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BOOK REVIEW


Bernard M. Dickens*

George Annas is America’s preeminent medico-legal analyst and commentator whose penetrating vision places contemporary health care incidents within evolutionary frameworks. His latest book, Some Choice,¹ the fourteenth in a sequence of books written, co-authored, or co-edited by him, will maintain and probably enhance his status as the benchmark commentator. No topic of medico-legal interest is considered of actual or potential significance until it achieves his attention. The title Some Choice points to the gravity and profundity of decisions made in clinical and public health care. But more often the work is a pithy reaction to the dilemma confronting decision makers who have no real choice at all, except to select between options that are either bad or worse, or to succumb to the frustration felt by those most affected by decisions, the exact ones who have no power to influence them.

The book possesses the many strengths, and the few weaknesses of its origins in articles that George Annas has previously published, primarily in the New England Journal of Medicine. For those both unfamiliar and familiar with the regular “Legal Issues in Medicine” featured in the New England Journal of Medicine, it is convenient to have so many incisive analyses of recent developments and events, updated when necessary, newly synthesized into a book. Most of the articles are sufficiently durable to retain their significance for some time to come, although one or two include a volume of detail that readers may now find secondary to the underlying enduring themes. The book’s subtitle, Law, Medicine,

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"and the Market," alludes to its focus on the impact of commercial profit incentives on patient-centered health care. Annas often finds that such profit uncertainties limit the choices promised by the rhetoric of free market enterprise.

The book's twenty-two chapters are divided into six sections. The first four chapters constitute Part I, entitled Market Choices. Chapter One, Choice's Echo, uses the approaching possibility of human cloning to illustrate the necessary limits of choice, and how boundaries imposing on market initiatives may be justified by choice. Annas ranges from classical mythology, to literature, to constitutional theory, to the modern frontiers of biotechnological knowledge in explaining why proposals to clone a human being from the cells of a pre-existing person are dysfunctional and ethically unacceptable. He argues that such cloning should be administratively prohibited and legally condemned, both nationally and internationally. He distinguishes human reproduction, which he acknowledges enjoys constitutional protections, from replication. By characterizing cloning as replication, and by inviting comparisons between the original person and the replicated person, Annas demonstrates that cloning is a violation of human dignity and devaluation of human life and thus warrants no legal protection. Annas would apparently tolerate individual twinning by splitting an extracorporeal human embryo, but only if the twinned embryos are implanted in utero at the same time. This would prevent the birth of "delayed twins," which he observes to be at the center of the cloning controversy.

George Annas is rarely less than vehement in his disapprovals, which may explain why he justifies them so scrupulously. Nevertheless, in his conviction that the prospect of the cloned baby must be thrown out, he may risk throwing out valuable bathwater with the baby. Although Annas distinguishes induced twinning of an embryo for contemporaneous implantation in utero from cloning, in the hope to improve the efficacy of in vitro fertilization, there is no obvious case to be made for replication of a person from the cells of one previously born. If cloning of a person's cells can be selectively refined, however, to produce tissues or organs for which the person has a therapeutic need, such as neurons to counter Alzheimer's disease, cardiac tissues for heart attack victims, or kidneys for transplantation, health benefits can be achieved with no threat or insult to human dignity. Annas launches a skillful attack against cloning the cells of one person to produce another. However, he might want to avoid the risk of collateral damage to research, including
cloning techniques that would relieve individuals’ suffering through development of restorative substances from their own cells that are quite different from and significantly less than a creation of their genetic twin. Creation of pluripotential or totipotential embryonic stem cells appears to be a scientific precondition to such new therapies, but biotechnology has the potential to allow scientists to leave the pathway to cloning of a full person, at a very early stage, in order to induce cellular differentiation that results in growth of only the targeted therapeutic tissues. Incentives for promotion of stem cell research may have commercial potential, causing researchers to seek out venture capitalists and intellectual property attorneys, so that research towards therapeutic cloning may quickly become a major issue in the interaction of law, medicine, and the market.

The second chapter, entitled Women and Children First, addresses and criticizes how the interests of women and children have been sacrificed, notably by the financial encouragement of drive-through deliveries, and the goals and material ambitions of market-oriented managed care medicine. Annas explains that the issue rose to national visibility, and legislative correction, when the disadvantage resulting to women and children went beyond those who were poor and politically powerless and reached insured, middle-class women, and families. He further explains that the legislation is more symbolic than substantive as an overall contribution to health. It serves primarily to warn marketplace medicine and managed care that failure to establish a common guaranteed minimum benefit package for all subscribers that encourages health plans to compete on the basis of quality of care, rather than to confine choices to forms of substandard care on the basis of cost alone, will invite further legislative interventions.

Resolution of managed care disputes and appeals is addressed in Chapter Three, entitled Exit, Voice, and Choice, which examines the class action suit on behalf of the Medicare members of a health maintenance organization (HMO) decided in Grijalva v. Shalala. The need for patients’ complaints regarding denied coverage by influential judicial and other tribunals is particularly acute when patients are effectively confined to a particular managed care plan, or when alternatives accessible to them offer no better coverage than the basis for their complaints.

