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Biomedical Ethics and the Law: A Critical Perspective

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January 2007

(forthcoming, *Annual Review of Law and Ethics*)

Abstract: This essay critically reviews the theory of biomedical ethics from a law-and-economics perspective. It suggests that the best direction for society is toward greater reliance on property rights and recognized spheres of autonomy, coupled with freedom of contract within specified limits; and that as a result, the role of the biomedical ethicist should be diminished over time rather than enhanced. I consider applications to the duty of beneficence and commerce in body parts.

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Health law, a fast growing field of scholarship, appears to consist largely of two schools. One focuses on health care antitrust, taking as its fundamental premise the notion that health care markets should be distinguished from and treated differently than other markets. This premise underlying health care antitrust is based on a few recurring features of health care markets, such as informational asymmetry, that are taken as sufficient bases for treating them differently.¹ The other school of health law is biomedical ethics, which has taken on increasing importance in view of the many tradeoffs that arise when health care intersects with the law. Should, for example, a physician be required to disclose all of the risks of a procedure to the patient, even though disclosure might discourage the patient to his detriment? Should a physician proceed with a kidney transplant after discovering that the patient has offered the donor a financial reward, or refuse to go forward on ethical grounds? The view of biomedical ethicists is that they can develop a science of ethics that can be applied to answer these and many other tradeoff questions in health care law.

This essay will focus on the biomedical ethics school of health law. I am doubtful of the prospects for a science of ethics, based on the prevailing mode of analysis, that really helps resolve difficult health care policy tradeoffs in a manner that provides useful guidance for courts. I will suggest that the best direction for society is toward greater reliance on property rights and recognized spheres of autonomy, coupled with freedom of contract within specified limits; and that as a result, the role of the biomedical ethicist should be diminished over time rather than enhanced. Moreover, to the extent that the biomedical ethicist's recommendations are needed as guidance for the law, they should be based on an empirically-grounded social welfare analysis rather than the invocation of ethical principles.²

I. Questioning Basic Terms

Biomedical ethics, in comparison to its sister legal ethics, is an advanced field of interdisciplinary scholarship. Biomedical ethics textbooks date back to the 1803 publication of *Medical Ethics*, written by Thomas Percival, a physician. Today, the field is inhabited by PhDs in philosophy who spend time reading vignettes involving medical dilemmas, many of them from court cases, and linking the ethical problems raised in the vignettes with long standing problems in philosophy. Unlike legal ethics, medical ethics has reached the stage that it is taken seriously by students of philosophy everywhere, and taught within philosophy departments as well as within medical schools.³ This is a level

¹ Information asymmetry, and uncertainty generally, have been viewed as distinguishing features of health care markets since the publication of Kenneth Arrow's essay on medical care, see Arrow, Kenneth J., 1963. Uncertainty and the welfare economics of medical care. *American Economic Review*, 53, 941–973.

² For a general argument favoring welfare analysis over ethical principles as justifications for legal rules, see Louis Kaplow and Steven Shavell, *Fairness Versus Welfare* (Harvard Univ. Press, 2002). I recognize that this suggestion could lead to an expansion of the role of the biomedical ethicist. However, it would be an expansion into a different role, based on informing participants of the social costs and benefits of their decisions and attempting to guide them toward socially optimal decisions.

³ I do not wish this statement to be taken as a negative assessment of legal ethics – it is instead a comparatively positive assessment of medical ethics. I realize that the field of legal ethics has drawn

of interdisciplinary interaction that legal ethics professors can only hope to see develop within their own fields someday.

One of the top texts in the field is Beauchamp and Childress's *Principles of Biomedical Ethics*.⁴ I will take this as a key source in presenting my critique of the field. It is a marvelous example of the integration of philosophical literature with the practical field of medicine. I will refer to the Beauchamp and Childress textbook below as *Biomedical Ethics* and treat it as synonymous with the field.

As someone outside of the field – and, in the interest of full disclosure, as a lawyer and economist – the first thing that struck me about *Biomedical Ethics* is the architecture of language. Some of the language is familiar right away. For example, biomedical ethicists distinguish normative ethical theory from positive or descriptive ethical theory.⁵ Normative ethical theory attempts to set out a prescription based on ethics of how things should be done. Positive or descriptive ethical theory attempts to explain the ethical norms that seem to be consistent with the views expressed by medical professionals or the actions that they take. These terms are similar to the familiar distinction in economics between normative and positive economic analysis; the former aiming to prescribe what should be done, the latter aiming to explain or justify economic conventions that exist.

However, even here, working with terms that I find familiar, I am troubled by a difference in approach to the most basic terms. When an economist presents a positive theory of some economic convention, he or she is usually attempting to explain some course of conduct that is observed and typically measurable. For example, one well examined area of positive economic analysis is the prediction and testing of the employment effects of a minimum wage statute.⁶ The descriptive or positive ethical theories, however, attempt to describe the norms that are consistent with the views expressed by physicians on important policy issues.

This is a distinction that deserves to be highlighted. A theory that aims to explain the moral norms expressed by people runs into the problem that the people surveyed may not really believe in the moral norms that they are offering to account for their action. They may believe in other norms that would fail to merit respect as moral norms. Alternatively, they may be acting out of self interest without regard to morality, and find

increasing attention from philosophy professors. But the number of philosophy professors studying legal ethics is far less than the number studying medical ethics.

