Experimentations; Ch. 6, Wrongful Life or Wrongful Birth; Ch. 7, Procreational Restraints; Ch. 8, Surrogation; Ch. 9, Fetal Abuse; Ch. 10, Of Clones and Cryons; Ch. 11, The Right to Die with Dignity.

sent, and rationing health care, but also contains chapters entitled "Embryonic and Fetal Experimentations," "Fetal Abuse," and "Of Clones and Cryons." In addition to its international scope and depth, which is the result of Smith's extensive travel and study abroad,[27] *Bioethics and the Law* is timely, which any reading of the contemporary press will reveal.[28]

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27. *See, e.g., id.* at 29 (Britain's national health care system); *id.* at 38-39 (Sheffield Standards for determining whether to withhold care from handicapped infants); *id.* at 46-47 (Akamba people's approach to allocating medical resources); *id.* at 127 (fetal experimentation in Britain); *id.* at 180-86 (Canadian and British approaches to procreational restraints, such as sterilization); *id.* at 205-06 (Britain's approach to surrogation and artificial insemination); *Id.* at 296-97 (Canadian and British approaches to assisted suicide).

28. On fetal experimentation, compare SMITH, *supra* note 5, at 124-27 (the federal position) with Paul Recer, *US Funds Fetal Tissue Research*, BOSTON GLOBE, Jan. 3, 1994, at A3 ("The federal government yesterday approved the first grant for fetal tissue research since President Clinton lifted a five-year ban on studies using cells from aborted fetuses."). *See also* SMITH, *supra* note 5, at 130-32 (discussing the Waxman Bill and President Clinton's lifting of the moratorium on federal funding of research involving fetal tissue from abortions). On fetal experimentation and surrogation, compare SMITH, *supra* note 5, at 127-28, 204-07 with Neil Davis, *Comment: The Constitutionality of Fetal Experimentation Statutes: The Case of Lifchez v. Hartigan*, 25 J. HEALTH & HOSP. L. 37, 38-40 (1992); William Miller, *British Debate: Does Fertility Science Break "Natural Law"?*, BOSTON GLOBE, Jan. 9, 1994, at A2 (utilization of eggs and ovarian tissue taken from aborted fetuses and corpses "to create babies in infertile women"); *Not Too Late*, ECONOMIST, Jan. 8, 1994, at 78-79 (recounting the European debate about embryo transfer for older, infertile women). On genetic policy and gene mapping and therapy, compare SMITH, *supra* note 5, at i-iii, 172-76, with *China Proposes Eugenics Law*, WALL ST. J., Dec. 21, 1993, at A6 ("China introduced a bill to use abortions and sterilizations to avoid 'births of inferior quality and heighten the standards of the whole population'"); *MegaYAC Map*, ECONOMIST, Dec. 18, 1993, at 78-79 (recounting the year's development in gene mapping); *More Than It Can Bear*, ECONOMIST, Jan. 29, 1994, at 86 (gene therapy possibilities for coronary heart disease). On human and fetal experimentation and informed consent, compare SMITH, *supra* note 5, at 89-90, 99-102, 117-18 with *Silent Death*, ECONOMIST, Jan. 8, 1994, at 77-78 (describing the US Atomic Energy Commission's experiments on the effects of radiation exposure on human beings, "some without their knowledge"); Arthur Caplan, *For the US, A Shameful Legacy of the Cold War*, BOSTON GLOBE, Jan. 6, 1994, at A11 ("Didn't anyone take seriously the Nuremberg Code, issued by US judges at the conclusion of these trials, that made informed consent an absolute, inviolate requirement for all research involving human subjects?"); *Cincinnati Patients Irradiated in '72*, BOSTON GLOBE, Jan. 6, 1994, at A19; Sean P. Murphy, *Prison "Trips" Altered 2 Inmates' Paths*, BOSTON GLOBE, Jan. 6, 1994, at 21 (LSD experiments conducted by Timothy Leary); *see also* George J. Annas, *Mengele's Birthmark: The Nuremberg Code in United States Courts*, 7 J. CONTEMP. HEALTH L. & POL'Y 17 (1991); ROBERT N. PROCTOR, RACIAL HYGIENE: MEDICINE UNDER THE NAZIS 217-22 (1988). On Institutional Review Boards, clinical trials, and drug research, compare SMITH, *supra* note 5, at 96-98 with Daniel Golden, *Stakes High in Clinical Drug Trials*, BOSTON GLOBE, Jan. 6, 1994, at A1, A13 (recounting the problems associated with the safety of omniflox, a newly-approved antibiotic, and the flawed processes of some clinical trials and institutional review boards). On rationing health care and the Oregon experiment, compare SMITH, *supra* note 5, at 25-36 with Tracy Erwin, *The*