That is, they have neither voice nor choice in the coverage available to them and cannot leave for a superior HMO. The claim in Grijalva was that HMOs were violating federally mandated provisions regarding procedures for appeals against refusals of coverage for them, and that the Department of Health and Human Services (HHS) was not enforcing the provisions.  

Annas explains and explores the legal means by which patients' complaints against private health care entities engage government, and so become subject to constitutional due process standards. He then lays out the basis on which the judge concluded that HHS had violated federal law by contracting Medicare coverage with HMOs that failed to meet constitutional due process requirements on notices of denied coverage and the conduct of hearings.

The Grijalva Court identified detailed rules by which the Medicare beneficiaries enrolled in HMOs and were entitled to have claims resolved. These rules were generally reflected in the HHS final rules for an expedited review process. Drawing on the evolution of these rules, surrounding litigation and unaccommodating HMO practices, Annas observes that "[a]ll patients, not just Medicare patients in HMOs, should have legally established grievance and appeal rights." From a Canadian perspective, this appears sensible and familiar, but a novel, or at least emerging, perception to find in the U.S. resistance to Canadian-style, government-sponsored, universal health insurance. The U.S. resistance has been based on a variety of grounds, underlying many of which is suspicion of big government, bureaucracy, and intrusion into the doctor-patient relationship. The regulatory and remedial role of government, reinforced by political accountability, does not necessarily ensure the promptness or sympathy of response that all Canadian claimants demand, but it ensures that denials of coverage are easily contestable and open to judicial, and particularly, administrative and governmental scrutiny.


4. See id. at 749.
6. See ANNAS, supra note 1, at 41.
and incorporates classical and modern literary analogies and allusions into much of his writing. Sharply aware of the power of language, he shows how the choice of metaphors to describe medical approaches to illness not only reflects predisposing attitudes, but can induce the distortion that transforms the metaphorical into an operative reality. Medical practitioners who invoke, for instance, military metaphors to mount a "war" to "battle" disease and "fight back" against the "attack" of infection are drawn into the desperate extremism and myopia characteristic of action compelled by the struggle for survival, such as the "total war" concept that justifies devastation of non-combatant targets. Priorities of the "fighters," their sense of proportion, and their will to suffer and impose immense costs become concentrated on the urgency to win the war, to overcome resistance, and to conquer the invader. Fear of extravagance in the deployment of available weapons is no constraint, the requisition of weaponry from a distant theatre of conflict to fight the war immediately at hand is necessary or at least justifiable, and sacrifice of some non-combatants, though regrettable, is not excessive under pressure of medico-military combat.

Perhaps even more transformative than the medicine as war metaphor, Annas finds, is the medical care as market service metaphor. Patients become consumers or purchasers, health care professionals become health service providers, and the calling to cure and care for the sick becomes a market opportunity for profitable service and product promotion and exploitation. Providers to markets satisfy "wants" rather than needs, have incentives to promote "wants," and serve those able and willing to pay, favoring service to those able to pay more over service to those able to pay only modestly. The market contains neither the commitment nor the constraint of the Hippocratic ethic. Positive market attributes such as efficiency and customer satisfaction can benefit both patient care and rational institutional deployment of scarce resources. However, the rationale of deployment may be shaped by other market goals such as profit maximization and outwitting or disadvantaging competitors, which can be contrary to the public interest. More significantly, inaccessibility of markets to those too poor to buy into them seems inimical to the high calling to which medicine has aspired. George Annas prepares the ground for arguing his promotion of his preferred metaphor, the ecology metaphor, which he associates with such words as integrity, balance, natural, limited (resources), quality (of life), diversity, renewable, sustainable, and stewardship.
Part II of the book addresses *Treatment Choices* through five chapters. The first of these, Chapter Five, entitled *Cancer, Prognosis and Choice*, contrasts familiar legal doctrine on the significance of patients’ informed and free consent to treatment against widespread instances of physicians not informing patients of facts in their possession that are material to the choices that have to be made. Relatively few of these instances result in malpractice litigation. Annas employs and criticizes the Supreme Court of California’s judgment in *Arato v. Avedon*\(^8\) to explore the nature of the physician’s legal duty of appropriate disclosure, and how the Court applied the duty very narrowly to find that the plaintiff had been informed.\(^9\) On the more critical patient-oriented reading of the facts presented by Annas, the choice was uninformed and illusory.

A theme introduced in Chapter Five is elaborated on in the following chapter, entitled *Culture, Economics, and Choice*, which compares and contrasts different cultural approaches to death and health service expenditures, particularly on care for terminal patients, in the U.S., Britain, and Japan. The former chapter contrasts the medieval European ghoulish fascination with death with the modern American culture of death denial, which celebrates the costly technology that forestalls death. Chapter Six contrasts the decline of both the British Empire and Imperial Japan at the end of the Second World War with ascendency to world dominance of the more egalitarian United States, on the strength of death-producing atomic technology. Annas observes, however, that during the following half-century, and particularly since the triumphant end of the Cold War, the U.S. has concentrated attention on death-defying technology. Decisions about patients’ care tend to be made within the physician-patient relationship, under the influence of information the physician gives the patient. Physicians’ reluctance to inform patients that their prognosis is unfavorable and that imminent death is in prospect, that proposed treatment has a low chance of prolonging life, and that the treatment suffers from considerable scientific uncertainty, may result in decisions to administer expensive treatments that will in fact have little beneficial effect on longevity. Much turns, therefore, on physicians’ legal duties of disclosure of prognosis, and statistical chances of patients’ survival after administration of proposed treatments.