⁴ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (5th ed., Oxford Univ. Press, 2001). For two other impressive textbooks, see Thomas A. Mappes and David DeGrazia, *Biomedical Ethics* (5th ed. McGraw-Hill, 2001) and Robert M. Veatch, *A Theory of Medical Ethics* (New York: Basic Books, 1981).

⁵ Beauchamp and Childress, at 2 (distinguishing normative and nonnormative approaches to ethics).

⁶ Theory predicts in the standard case, employment will fall as a result of the minimum wage, and most empirical studies confirm the prediction. For a study challenging the standard theory and result, see David Card, *Do Minimum Wages Reduce Employment? A Case Study of California, 1987-89*, 46 *Industrial & Labor Relations Review* 38 (1992).

that the use of moral norms to justify their conduct makes it easier for others to accept their actions.

It is difficult to determine what really motivates someone to do something. Moral justifications have the property that they stand in contrast and often in opposition to self interest. For this reason, moral justifications will always appear attractive as concealing garments for conduct that is motivated by self interest. This is the reason that professional associations have tended to use ethical codes as the primary instruments for establishing and policing collusive anticompetitive practices.

To take an example, the American Medical Association Code of Ethics once prohibited physicians, on ethical grounds, from accepting salaried positions in connection with prepaid medical care.⁷ In other words, what is common today – physicians accepting salaries to work in Health Maintenance Organizations – was considered a serious ethical breach by the American Medical Association sixty-five years ago. It is also true that today most physicians or medical ethicists would have a difficult time offering a persuasive ethical justification for the AMA's early prohibition of salaried practice. Indeed, there is no persuasive ethical justification. The most plausible reason for the prohibition was to limit the entry of a low-cost competitor to the standard pay-for-service system that used to prevail in the medical profession. By any objective measure of social welfare, the introduction of salaried medical practice has been a benefit to society and has improved the public's health.

Given that only sixty-five years ago, professional associations were enjoining on ethical grounds conduct that is considered unworthy of comment or even socially beneficial today, one should consider the possibility that some conduct that is considered unethical today might be recognized as socially desirable in the future. And if that occurs, we may want to look back and ask ourselves why we considered it unethical today. Perhaps we will discover that the ethical justifications that were once offered were in fact hollow; that the real motivations had nothing to do with ethics. However, the ethical justifications were useful precisely because they were hollow. It is because a policy is based on self interest and is harmful to some set of interacting parties, such as consumers, that professionals have an interest in promoting ethical justifications as concealing garments.⁸

This example should be sufficient to express my unease with some of the terms that appear to be of fundamental importance to *Biomedical Ethics*. As a positive or descriptive theory, it invites questions about the motives behind our actions. An uncooperative student of ethics might continue to raise questions about the balance of principle versus self interest as motivations for our actions. A skeptic might doubt

⁷ See *American Medical Association v. United States*, 130 F.2d 233 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943).

⁸ The point that ethical arguments are sometimes self serving has been noted before in the context of medical ethics. See, e.g., Robin Hanson, *Why Health is Not Special: Errors in Evolved Bioethics Intuitions in Bioethics* 153, 170 (Ellen Frankel Paul, Fred D. Miller, Jr., and Jeffrey Paul, eds., 2002).

whether moral principles are ever the real motivations behind our actions, even when we have convinced ourselves that they are.

Obviously, the skeptical view is vulnerable to the critique that it is disingenuous. If a man were to assert that all men habitually lie, we could not take his word if he also claims that he is a man telling the truth. Similarly, one might argue that a generally disrespectful view toward ethical rationales is itself a contradictory position and unworthy of respect. But the skeptical view suggested here is somewhat more limited. It says nothing more than that moral and ethical justifications are sometimes hatched from a will to dissemble. Non-moral and unethical justifications, especially those based on self interest, are less vulnerable to this critique. To be more explicit, the skeptical view of ethics takes into account the strategic value of ethical arguments. In a society consisting of some combination of genuine altruists and genuine egoists, the egoists would have a strong incentive to use ethical arguments in order to pool with the altruists. By pooling with the altruists, the egoists would reduce the probability that a rational observer will discount their arguments. Given this incentive, it is rational to approach ethical arguments with some degree of skepticism.

To be sure, the skeptical view cannot be completely valid. Hume, Smith, and others have explained that men are both genuinely interested in the welfare of others and in how they are regarded by others.⁹ Humans are by nature accountable. They are capable of judging their own actions by the measure of an external observer. The ability to empathize with others and to have an internal sense of the social desirability of following the Golden Rule no doubt provides a wellspring for moral and ethical principles. A skeptic in the tradition of Bentham might doubt even this argument, but it seems plausible that humans would evolve to be social in precisely this sense.

Our interest in being held in esteem by others, and thinking that this is deserved, should lead us to develop moral and ethical rules to guide our conduct. However, it also leads us to develop ethical justifications as concealing garments for our motivations. In primitive times, expropriation and murder were probably viewed as alternatives to contract. This is thankfully not so today, but that does not mean that the baser impulses have entirely disappeared from our thought processes. The language of contract has required somewhat softer, other-regarding, rationales for conduct. Evolution has probably rewarded those of us who developed the capacity to use such language.