Although Smith's philosophy of principled decisionmaking is a unique and sensitive construct in its concordant emphasis on societal and individual welfare, it fits better in some areas of the book than others. For example, in this and other works,[29] Professor Smith argues persuasively that the use of costly medical resources for terminally ill, inoperable, or brain dead individuals is not only an unreasonable and inefficient use of exotic and scarce medical resources but also inhumane and unjust. Smith argues that, although "[s]ocial justice demands that each individual be given an opportunity to maximize his individual potential,"[30] when an individual is so disabled or ill, lacking "any 'truly human' qualities or relational-potential, then the best form of treatment should be arguably no treatment at all."[31] As such, the "attainment of the quality of purposeful, humane living becomes a coordinate or complement to total economic utility."[32]

In chapter eleven, moreover, Smith recounts the varied and contemporary statutory and medical definitions of death which "endeavor to place and to recognize the moment of death earlier in the continuum of life than earlier practice and definitional structure did."[33] Smith argues that

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Oregon Plan: An Ethical Solution to the Health Care Crisis?, 26 J. HEALTH & HOSP. L. 133, 135-37 (1993); Marilyn Chase, *Oregon's New Health Rationing Means More Care for Some But Less for Others*, WALL ST. J., Jan. 28, 1994, at B1. On assisted suicide and the right to die, compare SMITH, *supra* note 5, at 300-02 with Michigan v. Kevorkian, 62 U.S.L.W. 2411 (Mich. Ct. App. Dec. 13, 1993); Dick Lehr, *Seattle Group Sues to Void Suicide Ban*, BOSTON GLOBE, Jan. 26, 1994, at A7 (describing an action in U.S. District Court "seeking to overturn on constitutional grounds the state's criminal ban against assisted-suicide"); Dick Lehr, *Supporting Those Who Want to Die*, BOSTON GLOBE, Jan. 18, 1994, at A3 (describing the organization "Compassion in Dying," which offers "face-to-face guidance on suicide").

29. *See, e.g.*, George P. Smith, II, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?*, 22 U.C. DAVIS L. REV. 275, 418 (1989), *cited in* Cruzan v. Director of Mo. Dep't of Health, 497 U.S. 261, 280 n.8 (1990)).

30. SMITH, *supra* note 5, at 48.

31. *Id.* (endnote omitted).

32. *Id.* at 49 (endnote omitted); *see also id.* ("Or, stated otherwise, decisions regarding the allocation of health care services should be reached by balancing the gravity of the economic harm that will accrue in a particular case of use or maintenance against the utility of the social good that will occur if that resource is not used.").

33. *Id.* at 303-04 (Because of medical technology, death today is more complex: "Man's physiological system does not collapse and fail in a moment's time."); *see also* Commonwealth v. Golston, 366 N.E.2d 744, 747 (Mass. 1977) (recognizing the so-called "Harvard Standards" for determining brain death as the legal standard of death); KAREN G. GERVAIS, REDEFINING DEATH 167-68, 207 (1986) (Subject to a conscience clause, human death occurs where there is irreversible cessation of brain functions necessary for consciousness.); Annas, *supra* note 8, at 444-45 (summarizing the advent of brain death statutes and decisions); Steven Goldberg, *The Changing Face of Death: Computers, Consciousness, and Nancy Cruzan*, 173 SPECIALTY L. DIG.: HEALTH CARE L. 7, 29-31

these developments, when coupled with an overall recognition of patient autonomy and enlightened self-determination, not only allow for a more dignified and merciful death "but also preclude the assessment of heavy economic burdens of caring for one who has lost the basic attributes or indicators of personhood."[34] To Smith, therefore, death is in large part a function of the indicia of a person's meaningful life.[35] Thus, although Smith recognizes the primacy of a physician's duty "to eschew patient harm," he also counsels the medical community to realize that "humane and individualized care may well direct his assistance in assuring the implementation of his patient's right to death with dignity."[36]