In the U.S., the concept of “informed consent” evolved in order to

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8. 858 P.2d 598 (Cal. 1993).
9. See id. at 599-600.
promote physician-patient shared decision-making. This should allow patients to decline interventions and other proposed treatment they disfavor. It should also allow physicians to decline to offer options that appear contraindicated or futile, although the ultimate choice among alternative treatments rests, in principle, with the patient. Missing from the U.S. choice system is a general right to be a patient for those ineligible for government aid, or an employer’s cover, and unable to meet costs by other means for non-emergency care. Under the U.K. National Health Service, universal care is available, but under governmental budgetary constraints. These constraints accommodate less patient autonomy than U.S. law allows to patients. Indeed, the highest court has rejected the concept of informed consent, believing it to be only a “transatlantic doctrine,” notwithstanding its vigorous presence across the English Channel in France, Germany, and elsewhere in Europe. British physicians need give only the information that other physicians would give.

Japan has universal health care modeled on the German employment-based system, and a strong German influence in its law, but does not follow German influence regarding informed consent, despite the efforts of the doyen of its medical lawyers, Professor Koichi Bai. An interesting feature of Japanese culture reflected in its law is that legal duties of disclosure can be satisfied by disclosure to patients’ family members when no information is provided to patients themselves. This is consistent with the observation that “[a]utonomy ... is out of keeping with the Japanese cultural tradition . . . . To be autonomous and independent is sometimes regarded as egocentric. Thus, in Japan, each hu-

14. Id. at 883.
17. See ANNAS, supra note 1, at 69.
man being is dependent on others in the family, and the social, economic and political communities.”

The second half of the chapter compares and contrasts different countries’ policies on terminal treatment expenditures and resource allocation. In Japan, patients’ options are severely limited by the style of medical practice, whereas in Britain, the government sets the limits. In the U.S., however, Annas finds that the position is little if at all better. He observes that “[t]he United States accords the highest status to informed consent in part because we engage in the fiction that patients actually exercise economic choice when they purchase medical services.” Notwithstanding any prevailing fiction, however, he concludes that “informed consent, especially regarding the truth about prognosis, may be the only way the United States can, consistent with cultural expectations about patient autonomy, limit the use of expensive and ineffective treatment at the end of life.”

Chapter Seven explains a court-ordered use of expensive and ineffective treatment to prolong a life without hope. This abuse of individual discretion appears so absurd and outrageous that one is driven to hope that the travesty of care was a judicial aberration. Entitled *Treating the Untreatable*, the chapter addresses the case of Baby K, an anencephalic infant whose mother refused a do-not-resuscitate order and insisted upon repeated ventilation initiated to relieve the respiratory difficulty the infant experienced several times after birth. The trial judge considered the issue almost exclusively under the federal Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA was enacted to prevent hospitals from refusing to treat persons in medical emergencies when they lack insurance or other means to pay for care. The U.S. Court of Appeals affirmed the judgment, in a two-to-one opinion, on the ground that EMTALA expressed no clear exception for respiratory distress. George Annas explains the many medical, counseling, ethical, and judicial errors that resulted in utterly futile care provided to Baby K for thirty months until the child died. Annas recom-

20. *Id.* at 78.
mends that physicians should set and observe standards for the treatment of anencephalic infants rather than pass the burden to judges to prescribe treatment standards on the basis of laws developed to address different purposes.

In Chapter Eight, *Outlawed Choices*, Annas turns from mandated care that is incapable of helping the patient, to prohibited care capable of providing a patient with relief from pain and distress. Whatever personal opinions may be held on marijuana for recreational use, Annas presents evidence that, when smoked, marijuana can be benign, effective, and non-addictive in management of serious illnesses, especially cancer and AIDS. With ties to his preceding chapter on national cultures and Chapter Four on the significance of metaphors, Annas shows how in the U.S., the “War on Drugs” brooks no accommodation of the enemy marijuana, and how the alleviation of suffering may be sacrificed for the cause of combat. Annas discusses legislative initiatives in California and Arizona that permit physicians to prescribe marijuana on medical grounds. Such initiatives have met resistance at high levels in both Republican and Democratic Administrations, and have encountered threats that heavy federal sanctions will be enforced against physicians who rely on any such legislation. Annas explores the legality of federal threats against physicians whose discussions with their patients contemplate use of marijuana, and the quality of evidence that is necessary to make the drug available by prescription. The prohibitive policy appears to be based on ideological rather than pragmatic grounds, however, it is not clear that it will yield to rationally interpreted evidence, nor learn the lesson of Prohibition’s legacy of organized crime and induced disrespect for law.\(^{24}\) Annas observes that “[d]octors are not the enemy in the war against drugs: ignorance and hypocrisy are.”\(^{25}\) He shows that both ignorance and hypocrisy are widespread in opposition to the legality of medical prescription of marijuana for patients with cancer, AIDS, and comparable conditions.