II. Take-it-or-leave-it Essentialism: Moral Excellence versus Self Interest

In addition to the skeptical or even churlish questions that I cannot avoid asking about moral principles as genuine motivations for observed conduct, I am troubled by the peremptory essentialism that comes along with some of the basic terms in the language architecture of *Biomedical Ethics*. Beauchamp and Childress describe the notion of *moral excellence* in a passage on Aristotle.

⁹ David Hume, *An Inquiry Concerning the Principles of Morals* (1751); Adam Smith, *Theory of Moral Sentiments* (1759).

An action can be right without being virtuous, [Aristotle] maintained, but an action can be virtuous only if performed from the right state of mind. Both right action and right motive are present in a virtuous action: “The agent must ... be in the right state when he does [the actions]. First, he must know [that he is doing virtuous actions]; second, he must decide on them, and decide on them for themselves; and third, he must also do them from a firm and unchanging state,” including the right state of emotion and desire.¹⁰

In this description of moral excellence, we learn that it does not matter that you have done something that appears by observable evidence to be morally appropriate if your state of mind is not right. The external and immediate is given relatively little weight, and the internal motivation is given priority. This is a view of ethics that appoints the ethicist as the sole judge of whether conduct is morally appropriate, regardless of its effects.

Peremptory, as in take-it-or-leave-it, is one way of describing this exacting notion of moral excellence. If, under the theory of ethics advanced by Beauchamp and Childress, the morality of conduct cannot be determined by observing available evidence – the conduct itself and its observable effects – then ordinary individuals are incapable of serving as judges of moral excellence. Only a recognized judge of moral excellence, the biomedical ethicist or the “gatekeeping physician”,¹¹ can serve as a judge. Moreover, the ethicist’s assertion that someone or something possesses moral excellence is largely unassailable by an ordinary individual. There are no accepted methods of testing an assertion of moral excellence against facts or objective measures.

I have also described the notion of moral excellence advanced by Beauchamp and Childress as essentialist. It is essentialist in the sense that it refers to some inherent quality in the nature of action and the actor, and not to the external conditions and effects of the action. The theory aims to reward and promote this inherent quality, without regard to its observable effects. Moral excellence, in this view, is like a gem that shines through the dust surrounding our actions. A morally excellent person will have this gem-like quality, even if his conduct is not obviously consistent with conventional moral objectives (e.g., helping the unfortunate, honesty, etc).

Before considering the practical applications of this notion of moral excellence I should pause to state some objections that have been advanced before, perhaps most obviously by Popper, who coined the term essentialism, and certainly some strains of this critique appear in John Stuart Mill. Take-it-or-leave-it ethical arguments are questionable because they demand of the ordinary individual that he sacrifice the authority to judge, on the basis of observable evidence, the morality of the conduct of others. This is a system of ethics that appears to be inherently contradictory because it refuses to give full respect to the ordinary individual while at the same time expressing a great respect for autonomy as an abstract principle. But if autonomy means anything, surely it must mean that every

¹⁰ Beauchamp and Childress, at 28.

¹¹ Id. at 49 (describing moral gatekeepers).

fair-minded individual is authorized, within the ethical system, to weigh the evidence on his own in order to determine whether the conduct of another person, or any specified course of conduct, is morally objectionable or unobjectionable. A notion of moral excellence that denies the capacity of the ordinary individual to determine this quality by observing the conduct of others fails to respect the ordinary individual as a potential equal in status to the ethicist.

In addition, there is the issue of proving or disproving the presence of moral excellence. The ethicist might retreat and say, “oh sure, you can decide for yourself whether someone is behaving morally. Nothing in this theory attempts to deny that to the individual.” But the notion of moral excellence advanced by Beauchamp and Childress is something that cannot be tested against observable facts. It is an inherent quality that is unobservable, and it tells us whether we have moved beyond being right to being virtuous. It means nothing to tell me that I am free to attempt to determine the presence of this quality myself if I have no tools that would permit me to observe it or to prove or disprove its presence. An ethical theory that respects the individual should do more than simply abjure take-it-or-leave-it propositions. It should also tell us that these assertions can be tested against the facts of ordinary experience.

Later, in an application, we get a glimpse of what the concept of moral excellence implies in a practical setting. Beauchamp and Childress discuss the issue of organ donation. Health care professionals, they assert, “sometimes function as moral gatekeepers to determine who may undertake variably risky acts of living donation of organ and tissues for transplantation.”¹² It is appropriate, they argue, “for transplant physicians to consider potential donors’ motives, at least to the extent of investigating whether financial gain is the motivating factor.”¹³

It is reassuring and a bit of a relief to see financial gain cited as an example of a failure of moral excellence. Indeed, it is the only absolutely clear failure of virtue appearing in Beauchamp and Childress’s discussion of virtuous conduct. The other examples they mention are various failures of competence, and the nurse’s mistake of being excessively obedient, zealous, or devoted to the attending physician.¹⁴

¹² Beauchamp and Childress, at 49.