In this age of health care reform, cost containment and patient autonomy coalesce nicely to reduce the use of technology for those who do not want it. Indeed, at both the state and federal level, the courts and legislatures have supported the patient's right to refuse life-sustaining treatment and have created devices to carry out that right, such as living wills and durable powers of attorney.[37] Whether these developments, including the Patient Self-Determination Act of 1989,[38] are based largely on a new appreciation for patient autonomy or a new recognition of the old concern for the bottom line, or both (and one suspects the latter), it is clear to Smith that "the whole health care provider system will be able to deliver its services more efficiently and economically without undue judicial interference and supervision."[39]

(July 1993) (discussing the impact of the development of "self-aware" machines on society's definition of death and the resultant treatment decisions of terminally-ill patients); SMITH, *supra* note 5, at 268-71 (discussing the various definitions of death and their implications for "individuals presently in cryonic suspension of those anticipating its use"); Robert W. Pommer, III, Commentary, *Donaldson v. Van de Kamp: Cryonics, Assisted Suicide, and the Challenges of Medical Science*, 9 J. CONTEMP. HEALTH L. & POL'Y 589, 603 (1993) (discussing cryonic suspension before "natural" death).

34. SMITH, *supra* note 5, at 303. As an added benefit, Smith notes that "the body parts that survive death—as thus newly classified and defined—may be harvested and made available to deserving recipients without the physicians being fearful and uncertain that their acts might be considered invasions of privacy or criminal assaults." *Id.* (endnote omitted).

35. Professor Smith sees meaningful life in the context of personhood, which, as he defines it broadly, is the enjoyment of states of consciousness, the capacity to have experiences linked together by memory, and the capacity for love and interpersonal relationships. *Id.* at 285.

36. *Id.* at 302.

37. *See id.* at 290-93.

38. *See id.* 297-98; *see also* Barbara Mishkin, *Advance Directives for Health Care*, *in* 1993 HEALTH LAW HANDBOOK 363 (Alice G. Gosfield ed., 1993).

39. SMITH, *supra* note 5, at 298.

Contrary to at least one published report,[40] Smith sees no offense to the principle of nonmaleficence in a patient's enlightened exercise of total control over comfort care on the edge of life. In this light, "the concept of euthanasia is relegated to obscurity or nonuse and—in its place—enlightened self-determination is the primary vector of force or paramount goal in decisionmaking."[41]

The question then becomes whether, under Smith's theory, patient autonomy and cost containment will, on the edge of life, create disharmony in the public's eye and within the medical profession in part because utilitarianism argues that it is in *our own* interest to maximize the utility of all.[42] Indeed, whether the issue is rationing health care in general or assisted suicide, questions remain that will test Smith's theory when patient autonomy and cost containment diverge. For example, will the mandate to control costs for society's good overrun a patient's decision (on religious or moral grounds, or purely out of self-preservation) to use technology to live in whatever form that life takes place?[43] Can we value personhood and quality of life to override a patient's wish to receive the benefits of technology when they are not "worth" the cost? When a patient either expresses, or cannot express, the will to live rather than die in this era of cost containment, "to what extent are physicians required to furnish access to health care regardless of resource constraints?"[44]

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40. OFFICE OF TECHNOLOGY ASSESSMENT, LIFE-SUSTAINING TECHNOLOGIES AND THE ELDERLY 145 (1987) ("Since the need to change society's standard in order to allow mercy killing to relieve pain and suffering is uncertain, and since such a change presents potential dangers to society through abuse, decline of trust within medical relationships, and the threat to the principle of nonmaleficence that prohibits killing, there do not appear to be sufficient reasons to change the prohibition against killing.").

41. SMITH, *supra* note 5, at 302; *see also National Conference on Birth, Death and Law*, 29 JURIMETRICS J. 403, 432 (1989) (The conference "concluded that *it should be lawful, under certain circumstances, for a physician to assist a patient who chooses to end his or her life by the introduction of a lethal agent.*").

42. *See, e.g.*, JOHN L. MOTHERSHEAD, JR., ETHICS: MODERN CONCEPTIONS OF THE PRINCIPLES OF RIGHT 241 (1955) (critiquing utilitarianism as an ethical theory because of its tendencies to mimic egoistic hedonism, naturalism, and intuitionism).