The final chapter under *Treatment Choices*, entitled *Genetic Prophecy and Genetic Privacy*, accepts that knowledge is power, and tackles the issue of control of genetic information. Individuals have no choice over their genetic inheritance, of course, and general gene therapy and en-

\(^{24}\) See NAT’L COMM. ON LAW OBSERVANCE AND LAW ENFORCEMENT, REPORT ON THE ENFORCEMENT OF THE PROHIBITION LAWS OF THE UNITED STATES 43-60, 91-98 (1931).

\(^{25}\) ANNAS, *supra* note 1, at 95.
hancement seem too remote to offer any foreseeable choice for change of inherited conditions. Individuals may, however, expect a choice with respect to control of their own genetic information. Creation of genetic databanks, and genetic tissue or DNA databanks poses an obvious threat to genetic privacy and confidentiality. Such databanks create the potential for so-called DNA fingerprinting and may prevent full anonymity. However, banking of genetic data and samples promises advances in public health science and in clinical awareness. For instance, patients may learn of their destinies if they remain untreated and of susceptibilities against which they can be protected. Popular reactions to medical data retention show greater concern with information getting into the wrong hands than with information not getting into the right hands. That is, concerns are more prevalent about misuse of data than about failures to employ available data to protect and promote clinical and public health.

George Annas explains why banking DNA molecules for future analysis presents novel privacy issues that merit widespread discussion. For instance, such samples may be tested for purposes that could not be imagined at the time they were given, and therefore, for which donors could not have given their consent. Increasingly precise genetic information may afford individuals more control over their life choices. Outsiders may obtain more influence over individuals by such means as discrimination and revival of eugenic stigmatization. For instance, Annas identifies a tendency of insurance companies to treat predisposition to genetically-linked disease as a disease in itself. Attention must accordingly be directed to medical records law and its effective enforcement, and to legal protection of genetic privacy. Further, as Larry Gostin emphasized, attention is necessary to human rights laws and the development of an atmosphere through which the practice of discrimination, on genetic and other grounds, is prohibited.²⁶

If benefits that counter the risks of genetic data and tissue banking are to be realized, medical researchers and epidemiologists must be able to inspect and protect their possession of genetic information in order to propose and test preventive interventions. In addition to new therapeutic interventions and strategies, studies may also include data that are not informative and information that ethically, should not be sought or given. For instance, parents should not acquire genetic data of their chil-

dren’s susceptibility to late-onset genetic disorders such as Huntington’s disease, since this knowledge might harmfully distort childrearing and the children’s choices among life preferences.

Illusory choices are the theme of Part III of the book, composed of five chapters. The first, Chapter Ten, entitled Choosing a (Healthy) President, traces the history of the erosion of the right of U.S. presidents, as well as presidential candidates and aspirants, to deny information of their health status to news media and the public. Indeed even without request, news media releases may be given of their periodic health check-ups as part of routine politics. The desirability of this level of public disclosure may be questioned, but prevention of the harmful domestic and international speculation about a leader’s health and mental capacity may appear to serve the public interest. Public availability of data may also serve to protect such reputation as political leaders enjoy. For instance, revelation of their DNA may provide means to disprove their alleged paternity.

Chapter Eleven explains the Johnson Controls case, in which a choice was finally made not to be entirely illusory. Under the title A Woman’s Choice at Work, the chapter traces the history of the Johnson Controls Company’s 1982 policy of excluding pregnant women and women who are capable of bearing children from jobs involving exposure to lead. This meant that the only ones eligible for these better paying jobs were those who had medical confirmation that they could not bear children. In 1984, a class action was brought under Title VII of the Civil Rights Act of 1964, as expanded by the Pregnancy Discrimination Act of 1978, alleging unlawful discrimination. Following federal district court and U.S. Court of Appeals judgments in favor of the company, the case reached the U.S. Supreme Court. The Court unanimously reversed the lower courts, finding that the pregnancy-based policy that allowed fertile men, but not fertile women, a choice to take reproductive risks in particular jobs was unlawfully discriminatory on grounds of sex. The Court found that Congress had left the children’s welfare to their parents, not their parents’ employers, and that the pro-

28. See generally id.
29. See id. at 192.
30. See id.
32. See Johnson Controls, 499 U.S. at 187.
33. See id. at 206.
tection that this employer’s policies proposed applied only to infants of female employees.\footnote{See id. at 206-07.}