¹³ *Id.* at 50. The notion that financial gain should not play any role in the decision to donate an organ appears to be solidly entrenched among biomedical ethicists. See, e.g., Leon Kass, *Organs for Sale? Propriety, Property, and the Price of Progress*, 107 *The Public Interest* 65 (1992). Among transplant surgeons there appears to be a range of views – for example, at least one prominent transplant surgeon has rejected the position of the biomedical ethicists on this issue, see Arthur J. Matas, *The Case for Living Kidney Sales: Rationale, Objections and Concerns*, 4 *Am. Journal of Transplantation* 2007 (2004). The biomedical ethicists’ arguments against financial gain to organ donors typically follow Kantian lines. However, as I noted in an earlier contribution to this journal, the modern ethicists are typically stricter and recognize fewer exceptions than the original argument against the selling of body parts advanced by Kant, see Keith N. Hylton, *The Law and Ethics of Organ Sales*, *Annual Review of Law and Ethics*, 115-136, at 118-199, *Band 4* (1996). Kant’s original argument against selling body parts includes exceptions and qualifications that can be interpreted as approving the sale of body parts for a sufficiently important purpose, such as saving a life. *Id.*

¹⁴ Beauchamp and Childress, at 32.

Virtues, since Plato, have been upheld as a set of motives that are wholly different from and in opposition to self interest. It was also fundamental to Plato's conception of an ideal society that the relentless pursuit of financial gain should be undertaken by a class that would be excluded from consideration as moral guardians. The reason is straightforward: the pursuit of financial gain may put pressure on the actor to compromise his ethical integrity. It is reassuring and a bit of a relief to see that this fundamental formulation of ethics remains largely unchanged, and requires no substantial reformulation for the context of health care.

The question this raises is whether self interest deserves the treatment that it gets in *Biomedical Ethics*. There are ethical arguments to be made in favor of self interest, or the seeking of advantage generally. The tone of Beauchamp and Childress suggests that such arguments would strike biomedical ethicists as entirely foreign, at least in the context of health care.

Adam Smith offered a direct refutation of the view that self interest should be viewed as a base impulse to be relegated to a confined sphere of society or perhaps eliminated.¹⁵ Of course, Plato did not argue that self interest should be eliminated from society altogether; he argued that it should be contained within a sphere inhabited by a second class of citizen. At least Plato seemed to have a sense that there needed to be some engine to drive the economy and to serve as a means of practical administration, in the sense of allocating resources, within his ideal society. *Biomedical Ethics* apparently envisions either no role at all, or a minuscule role at best, for self interest in the health care market.

Self interest plays an important role in the organization of society. It is through self interest that we obtain the degree of social organization that permits basic needs and desires to be met. A system of social organization, such as the market, that takes advantage of self interest to ensure the supply of goods and services provides a solid foundation for its own existence and survival. Self interest is not a mere byproduct of social organization. It is a primitive fact which should be taken into account in any effort to design a system of social organization. And given its existence as a basic human motivation hard-wired by evolution, an ethical system that failed to accord self interest any weight whatsoever in the design of appropriate social institutions would predictably fail.

Self interest is a difficult concept to define. Short-term self interest may and often does differ from long-term self interest. A society probably could not function if every one of its members acted on the basis of myopically short-term self interest. Indeed, myopic self interest has been identified as the core failure of some dysfunctional societies.¹⁶ Some level of trust and concern for others must exist, or at least be expressed in the actions of citizens for society to function reasonably well.¹⁷ And trust requires as a

¹⁵ Adam Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations* (1776).

¹⁶ Edward Banfield, *The Moral Basis of a Backward Society* (1958); see also Kenneth Arrow, *Gifts and Exchanges*, 1 *Philosophy and Public Affairs* 343, at 357 (1972).

¹⁷ Arrow, *supra* note 15, 357-58.

prerequisite many of the classic virtues that ethicists describe. A well functioning market system encourages the development of these virtues. Indeed, the natural human tendency to trade long preceded the development of virtues as we know them now,¹⁸ and the virtues probably evolved as a byproduct of economic exchange.¹⁹

There have been efforts to devise systems of social organization in which virtue rather than self interest would determine the extent to which needs are met. What is most notable about these systems is that they generally have failed as resource allocation mechanisms, after developing societies that were remarkably thin in the conventional virtues. The former socialist economies have experienced corruption and human trafficking on a scale that is far greater than that observed in market-based economies.²⁰ While the relatively large scale of corruption and human trafficking in transition economies may be attributed simply to poverty and the pressures of transition, some part of it may be due to a failure of these societies to develop or maintain the ethical norms that form a significant part of the social capital of market-based economies.

III. Applications of Basic Terms: Commerce in Organs and the Duty of Beneficence

It is with these general comments in mind that we should examine Beauchamp and Childress's application of the concept of moral excellence to the organ donation setting. Self interest, Beauchamp and Childress suggest, is an improper basis for providing an organ to an individual who needs a transplanted organ in order to survive. A physician, acting as moral gatekeeper, should refuse to accept a donation when it appears to be tainted by self interest.