43. *See* Matthew R. Gregory, *Hard Choices: Patient Autonomy in an Era of Health Care Cost Containment*, 30 JURIMETRICS J. 483, 484 (1990) ("Once the doctor has disclosed all treatment possibilities, including those she has ruled out, because the costs outweigh the benefits in her judgment, the patient may well demand additional treatment notwithstanding the doctor's recommendation.").

44. Maxwell J. Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?*, 25 CONN. L. REV. 349 (1993), *reprinted in* 176 SPECIALTY L. DIG.: HEALTH CARE L. 9, 12 (1993). Mehlman argues that, although "these cost containment efforts may be designed to achieve a societal goal of reducing health care costs, they impact directly on patients by creating the risk that physicians will withhold

Although Smith and others no doubt would respond that "[r]ational people would not want their insurance to cover every last ounce of beneficial and desirable care,"[45] the questions remain and are perhaps unanswerable as a rule.[46] Perhaps, too, the more important question is who will decide—a doctor, a judge, a legislator-and how will that decisionmaker go about making his decision?

In chapter three of his book, Smith answers that question in part by providing a framework for principled decisionmaking in a relatively new organization within the hospital: the ethics committee.[47] Although he envisions the limited use of ethics committees,[48] he also extends the traditional advisory concept of an ethics committee to encourage a model that assists patients in exercising their rights of self-determination by petition to an ethical tribunal comprising "a wide sampling of independent individuals." The tribunal has the power, after applying substantive standards and employing procedural safeguards, "to *decide* the issue before it [:]" whether a patient may "be assisted in ending his life."[49]

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beneficial medical services." 176 SPECIALTY L. DIG.: HEALTH CARE L. at 11; *see also* PRESIDENT'S COMM. FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 95-100 (1983) (Although society "is not obligated to provide every intervention that the patient or provider believe might be beneficial," the Commission advocates first the development of rationing principles generally, which may later be applied "to issues at the end of life.") (footnote omitted).

45. Robert M. Veatch, *Physicians and Cost Containment: The Ethical Conflict*, 30 JURIMETRICS J. 461, 466 (1990).

46. *Compare* SMITH, *supra* note 5, at 32 (arguing that the physician's role as a *de facto* gatekeeper "presents no real conflict with the patient's good; for not only are economics and ethics in congruence, but also are individual and social good as well as the doctor's and patient's interests") (endnote omitted) *and* George P. Smith, II, *Biomedicine and Bioethics: De Lege Lata, De Lege Ferenda*, 9 J. CONTEMP. HEALTH L. & POL'Y 233, 243 (1993) ("Under proper conditions, the principle of respect for autonomy can be overridden or infringed upon.") *and* Tom Tomlinson & Howard Brody, *Futility and the Ethics of Resuscitation*, 264 JAMA 1276, 1277 (1990) ("Actions that do not contribute to [the good of the patient] are not morally required.") *with* Dieter Giesen, *Vindicating the Patient's Rights: A Comparative Perspective*, 9 J. CONTEMP. HEALTH L. & POL'Y 273, 306 (1993) (describing the general role of doctor as "increasingly seen as one of assisting the patient in the exercise of his rights") *and* Robert M. Veatch & Carol M. Spicer, *Medically Futile Care: The Role of the Physician in Setting Limits*, 18 AM. J.L. & MED. 15, 36 (1992) (arguing that a physician has a duty to treat in spite of his conscience).

47. *See* PRESIDENT'S COMM. FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS app. F (1983).

48. SMITH, *supra* note 5, at 74.

49. *Id.* at 66 (emphasis added).