Annas explores the legal differences in the reasoning of the judges, all of whom concurred in the decision, but reveals his special sympathy with the more widely-based dissenting opinion in the Court of Appeals by Judge Easterbrook.\footnote{See International Union v. Johnson Controls, Inc., 886 F.2d 871, 908 (7th Cir. 1989) (en banc).} Judge Easterbrook noted the strong correlation between infants’ health and parents’ means of affording medical care. He determined that denying women access to Johnson Controls’ better paying jobs may reduce risk to infants from lead, but also, more probably, would reduce the levels of medical care and quality of nutrition they would enjoy.\footnote{See id. at 918.}

Men’s employment is the inspiration of Chapter Twelve, \textit{A Soldier’s Choice}. George Annas is a leading scholar on the background of the 1947 Nuremberg Code on experimentation,\footnote{See generally GEORGE J. ANNAS & MICHAEL GRODIN, \textit{THE NAZI DOCTORS AND THE NUREMBERG CODE: HUMAN RIGHTS IN HUMAN EXPERIMENTATION} (1992).} which was drafted in reaction against inhumane experiments on human victims to further the German war effort before 1945. Annas is also a leading advocate of the Code’s legally binding character. One can easily understand his anguish on seeing the U.S. military seek a waiver of the Code’s basic principle of informed consent during the Gulf War against Iraq, known as Desert Storm. The Department of Defense proposed to administer investigational drugs and vaccines to soldiers without their informed consent, contrary to Food and Drug Administration (FDA) regulations on human experimentation. The Department requested and obtained FDA approval and accommodation through a new regulation of non-consensual administration, on the ground that informed consent under combat conditions is not feasible, and troop refusals of consent are not tolerable because of military combat exigencies.\footnote{See 21 C.F.R. § 50.23(d) (1998).} In district court, an activist group failed to enjoin use of the accommodating FDA regulation.\footnote{See Doe v. Sullivan, 756 F. Supp. 12, 15-16 (D.D.C. 1991).} The judge refused to contradict the assessment of the Department of Defense.\footnote{See id.} Annas explains the basis of the Court of Appeals’ judgments that ap-
proached the issue differently, but declined to find against the FDA or the new regulation.\textsuperscript{41} He notes that no consent is needed under military law to give soldiers treatment, but that experimental uses of some products in this case were not intended for treatment. He finds comfort and illumination, however, in the fact that, although the Department of Defense and two courts discounted the decision making right of soldiers, the field commanders in Desert Storm did not. They gave the troops information of a proposed experimental vaccine, and the right to refuse to receive the vaccine.

George Annas states that "[t]he United States is and should remain at the forefront of the worldwide human rights movement."\textsuperscript{42} Few if any countries pay higher respect to human rights in their domestic practices than the U.S., but any claim to worldwide leadership would be exaggerated. The sophistication and penetration of national legal systems achieved by the jurisprudence of the European Court of Human Rights,\textsuperscript{43} for example, should be acknowledged. Within the U.S. itself, the incompatibility between national wealth, personal wealth, and an estimated forty-three million people without health insurance indicates at best only casual or incomplete respect for human rights. In addition, the incompatibility between bipartisan political advocacy of limited government and states' powers of punishment by execution of intellectually handicapped defendants seems equally careless of human rights. This is so, particularly in light of a capital defendant's compromised rights of access to experienced counsel.

Internationally, withdrawal by the U.S. from appearance before the International Court of Justice in adjudication of Nicaragua's complaint over the Bay of Pigs invasion\textsuperscript{44} was an enormous set-back for hopes of settlement of international disputes by adjudication. This withdrawal demonstrated what human rights lawyers strive to oppose; namely that powerful agents can ignore, with impunity, calls for equal justice made by the less powerful and the powerless. In international human rights treaty law, the U.S. has failed and refused to ratify leading instruments, including the International Covenant on Economic, Social and Cultural

\textsuperscript{42.} ANNAS, supra note 1, at 137.
\textsuperscript{44.} See Judgment on Merits in Case Concerning Military and Parliamentary Activities in and Against Nicaragua (Nicaragua v. United States) 1986 I.C.J. 14 (June 27, 1986).
Rights, and the International Convention on the Elimination of All Forms of Discrimination Against Women. Somalia and the U.S. are the only countries not to have ratified the International Convention on the Rights of the Child.

The non-participation of the U.S. in the international agreement to ban landmines, and the isolation of the U.S. with six other countries from the 120 United Nations (U.N.) members that in 1998 supported establishment of a permanent International Criminal Court with jurisdiction over war crimes and crimes against humanity, fits a depressing pattern of functional disengagement that may result in the U.S. forfeiting its vote in the U.N. General Assembly (but not its Security Council veto) for non-payment of dues. The incentive of U.S. politicians to condition payment on U.N. conformity with their domestic political agendas, and U.S. constitutional reasons for non-ratification of international treaties, may be understandable within the arena of U.S. politics. However, the dominance of domestic priorities over U.S. international collaboration denies the U.S. a place “at the forefront of the worldwide human rights movement.” George Annas and his colleagues deserve and need support in their valiant and principled efforts to transform wishful thinking of U.S. participation in legal advancement of human rights into a reality.