This view of the role of self interest in the supply of transplant organs is inconsistent with reality and questionable on ethical grounds. It is inconsistent with reality because it fails to come to grips with the role self interest already plays in organ transplantation. The physicians that harvest and transplant the organs are compensated, and many of them would not work in the field if they were refused compensation. They are not asked to supply their time and skill on the basis of altruism. The intermediaries that ship and prepare harvested organs for transplantation are sometimes profit-seeking firms.²¹ They are not asked to supply their services on the basis of altruism. If they were

¹⁸ Paul Seabright, *The Company of Strangers: A Natural History of Economic Life* (Princeton Univ. Press, 2004).

¹⁹ Id.; A.O. Hirschman, *The Passion and the Interests: Political Arguments for Capitalism Before Its Triumph* (Princeton Univ. Press, 1977).

²⁰ On corruption in transition economies, see, e.g., Pashev, Konstantin V., *Understanding Tax Corruption in Transition Economies: Evidence from Bulgaria* (2006), available at SSRN: <http://ssrn.com/abstract=931045>; Hellman, Joel S., Jones, Geraint and Kaufmann, Daniel, *Seize the State, Seize the Day: State Capture, Corruption and Influence in Transition* (September 2000), World Bank Policy Research Working Paper No. 2444, available at SSRN: <http://ssrn.com/abstract=240555>. On prostitution, see, e.g., Mihaly Simai, *Poverty and Inequality in Eastern Europe and the CIS Transition Economies*, DESA Working Paper No. 17, ST/ESA/2006/DWP/17, February 2006, available at http://www.un.org/esa/desa/papers/2006/wp17_2006.pdf.

²¹ See, e.g., Katz, Robert A., "The Re-Gift of Life: Can Charity Law Prevent For-Profit Firms from Exploiting Donated Tissue and Nonprofit Tissue Banks?" . *DePaul Law Review*, Vol. 55, No. 3, pp. 943-1015, 2006, available at SSRN: <http://ssrn.com/abstract=892065>.

refused any compensation whatsoever for their efforts in the transplantation process, they would not offer their services. And, of course, much of the capital (equipment and structures) used in the transplantation process is produced by profit-making firms.

If the physician, acting as moral gatekeeper, is authorized under the theory of biomedical ethics to refuse to allow a potential donor to donate his organ because the offer seems tainted by self interest, then shouldn't the same withering gaze be applied to all of the other actors involved in the organ procurement process? For the organ to be transplanted the initial raw material, the organ, must be present, and also the labor of the physicians involved must be present, as well as equipment specific to the transplantation process. It is unclear to me why self interest is allowed to control the supply of almost all of the factors of production in organ transplantation, except for the organ donor. For the physician to exercise his authority as moral gatekeeper, he must deny the authority of the individual donor to act upon the very same impulses that drive the physician's conduct. To do so is incompatible with the principle of autonomy, because it fails to treat the individual donor as an equal, in moral terms, to the physician gatekeeper.

Moreover, if we allow the ordinary individual to serve as a judge of virtue in the organ donation case, he will have to be allowed to consider the external evidence. If the principle of autonomy means that all fair-minded people are capable of being judges of the morality of conduct, then self interest would have to be understood as a factor that infects the decision making of all involved. The mere fact that it might be a motivation behind someone's actions cannot by itself be a disqualifying factor. The external judge, being unable to decide the matter on the simple ground that self interest has infected one party's actions, will then have to consider the observable welfare effects of the donor's decision.

An examination of the welfare effects of a decision to donate, even though that decision may be tainted by self interest, is a potentially complicated analysis. It is clear that the donation of an organ provides a substantial benefit to the potential recipient. But the donation may be questionable on moral grounds if the donor is unaware of the costs he may suffer.²² And indeed, one may take the position that lack of information is so severe in this context that donors should not be allowed to enter into contracts for selling organs to be harvested while they are still alive. But a contract to supply an organ after death involves far fewer potential costs to the donor.²³ A rational ethical policy might, in the end, bar all sales *inter vivos* and permit only contracts to supply organs after death.

²² For a discussion of the ethics of organ donation that considers empirical evidence bearing on consent and other issues, see Mary Simmerling, *Choosing to be Harmed: Autonomy and its Limits in Living Organ Donor Transplantation* (September 20, 2005), available at SSRN: <http://ssrn.com/abstract=896263>.

²³ Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 *Geo. Wash. L. Rev.* 1 (1989); Lloyd R. Cohen, *Increasing Supply, Improving Allocation, and Furthering Justice and Decency In Organ Acquisition and Allocation: The Many Virtues Of Markets*, 1:3 *Graft* 122 (July/August 1998); Richard Schwindt and Aidan R. Vining, *Proposal for a Future Delivery Market for Transplant Organs*, 11 *Journal of Health Politics, Policy and Law* 483 (1986); Henry Hansmann, *The Economics and Ethics of Markets for Human Organs*, 14 *J. Health, Politics, Policy, and Law* 57 (1989).