Of the several alternative models of principled decisionmaking,[50] Professor Smith shuns the ephemeral for the concrete. He endorses a utilitarian model based in substantial part on the principles of cost-benefit analysis.[51] This principle and the guidelines used by such a committee are not absolute, however, because "[l]ove, compassion and humaneness should perhaps be the primary constants in all deliberations of a hospital ethics committee."[52] In the best of all possible worlds, Smith endorses the proposal of Professor John C. Fletcher, which establishes an ethics committee as but one component of a total hospital ethics program that not only resolves clinical care dilemmas but also provides "on-going educational and ethical consulting services."[53]

Chapter four, entitled "Informed Decisionmaking," is not so much a proof of Professor Smith's theorem as a means of effectuating on a micro-level the goal of minimizing human suffering and maximizing the social good. Since patients have the autonomy to decide their destiny,

> [the] information disclosed must be complete, clear and understandable in the patient's own language so that he is thereby allowed to know not only the nature of his illness, its prognosis and the alternative modes of treatment together with their cost and probabl[e] effectiveness, but [also] the levels of discomfort and side effects on the ultimate quality of life.[54]

In his analysis, Smith distinguishes between lay and professional standards of informed consent (recommending the latter),[55] and describes the ethics of human experimentation in prisons and under the auspices of institutional review boards, fetal consent, proxy consent, and informed refusal. Although the absence of a normative conclusion to this chapter left it incomplete under Smith's overarching theory, the descriptive and normative elements of each subpart, especially its discussion for judges and lawyers dealing with informed consent claims before juries,[56] serve as

50. *Id.* at 68-70 (Teleological, Deontological, Personalistic, and Integrative).

51. *Id.* at 70 ("Under the utilitarian model, the controlling premise is that an act is good and meritorious if it promotes an increase of pleasure or good over pain for a majority of members in a defined community.").

52. *Id.*

53. *Id.* at 72.

54. *Id.* at 81.

55. *Id.* at 87 ("The wiser approach to develop here would be to acknowledge the standard for medical acceptability as being based solely on the perception of the reasonable practitioner.") (endnote omitted).

56. *Id.* at 87-89. For example, he notes that, before juries, the signature of a patient on the consent form is frequently determinative, *id.* at 89, when in fact the "participatory moral agency" between physician and patient focuses on "disclosure of all those levels of

strong process-based support for achieving Smith's utilitarian goals. Furthermore, Smith perceptively points to the often overlooked moral obligations of the patient himself, principally to be truthful and faithful to his health care provider.[57] Hence, Smith aptly recognizes that with the patient's rights of autonomy and self-determination come corresponding duties and obligations.

In his discussion of informed consent, Smith further provides both an excellent discussion of the ethics of human experimentation in therapeutic, nontherapeutic, and mixed settings and a concise presentation of "the conundrum of whether it is necessary to disclose to the patient that an experiment is being conducted and the very nature of the experiment itself."[58] Although Smith describes as "unquestioned" the duty to obtain informed consent in mixed therapeutic and nontherapeutic experimentation, Smith's utilitarian theory neither addresses nor balances whether the principle of beneficence can override the principle of autonomy in randomized clinical trials that inexorably place the goals of research and potentially greater societal benefits at odds with the patient's autonomy.[59]

Consistent with his thesis, Professor Smith provides concrete guidance in other areas and debunks several myths he sees recurring within the contemporary evolution of bioethics and the law.

For example, Smith sees embryonic and fetal experimentation, "pursued as such in a reasonable and humane manner,"[60] as a necessary in-

information necessary for the patient to make a valid choice and genuine consent to surgically invasive or non-invasive medical treatments." *Id.* at 81. Perhaps, Professor Smith therefore believes that consent forms only should be considered nondispositive evidence of consent under all of the circumstances.

57. *Id.* at 82.

58. *Id.* at 90.

59. For example, Robert Veatch has, on the theory that the principle of beneficence can never override the principle of autonomy, stated that "it is never acceptable on grounds of scientific need to withhold preliminary data that persons would reasonably want," unless the patient agrees in advance. ROBERT M. VEATCH, THE PATIENT AS PARTNER: A THEORY OF HUMAN-EXPERIMENTATION ETHICS 11, 152 (1987). Smith does, however, critique the medical profession for its failure "ethically to use placebo trials . . . on AIDS patients." SMITH, *supra* note 5, at 98. *See generally* ARNOLD J. ROSOFF, INFORMED CONSENT: A GUIDE FOR HEALTH CARE PROVIDERS 257-64 (1981) (advocating the need for informed consent and special constraints on human experimentation); FAY A. ROZOVSKY, CONSENT TO TREATMENT: A PRACTICAL GUIDE 117-22, 570-76 (2d ed. 1984) (placebo trials and statutory precedent in human research); ARTHUR F. SOUTHWICK & DEBORA A. SLEE, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 369-73 (1988) (informed consent for innovative therapy, medical research, or experimentation).