Chapter Thirteen, Our Most Important Product, is an uncharacteristically journalistic piece that leaks minutes of a meeting of a top secret federal interagency group known as Perfect People. The chapter will not be reviewed here, but left as a surprise, or a lucky but frightening bonus, for those inspired by this review to read Some Choice. The chapter illustrates the meaning of the fashionable expression “value added.”

Chapter Fourteen is adapted from a critique of abuses in medical research first published in this Journal. Under the chapter title Plagued by Dreams, George Annas explains how conscientious hopes to find “a cure for cancer,” or for AIDS, can be exploited to open pathways to abuse of sick, desperate patients. He shows how much those who have “nothing to lose” have to lose. There is little in research, including innovative and unproven medical methodologies, genetic research, animal

46. ANNAS, supra note 1, at 137.
and human embryo manipulation and, pharmacology, that cannot be justified on the ground that it might discover "a cure for cancer." The duplicity he finds is both external and internal to investigators. Externally, they explain the humanitarian goals of their endeavors while pursuing them at a cost to human dignity and liberty. Internally, they convince themselves, often through linguistic sophistry, that their purposes are virtuous, and become blind and insensitive to the reality and risks of their methods. Annas traces ominous similarities between the exploitative outrages committed to serve the German war effort that were condemned at the Nuremberg War Crimes Tribunal, and secret nuclear studies conducted on behalf of the U.S. government compelled by fears of nuclear attack in the Cold War.

The Nazi doctors and more recent investigators have engaged in the doublethink that they are healers, while in reality they subjected vulnerable, often dependent persons to pain, indignity, false hopes, and more. Annas explores the inspiration and methodology of the Cold War Radiation Experiments, conducted by the U.S. federal government from the 1940s to the 1970s. He shows how investigators could justify, at least to themselves, injection of plutonium or uranium into terminally ill patients, irradiation of the testicles of prisoners to test its effect on their fertility and, exposure of nursing home residents to injection or unknowing ingestion of radium or thorium to measure its passage through their bodies. This was all done without the patients', prisoners', and residents' consent, and yet these investigators believed themselves different from, and superior to, the doctors properly vilified and condemned at Nuremberg. Annas contrasts the dismissive response to a 1986 House Subcommittee report on these experiments48 by the Reagan Administration with the dramatically different response to a 1995 report of similar radiation experiments49 received by the Clinton Administration. Annas explains these experiments in detail that is liable to cause shock, disgust, and disbelief. The President accepted the report, including its recommendations on apology and compensation, and created the National Bioethics Advisory Commission to advise the government on research with human beings and other bioethical matters.

Part IV of Some Choice addresses Toxic Choices, in four chapters. The first of these, Chapter Fifteen, titled AIDS and TB Choices, considers the contribution of human rights to public health values and strategies. Observing again the significance and steering effect of metaphor, Annas contrasts the “War on AIDS” concept that shaped a destructive, militarized HIV containment strategy that the U.S. pursued at its military base in Cuba, with the “human rights” inspired public health strategy applied to address tuberculosis (TB), including when TB is aggravated by the compromise of patients’ immune systems due to HIV infection.

Many Haitians fleeing by boat from gross human rights violations committed in Haiti under the military regime that seized power in 1991 arrived at the U.S. military base at Guantánamo Bay, Cuba. There, HIV tests were conducted, and refugees shown to be HIV-positive were housed, with no time set for their release, in prison-like conditions, subjected to severe discipline and denied the standard of medical care. The U.S. judicial condemnation of the injustices and human rights violations they suffered, resulted in releases from detention and admissions to the U.S.50 Annas hints that the arrival of HIV-positive refugees in major U.S. cities may have contributed in part to the revival of TB and the rise of multidrug-resistant tuberculosis especially among those with HIV infection.

Protection of public health and safety falls constitutionally under states’ police powers, and allows coercive measures, including mandatory reporting, involuntary detention in quarantine, and treatment. Nevertheless, exercise of police powers is subject to judicial scrutiny on human rights and civil liberties grounds, and public health officers usually prefer to act according to a medical, rather than a police model. This measure respects patient confidentiality, health education, and collaborative relationships. Mental health law analogies illustrate how balances are struck among public protection against demonstrable danger by involuntary detention, maximization of personal liberty, and patient encouragement to self-help under protective surveillance and minimized intervention. For instance, quarantine detention can be obviated when infected persons attend health care centers to receive directly observed therapy, which ensures that they take necessary medications on schedule throughout the therapeutically prescribed period.

The three remaining chapters in this Part deal with tobacco choices, tobacco product advertising, and lawsuits for tobacco-related illnesses. Chapter Sixteen explains the route of the *Cipollone* case\(^5\) to the U.S. Supreme Court, and the different opinions expressed there on tobacco company liability arising from a smoker’s cancer death claimed to be due to her addiction.\(^2\) The case is replete with procedural matters and narrow rules of statutory interpretation relevant to claims of the defendants’ failure to warn of harmful effects of their products, breach of express warranty, and fraudulent misrepresentation, including false representation and concealment of facts relevant to known effects of use of products on consumers’ health. The transcending difficulty for private plaintiffs that the case discloses, which influenced the decision to discontinue it, is persuading juries that their smoking was not a voluntary choice but induced by tobacco companies’ misrepresentations and concealment of material information of harmful effects of smoking.