Whatever a rational ethical policy would entail, it probably would not bar every transaction in which the organ donor appears to be motivated by the receipt of a financial reward. Such a policy would be unethical within the framework of *Biomedical Ethics* in the sense that it fails to respect the autonomy of the individual and treats him as less than the moral equal of the gatekeeping physician.²⁴ It would be unethical in practical utilitarian terms because it denies a clear and substantial gain to the desiring recipient in some cases in which the loss to the donor is trivial (e.g., the transfer occurs after death of the donor).²⁵

In a system of ethics that takes the principle of autonomy seriously, the proper role of the gatekeeping physician is to ensure that the potential organ donor is in a position to serve as a *fully informed judge* of the morality of his own conduct; and, if that is not possible, to constrain his decisions only on the ground that the potential donor appears to be unable to serve in this fashion. In other words, informing the potential donor of the potential costs he may bear or he may impose on others is the first ethical requirement of the gatekeeping physician. That implies a dialogue between the potential donor and the physician in which the two work their way toward a common understanding of the right decision. Such a dialogue starts from the premise that the donor and physician are equals on moral grounds.

One could assert that no system of ethics should require the physician to perform a medical procedure that he or she finds ethically abhorrent. Surely, one might argue, in a system that treats all actors as potentially equal in moral status, this has to be conceded. However, the gatekeeping physician's position should foist on him a duty to bend away from rigid adherence to abstract principles in order to improve the welfare of the patients he is charged to care for. Integrity is cited by Beauchamp and Childress as one of the important virtues,²⁶ but it has a price. If the price of integrity in this setting is that a potential organ recipient must forgo a new organ, or return to the waiting list, then the gatekeeping physician's concern for ethical integrity becomes a source of substantial harm.

The role of implicit prices, or cost-benefit analysis in general, suggests a larger problem in *Biomedical Ethics*. Most ethicists have a strong attachment to principles as well as an aversion to the constant balancing of interests done by economists and utilitarians. The same tendency to set out principles to guide conduct is observed in

²⁴ It should be obvious that I am setting aside the case of an incompetent party, when the gatekeeping physician must act paternalistically. Instances in which one party is incapable of making a decision (because he is unconscious, brain dead, etc.) occur frequently in the medical care context. It is clear that a physician cannot be asked to treat the incompetent party as an "equal" in the decision making process. However, even in this set of cases, the law has developed rules respecting the autonomy of substitute decision makers. These rules effectively limit the discretion of the gatekeeping physician.

²⁵ Even if the transfer occurs while the donor is alive, one should be able to argue persuasively, on ethical grounds, that an individual, or consenting parties, should have a right to take reasonable risks in order to preserve a life. For an effort to tie this argument into the law, see Volokh, Eugene, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, Harvard Law Review, Vol. 120, April 2007, available at SSRN: <http://ssrn.com/abstract=941868>.

²⁶ Beauchamp and Childress at 35-37.

Beauchamp and Childress. Of course, recognizing the difficulty of solving real problems with broad moral principles, Beauchamp and Childress provide several multi-step algorithms for solving particularly knotty problems. But these multi-step algorithms invariably appear to be equivalent to cost-benefit analysis, just dressed in different garments.

For example, consider the following set of principles Beauchamp and Childress set out for dealing with “specific beneficence and the obligation to rescue”.²⁷ Beauchamp and Childress say that

Apart from special moral relationships, such as contract or the ties of family and friendship, a person X has a determinate obligation of beneficence toward person Y if and only if each of the following conditions is satisfied (assuming X is aware of the relevant facts):

1. Y is at risk of significant loss of or damage to life or health or some other major interest.
2. X’s action is needed (singly or in concert with others) to prevent this loss or damage.
3. X’s action (singly or in concert with others) has a high probability of preventing it.
4. X’s action would not present significant risks, costs, or burdens to X.
5. The benefit that Y can be expected to gain outweighs any harms, costs, or burdens that X is likely to incur.²⁸

Thus, according to Beauchamp and Childress, conditions 1 through 5 present necessary and sufficient conditions for the existence of a moral duty to rescue. Since the foregoing proposition refers to an obligation of beneficence, Beauchamp and Childress presumably have more in mind than rescue situations. Perhaps the beneficence proposition applies to any setting in which X is capable of doing something to help Y.

The foregoing beneficence proposition is an example of an effort to take an abstract utilitarian principle and crystallize it in the form of an ethical rule of conduct. In tort law, the basic utilitarian principle has been described as the Learned Hand formula,²⁹ which compares the burden of precaution (*B*) with the expected harm that could be avoided by taking a particular precaution. If *P* is the probability that harm will come to the victim, and *L* the victim’s loss, the expected harm that could be avoided by taking precaution is *PL*. Under the Learned Hand formula, an actor should take a precaution to avoid causing an injury to another if and only if:

$$B < PL.$$

²⁷ Id. at 170.

²⁸ Id. at 171.

²⁹ The Learned Hand Formula was stated by Judge Learned Hand in *United States v. Carroll Towing*, 159 F.2d 169 (2d Cir. 1947).

The Learned Hand formula can be applied easily to the rescue scenario. In the rescue scenario, one should compare the burden of a rescue with the expected harm that could be avoided by the rescue. If the burden is less than the expected harm that could be avoided, then the utility maximization objective requires rescue.