60. SMITH, *supra* note 5, at 115.

strument of medical research and progress with a goal "to correct [costly] genetic anomalies or prevent subsequent disease through actual surgical intervention."[61] While noting the often overlooked Nuremberg Code[62] and the Uniform Anatomical Gift Act in discussing the ethical imperative on physicians and researchers to obtain the separate and informed consent of women who decide to abort and then donate the fetal tissue,[63] Smith concomitantly debunks the entire notion that fetal transplants will have an impact on the abortion decision.[64]

By examining the crux of society's inertia and "evaluating the very real dangers of *not* undertaking research in the first instance,"[65] Smith argues that, for the maximization of the social good, "it is ethically acceptable to use tissue from abortuses for research" under controlled and ethically rigorous guidelines,[66] such as those issued in a report by the Stanford University Medical Center Committee on Ethics.[67] As a metaphor for his philosophy on scientific intervention in whatever form, Professor Smith sees such research as a necessary vehicle to minimize human suffering and to maximize "sustained qualitative living within reasonable cost restraints."[68]

Similarly, in chapter seven, entitled "Procreational Restraints," Smith recounts the economic and social costs of genetic disease on a society with limited resources. Smith argues that, when the procedure is "truly voluntary"[69] and analyzed rigorously, sterilization may be an effective intervention when balancing social externalities and economic costs with reproductive rights.[70] To avoid impersonal and unnecessary judicial in-

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61. *Id.*

62. *See* George J. Annas, *Mengele's Birthmark: The Nuremberg Code in United States Courts*, 7 J. CONTEMP. HEALTH L. & POL'Y 17 (1991).

63. SMITH, *supra* note 5, at 117, 120-21.

64. *Id.* at 120-21 ("In the total array of real reasons that lead a woman to abort a pregnancy, fetal transplant donations will remain of very dubious 'significance.'") (endnote omitted).

65. *Id.* at 129.

66. *Id.* at 127, 130; *see also* Daniel J. Garry et al., *Are There Really Alternatives to the Use of Fetal Tissue from Elective Abortions in Transplantation Research?*, 327 NEW ENG. J. MED. 1592, 1592, 1595 (1992) (arguing that there are no reasonable alternative sources of fetal tissue for transplantation research other than that obtained from electively aborted fetuses).

67. SMITH, *supra* note 5, at 122-23, 130.

68. *Id.* at 130.

69. *Id.* at 171.

70. *Id.* at 186 ("A case-by-case or situational ethic will, of necessity, guide decision makers rather than blanket prohibitions either for or against sterilization."); *see also id.* at 210 (After examining a wealth of Supreme Court precedent, Smith concludes that "'pro-

terference with these decisions, Smith too sees the parent-guardian and the family as the person or vehicle "most able and responsible to protect and advance the best interests of the mentally handicapped or incompetent,"[71] with the attending physician as the check on familial abuse of discretion.[72]

For those lawyers and judges who believe that scholars often overlook the practical arena in which the law operates, chapter six, entitled "Wrongful Life or Wrongful Birth," is remarkable. After examining the commonalities among these causes of action,[73] Smith recommends an ordinary action in negligence filed by the family, which neither "ignore[s] causation issues" nor requires "doctors to employ every available diagnostic test."[74] In this area of the law, Smith prudently considers the costs of defensive medicine[75] and liability insurance[76] that inevitably increase as a result of these causes of action and the benefits of recovery to the family "confronted with the sad but unfortunately true fact that life in an impaired state is, in extreme circumstances, wrongful."[77]

In chapter eight, titled "Surrogation," Smith criticizes the family courts of this country for their singlemindedness in failing to provide "an accurate assessment of the child's best interest" and for their failure to assess

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creative autonomy includes both the right to remain fertile and the right to avoid conception,' but nothing more.") (endnote omitted).

71. *Id.* at 186 (endnote omitted).

72. *But see, e.g.*, Recent Case, 105 HARV. L. REV. 1426, 1426, 1429 (1992) (The court in *In re* Lawrance, 579 N.E.2d 32 (Ind. 1991), "failed to recognize that families and physicians making termination decisions may not always take the best interest of the patient into account or may place too much emphasis on factors other than the patient's best interest.") (footnote omitted).