Chapter Seventeen addresses the legal strategy developed to eliminate tobacco advertising to teenagers and significantly reduce it to adults. Containment of company-sponsored images such as the Marlboro Man and Joe Camel, employed to promote cigarette sales among adults and teenagers respectively, has now advanced, but first had to confront U.S. constitutional protection of free speech, including commercial speech. A country long committed to liberty of communication and to the maximally free play of market forces will understandably be unsympathetic to governmental suppression of advertisement of lawful products. Annas reviews details of FDA regulations designed to reduce demand for tobacco products among teenagers and underage smokers, the constitutional capacity of the FDA to regulate the tobacco industry, and First Amendment protections of commercial speech that the regulations affected. The distinction is noted between a ban on advertising products and regulation of advertising. Examples of advertising regulations are limiting size, location and color; for instance, allowing only black lettering on a white background since bright colors tend to attract children’s attention. A byproduct of restrictions on advertising and permissible image-making is the promotion of imagination, ingenuity, resourcefulness, and allusion in the advertising and sales-promotion industry.

The following chapter, *Smoking with the Devil*, describes how law-


\(^{52}\) See id.
suits drove the tobacco industry to make payments to state governments and limit advertising, in exchange for immunity from lawsuits and exposure to punitive damages. Students of civil procedure and litigation strategy, in particular, will appreciate this overview of the attack upon and defense of, the tobacco industry. Discovery of secret industry documents showing internal awareness of health risks of products and manipulation of nicotine levels to induce addiction compromised the defendants' denials of knowingly causing harm to consumers. Annas reviews the principles that define a class for purposes of initiating class actions, outlines the more significant state medical-cost reimbursement suits, and considers whether access to the newly discovered industry documents will revive individual smokers' lawsuits with greater viability than the Cipollone action possessed. This chapter provides a continuing basis for understanding the future development of legal proceedings against the tobacco industry brought by different claimants, and moves towards a politically negotiated global settlement. Annas does not disguise his frustration as a public health advocate, however, that so harmful a product is legally marketable, and that terms of a settlement are likely to protect its availability and profitable sale.

It is a short distance from these last three chapters on the tobacco industry to the three chapters that constitute Part V of the book, on Choices in Dying. In Chapter Nineteen, The Kevorkian Syndrome, George Annas sees beyond his earlier identification of the American death-denying culture to observe that, when death is faced, it is the process of dying in the impersonal modern hospital that is feared more than death itself. The movement towards assisted suicide and medically assisted death is seen to be a response that preserves individuals' autonomy and control over the circumstances of place, company, and time in which they die. The chapter reviews the origins of Michigan's legal attempts to prevent Jack Kevorkian from operating his suicide machines, which use drugs and carbon monoxide, in the state. Injunction, suspension of his medical license, murder charges and legislation temporarily criminalizing assisted suicide, the details of which Annas analyses, have proven ineffective to deter these activities. Annas takes the American Medical Association to task for failing to distinguish between the acts of Kevorkian and the lawful and ethical act of Dr. Timothy Quill,53 who prescribed medically indicated barbiturates to a terminally ill patient.

who said she might use them for suicide at an unspecified later time. Dr. Quill did not act with intent that his patient should die, or with intent to facilitate her suicide, but with intent to alleviate pain and suffering.

Jack Kevorkian is not proactive, but only reacts to those who seek his assistance. Why they do so Annas explains is due to failures in how medicine is practiced and terminal care given. In several states, initiatives have been taken to legalize medically assisted death or assisted suicide, which are described in Chapter Twenty, Oregon's Bloodless Choice. After reviewing Washington State's unsuccessful Initiative 119, favoring legal medical euthanasia, and California's equally unsuccessful death-with-dignity Proposition 161, the chapter addresses a measure that, following two earlier rejections in Oregon, was accepted in 1997, Ballot Measure 16. This is modeled on Dr. Quill's act of prescription of drugs and rejection of Kevorkian's means of facilitating suicide. However, Annas explains his view that both the control and the choice that the provisions of Ballot Measure 16 seem to offer may be illusory, and identifies several controversies enactment of the measure as proposed would fail to resolve. A key controversy is whether the measure achieves anything that is not already lawful. Annas explains that physicians legally may, and should, prescribe potentially lethal drugs that have an independent legitimate medical use to their terminally ill patients upon request, if they believe that use will allow the patients to live better. He fears that attempting to legislate this practice will create an erroneous impression that, in the absence of, or outside the terms of, new legislation, it is currently illegal. Federal opposition to Oregon's initiative is addressed in Chapter Eight, including threatened action against physicians who use regulated drugs with intention to induce death.