The utilitarian approach immediately suggests the rules stated in the beneficence proposition of Beauchamp and Childress. But it also suggests a large number of variations on those rules. For example, suppose X's action has a low to moderate probability of preventing the loss to Y. Rescue may still be required under the utilitarian norm if Y's potential loss is extremely large (for example, an outcome that some might consider worse than death) and the burden of rescue is slight. Similarly, the utilitarian norm might require X to incur a significant risk if the benefit to Y is sufficiently large.

What this suggests is that the beneficence proposition stated by Beauchamp and Childress is not a principle as much as an attempt to summarize the implications of cost-benefit analysis. Because its justification is grounded in cost-benefit analysis, it is somewhat misleading to suggest to the student that these are principles in the sense of categorical imperatives. Moreover, the beneficence proposition is incomplete to the extent that it fails to set forth all of the implications of the utilitarian norm that underlies it.

Beauchamp and Childress apply the beneficence principle to *McFall v. Shimp*.³⁰ Robert McFall had contracted aplastic anemia. His physician believed that a bone marrow transplant could greatly improve his chance of survival. McFall's cousin, David Shimp, agreed to be tested for tissue compatibility, and the test showed that Shimp was a compatible donor. However, Shimp refused to submit to a second test, for genetic compatibility. McFall sued to force his cousin to submit to the second test and to donate bone marrow if the second test showed genetic compatibility. The court agreed that Shimp's conduct was morally indefensible, but ruled in favor of Shimp.

Beauchamp and Childress argue that the court's holding in *McFall v. Shimp* is consistent with the beneficence proposition. They say that although the first two conditions were satisfied in that case, the third condition (X's action has a high probability of preventing the harm to Y) was not clearly satisfied. The reason they offer in support of this view is that "McFall's chance of surviving one year would have only increased from 25 to between 40 and 60 %".³¹ They also suggest that condition four was not clearly satisfied because even though the risk incurred by the bone marrow donor is minimal, Shimp "believed the risks were greater."³²

This is a highly questionable argument, and most likely wrong in key respects. The court's sense that Shimp's conduct should be criticized on moral grounds was probably correct.³³ First, the third condition of the beneficence principle appears to have

³⁰ 10 Pa.D. & C. 3d 90 (1978).

³¹ Beauchamp and Childress, at 171.

³² Id. at 172.

³³ Id. at 172 (quoting court's description of Shimp's conduct as "morally indefensible").

been satisfied in this case. A medical procedure that increases a gravely ill person's one-year survival rate from 25 to as much as 60 percent should be considered an action that has a high probability of preventing the harm the person seeks to avoid, in this case death. I doubt that the typical physician would view such a procedure as a long shot approach toward enhancing survival odds. Second, the fourth condition of the beneficence principle appears to have been satisfied too. The risk associated with bone marrow donation is minimal, and the physicians had disclosed the risk to Shimp. That he chose to cling to an unfounded belief that the procedure would impose a great risk of harm on him is not an argument for finding against the existence of a moral obligation to rescue. The important question in the application of the beneficence principle is whether a *reasonable person* would regard the risks incurred in rescue as substantial. Shimp's belief that the risk was substantial is different from that of a reasonable person, and for that reason should not factor in an application of the beneficence principle.

If it is clear that the court's holding in *McFall v. Shimp* is inconsistent with the beneficence principle, then is it possible to justify the decision on any theoretical basis? The decision in *McFall v. Shimp* is not at all surprising to anyone familiar with the law on consent to bodily invasions. There are other decisions in which courts have sided with defendants who refused to submit to some invasive procedure when the moral case for forcing submission was obviously strong.³⁴ The core justification for decisions such as *McFall v. Shimp* is that the law requires the consent of the patient before any invasive medical procedure is deemed lawful, unless the conditions are such that consent would be almost impossible (e.g., medical emergency).

IV. Consent, Autonomy, and Self Interest in Biomedical Ethics

The student of ethics should be willing to dig further and ask why the law requires the consent of the patient to any invasive medical procedure. The most likely reason is that a rule permitting invasive medical procedures to be conducted in the absence of consent opens the door to a potentially troubling universe. The law does not permit others to decide when our bodies should be used in order to enhance social welfare. Naturally, this basic norm leads to troubling cases such as *McFall v. Shimp*. But an alternative rule, one permitting invasive procedures in the absence of consent, would generate more worrisome incentives.

The fundamental legal norm requiring consent is itself justifiable on the basis of a simple and familiar conceptual framework. If the cost of bargaining to reach an agreement to transfer an entitlement is relatively low, we should strongly encourage a consensual transaction. *Property rules*, as defined by Calabresi and Melamed,³⁵ are legal rules that protect holders of entitlements by forcing those who would wish to acquire

³⁴ See e.g., *Doe v. Doe*, 632 N.E.2d 326 (Ill. App. 1994) (competent pregnant woman has absolute right to refuse caesarean section even if the refusal may harm the fetus).