73. SMITH, *supra* note 5, at 160 ("When viewed together, claims of wrongful life and wrongful birth are basically identical." (endnote omitted)); *see also id.* ("Moreover, in both actions, the monetary result is usually the same—either an infant or his parents recovers money for medical costs.") (endnote omitted).

74. *Id.* at 160-61.

75. "In order to avoid subsequent malpractice suits, the doctors — in turn — will practice 'defensive medicine' thereby raising the frequency in which both genetic counseling and prenatal testing are utilized in cases when they would not otherwise be used." *Id.* at 156; *see also id.* at 161 ("Thus, to avoid the costs associated with defensive medicine, courts should not require doctors to employ every available diagnostic test, and further, should carefully limit damages in order to discourage doctors from haphazardly recommending abortions just because they fear liability.").

76. "Those physicians who do remain will be forced to pass along the costs of higher malpractice premiums to their patients in the form of higher fees." *Id.* at 156 (endnote omitted).

77. *Id.* at 160. Perhaps in this area, as well as others described by Smith, the attention of state legislators is required. *See id.* at 215 ("The legislative branch of government is far better equipped to deal with [surrogation] than the executive or judicial branches.").

"adequate care for the child" in the final surrogation decision.[78] Smith thereby debunks the familiar popular emphasis on "extra-constitutional *moral* and *political* norms" in the deliberative process and focuses instead on deriving a "*practical* rule" from the legislative morality expressed in a statute.[79] This is accomplished with a marked emphasis not on parental tribulations but rather on "the assurance that the child's health and development will not be jeopardized or indeed compromised."[80] To implement this goal, Smith employs his situational balancing test[81] and recognizes that, "[i]f the goal of law is to maximize the welfare or utility of all human beings, a prima facie case could be posited for according children some measure of legal protection against their parents."[82]

Although Professor Smith recognizes and endorses the benefits that can be derived by infertile couples through the use of surrogation and new reproductive technologies, he also emphasizes "the risks of abuse inherent in the 'solution.'"[83] He minimizes those risks by focusing on the values and *duties* owed by individuals and society to the endeavor of bringing life into this world. Paramount among these are protecting and promoting the best interests of the child.[84] Bravo!

In chapter nine, entitled "Fetal Abuse," Smith continues this theme by describing the shocking potential (or reality) of the creation of a "bio-underclass:"[85] babies who emerge from the womb and suffer "irreparable dysfunctional development" as a result of their mothers' addiction to drugs or alcohol. Because by one estimate 375,000 babies have been exposed to drugs in the womb,[86] Smith takes a no nonsense approach to fetal abuse and supports the emerging trend among states to abolish the doctrine of parental immunity.[87] Indeed, Smith recognizes that "[t]he law

78. *Id.* at 199.
79. *Id.* at 202 (endnote omitted).
80. *Id.*
81. *Id.* at 200 (listing factors).
82. *Id.* at 200-01 (endnote omitted).
83. *Id.* at 220.
84. *Id.* at 219 ("Although I find nothing abhorrent with the development of legislation validating surrogate contracts, I find a greater comfort in having the court seek a reasonable balance of competing interests in determining where the disputed child's best interests may be assured and protected."); *see also* Cynthia L. Gallee, Comment, *Surrogate Mother Contracts: A View of Recent Legislative Approaches*, 25 J. HEALTH & HOSP. L. 175, 179 (1992) (endorsing the Uniform Status of Children of Assisted Conception Act because it "will avoid uncertainties in the law and protect the best interest of children born as a result of advances in reproductive technology").
85. SMITH, *supra* note 5, at 235.
86. *Id.* at 243.
87. *Id.* at 236, 239.

must respond by imposing liability for such actions — preferably re-education and rehabilitation [of mothers]; but, in certain cases, civil damages, imprisonment and eve[n] sterilization."[88] In his analysis, Smith debunks both the notion that such liability will spawn a prenatal police force[89] and the notion that a woman who "*knowingly* jeopardizes or even permanently injures her fetus"[90] is anything more than a biological conduit who ignores the "honor *and* responsibility" of motherhood.[91]