The final chapter in this Part and penultimate chapter of the book, Chapter Twenty-one, The Bell Tolls, addresses two U.S. Supreme Court decisions of 1997 reversing lower court decisions, and rejecting a constitutional right to medically assisted death. The decisions are consistent with an amicus curiae brief George Annas co-authored with a number of bioethics professors. The cases, initiated by Dr. Timothy Quill and a

54. See id. at 693.
pro-assisted-death group, argued that medically-assisted suicide by drug overdose has, or should have, the status of a constitutional right. The Supreme Court’s rejection of that claim clarifies areas of law that had been contentious by force of the unanimity of both judgments. Despite their emphatic nature, however, the judgments leave unresolved issues of what their full impact and meaning are. Continuing contention is perhaps inescapable, since the Supreme Court did not resolve conflicting priorities, between respect for the sanctity of human life, and for the quality of life, that divide adherents to pro-life and pro-choice positions regarding abortion. Many who give priority to life’s inherent sanctity oppose both abortion and medically assisted death, and many who prioritize individual choice on abortion approach assisted death in the same way. Arguments opposing one, but endorsing the other of these options, require clear explanation and distinction.

Annas reviews the lower court decisions that the Supreme Court reversed. The U.S. Court of Appeals for the Ninth Circuit invoked the constitutional right to abortion to support finding the same right to what it described as physician-assisted suicide. In the U.S. Court of Appeals for the Second Circuit, the subsequent decision of the court rejected this reasoning, but found a constitutional right by way of an analogy between the undoubted right to refuse treatment and a right to hasten death. Annas is sharply critical of both courts’ reasoning, and takes care to distinguish a false analogy he finds between assisted death and abortion. For instance, a physician’s right to perform abortion follows from a woman’s right to have one, but individuals have no recognized right to suicide, even though attempted suicide has been decriminalized. Further, abortion is a medical procedure, but medical qualification is not a precondition to assisting suicide.

The two U.S. Supreme Court judgments are addressed with more favor as Annas traces their grounds for rejecting the reasoning followed in the courts below. Several Justices gave concurring opinions, which Annas explores, but the common feature is that they all agree that no right to commit suicide is rooted in U.S. history and tradition, and that therefore, there is no right to give assistance. They noted in contrast the long

59. See Compassion in Dying v. Washington, 79 F.3d 790, 813-14 (9th Cir. 1996).
60. See Quill v. Vacco, 80 F.3d 716, 729 (2nd Cir. 1996).
history of prohibition of attempted and assisted suicide in all but a few states' laws, which was, of course, the target of the original legal challenges. Decriminalization was intended to re-characterize attempted suicide as a mental health, rather than a criminal law concern, but not to constitute it as a right individuals could demand.

The closing thoughts on this theme that George Annas offers are directed not to legal permission or prohibition of medically assisted suicide, but to mitigating the fears that cause people to request it. Respect for patients' rights to effective pain management and care in comfort would achieve much, and might be advanced through patients' economic access to motivated lawyers to act on their behalf. Physicians accustomed to viewing lawyers' interventions in health care apprehensively, however, may need to be persuaded that the proposed scheme to develop a network of not-for-profit public-interest health care law firms or centers would advance patients' care, even when it secured their rights.

The final part of the book, Part VI on Global Choices, is composed of the single Chapter Twenty-two, entitled Toward a Globalization of Human Rights and Medical Ethics. This builds on the work George Annas has undertaken on the Nuremberg Code, applicable to medical research on human beings, and on the ostensibly competing World Medical Association's Declaration of Helsinki, first adopted in 1964 and subsequently amended, most recently in 1996. Annas views the Declaration subtitled "Recommendations guiding physicians . . .", as inferior or compromised. Even the subtitle indicates that it lacks the binding effect Annas ascribes to the Nuremberg Code, and that it is oriented to physicians who are recruited to serve in biomedical research, rather than primarily protective of individuals, whether they are patients or not. Annas argues that the World Medical Association has acted largely as a professional trade association concerned primarily with its members' welfare.

In his quest for an international agency to hold physicians to observance of human rights, Annas canvasses the feasibility of constituting a permanent, international Nuremberg-type medical tribunal, ideally under the auspices, or at least with the endorsement of the United Nations. In preparation for this admittedly distant prospect, the closer coupling of medical ethics and human rights principles is necessary; that is, physicians conscious of the professional requirement of ethical conduct might acquire insight and experience from the institutions and literature that protect and promote human rights. Annas cites an example in which

61. See generally ANNAS & GRODIN, supra note 37.
human rights concepts can identify requirements of ethical conduct, namely in maternal-fetal HIV transmission prevention trials in Africa.

George Annas is never less critical of lawyers than he is of physicians, and recognizes the nobility that each can achieve when they respond to the best traditions of their professions. He urges their transnational collaboration "to identify, publicize, and isolate physicians, lawyers, and judges involved in human rights abuses." In 1996, with his colleague Dr. Michael Grodin, he founded Global Lawyers and Physicians as an international non-governmental organization to work collaboratively toward implementation of the health-related provisions of the Universal Declaration of Human Rights and the international treaties that give substance and legal enforceability to human rights. George Annas is a guiding light in the U.S. and beyond, as demonstrated in the scholarship, humane principles, and integrity that shine through his latest book.

62. ANNAS, supra note 1, at 257.