In order to avoid the societal disregard of "the coordinate responsibility attendant to the procreative right of autonomy under the guise of the prenatal immunity doctrine" and the resulting debasement (or perversion) of "the whole status of motherhood, the family, and thus, society,"[92] Smith advocates the use of section 895(G) and Comment K of the Second Restatement of Torts "together with the utilization of a simple balancing test."[93]

CONCLUSION

In *Bioethics and the Law*, Smith succeeds in making his collection of essays accessible both to those already initiated into the challenges of the twenty-first century and to those, like this reviewer, who are suffering from some antiquated conceptions about bioethics. Indeed, in the discussion of surrogation, the reader will learn the alarming fact that, "[w]ith the startling new advances in reproductive technology, or what has been termed 'collaborative conception,' it is now possible for a child to have up to five 'parents': an egg donor, a sperm donor, a surrogate mother who gestates the fetus and the couple who actually raises the child."[94]

The text, moreover, is both descriptive and normative, and the

88. *Id.* at 236; *see also id.* at 244, 247-48 (discussing the possibilities (and side effects) of Norplant in the sterilization decision).

89. *Id.* at 236, 244.

90. *Id.* at 246.

91. *Id.* at 247; *see also id.* at 246 ("The level of personal dignity accorded each member of society is contingent upon a level of full membership in a moral community — for the social contract each has within that community creates duties and obligations and a level of responsibility upon breach of that agreement.") (endnote omitted); *id.* at 236 ("Just as general obligations are imposed upon all individuals to refrain from harming infants after their birth, so too must society impose similar obligations [t]o assure that a mother's prenatal actions are consistent with this duty to protect children.") (endnote omitted).

92. *Id.* at 246.

93. *Id.* ("The gains to the child [and future children] would be weighed against the harm to the child's mother as a consequence of adopting such a policy.") (endnote omitted).

94. *Id.* at 197.

endnotes provide a comprehensive source for scholars, judges, lawyers, doctors, and nurses mired in one of the many situational dilemmas presented.[95] Although the emphasis of *Bioethics and the Law* is on the interaction between law, ethics, and science, Smith does not neglect religious[96] and policy (i.e., political)[97] issues, demonstrating his sensitivity, thoroughness, and pragmatism. *Bioethics and the Law* is therefore useful and thorough for the general reader of contemporary medical ethics who desires both a critical and topical examination of them. It is, in addition, a valuable text for students to supplement the standard case book, for it will no doubt prove provocative. Finally, *Bioethics and the Law* has both a concise and sustained thesis, which is the mark of a truly integrated work, and, as such, should be read and used by lawyers, judges, legislators, doctors, and nurses not only for its intellectual creativity[98] and honesty but also for its laudable concern for both individuals and society confronting the present (and forthcoming) biomedical dilemmas of the twenty-first century. As Donald G. Casswell, Professor and Associate Dean of the School of Law at the University of Victoria, stated: "His book deserves a place on the shelf of anyone seriously interested in the new biology."[99]

95. The reader will undoubtedly be impressed with the wealth of American and international scholarship, statutes, case law, and press articles contained in this volume. By my estimate, the endnotes number over one hundred pages.

96. *See, e.g., id.* at 94-96 (religiously motivated refusals); *id.* at 128 (although it is a "legitimate act of faith to postulate that fetuses are persons . . . there is no absolute way to prove or establish its validity."); *id.* at 156-57 (wrongful life and wrongful birth).

97. *See, e.g., id.* at 126 ("What is seen very clearly here is the inextricable relationship between abortion and fetal research and experimentation and—even more importantly—a similar inextricability between politics and morality.") (endnotes omitted); *id.* at 97 ("Even today, patients and their physicians—as well as political leaders—continue to press harder for even more rapid testing and approval of investigational drugs.") (endnote omitted); *id.* at 214-15 (describing as constitutionally proper and in the child's best interest a state's limitation on artificial insemination and surrogation to married, consenting couples).

98. For example, based upon his expertise and teaching in property law, Professor Smith proposes an intradisciplinary approach to deal with cryonic suspension before death: namely, a modified wait-and-see doctrine which would allow a person "in state of cryonic suspension twenty-one years without fear of being pronounced dead," at which time a court would determine, upon settling the estate, whether the state of medical art reveals a possible or feasible cure for the disease. *Id.* at 269-70.

99. *Id.* at back bookcover.