³⁵ Guido Calabresi & A. Douglas Melamed, *Property Rules, Liability Rules, and Inalienability: One View of the Cathedral*, 85 Harv. L. Rev. 1089 (1972). For a modern application of Calabresi-Melamed, see Keith N. Hylton (2006), *Property Rules and Liability Rules, Once Again*, *Review of Law & Economics*: Vol. 2: No. 2, Article 1, available at: <http://www.bepress.com/rle/vol2/iss2/art1>.

them to bargain to gain access or possession. In the law, we observe property rules protecting such basic entitlements as exclusive possession of property and freedom from undesirable physical contact. The law in these areas permits the potential victim to enjoin a threatened violation and to seek compensatory damages if a violation occurs.

If the cost of bargaining to reach an agreement to transfer an entitlement – i.e., the transaction cost – is relatively high, we may prefer to permit nonconsensual transfers to occur with only a right to seek compensation *ex post* given to the victim. In this set of cases, a *liability rule* applies. For example, the cost of bargaining to reach an agreement permitting the imposition of risk in the traffic setting would be extremely high. No one has time to bargain with everyone that they might possibly run into with their car. In these settings, the law makes no attempt to encourage or force *ex ante* agreements.

There is a third category identified by Calabresi and Melamed that is governed by the *inalienability rule*. The inalienability rule protects holders of entitlements by forcing those who wish to acquire them to bargain for access. However, the inalienability rule also prohibits or severely constrains the holder's right to enter into a transaction to sell the entitlement. The entitlement holder is permitted, instead, to make a gift of the entitlement.³⁶ Given that the inalienability rule requires bargaining for access, it applies in low transaction cost settings, like the property rule, and provides property-rule like protection from expropriation to the holders of entitlements. The inalienability rule efficiently prohibits sale transactions when the seller is unlikely to accurately perceive his own objective or subjective valuation of the entitlement, and when the subjective loss associated with a transfer is likely to be severe.

McFall v. Shimp is a straightforward example of the application of a property rule in the sense of Calabresi and Melamed. On utilitarian grounds, the proper moral outcome would have required Shimp to submit to a test for genetic compatibility and, most likely, to serve as a marrow donor to McFall. But the law does not attempt to align itself consistently with utilitarianism, at least in the sense of balancing interests in the short run. The law has tended, instead, to develop areas of entitlement and autonomy in settings in which the costs of transaction are low. This approach encourages consensual transactions.

Why should there be a preference on ethical grounds for consensual transactions? To someone who is unfamiliar with the arguments of ethicists, this might appear to be a bizarre question. Is it not obvious, they might respond, that we should prefer voluntary over coerced transactions? But the biomedical ethics literature does not appear to reflect this commonsense viewpoint. One searches in vain in Beauchamp and Childress for the suggestion that consensual transactions might deserve some special deference on ethical grounds. This is entirely consistent with a viewpoint that never fully embraces the

³⁶ Inalienability rules can come in a variety of forms. The rule considered here permits gifts and prohibits sales. However, some rules may prohibit sales and gifts. For an economic analysis, see Susan Rose-Ackerman, *Inalienability and the Theory of Property Rights*, 85 *Columbia L. Rev.* 931 (1985). A moral account of inalienability rules, see Margaret Jane Radin, *Market Inalienability* 100 *Harv. L. Rev.* 1849 (1987).

concept of autonomy. Giving deference to consensual transactions, on ethical grounds, immediately suggests a willingness to allow individuals to serve as their own ethical gatekeepers. However, this would diminish the role of the medical ethicist.

Limited information and self-interest, two primitive features of the human condition, provide a sufficient basis for preferring consensual transactions on ethical grounds. Consider the limited information problem first. An ethical social planner, such as Beauchamp and Childress's gatekeeping physician, may sincerely have the best interests of all parties in mind when he decides whether a certain transaction should or should not be permitted on ethical grounds. But unless the gatekeeping physician is perfect, he will occasionally err by requiring a transaction to take place when it reduces the welfare of both parties or blocking a transaction that would have increased the sum of the welfare of both parties.

This argument implicitly assumes that welfare is an important concern to the ethicist. If Beauchamp and Childress are taken as exemplary of the field of medical ethics, it is clear that social welfare is an important concern to the medical ethicist. The beneficence principle and other practical problem-solving algorithms set out in their book are clearly utilitarian in structure. However, even if Beauchamp and Childress had not revealed an overarching concern for social welfare in the framing of their problem-solving tests, I would hold that social welfare should be a fundamental concern to the ethicist. And assuming that a system of ethics would attempt to produce results that are consistent with maximizing some conception of social welfare, consensual transactions should be granted some deference on the ground that the ethicist's limited information hampers his ability to make accurate assessments of welfare-enhancing transactions.

To take an example of the limited information problem, suppose A proposes to donate an organ to B for a minimum asking price of P_{Ask} .³⁷ Suppose that B is willing to pay a maximum offer price of P_{Offer} , where $P_{Offer} > P_{Ask}$. In order to donate the organ, A has to incur medical and travel expenses equal to P_o . In addition to such out-of-pocket expenses, the loss of an organ (through donation) may reduce A 's long-term ability to work, leading to some reduction in lifetime earnings equal to P_w .³⁸ Finally, A expects to incur additional subjective costs P_s – e.g., perhaps the organ fails in the recipient, and A

³⁷ This argument is based on Keith N. Hylton, *The Law and Ethics of Organ Sales*, *Annual Review of Law and Ethics*, 115-136, Band 4 (1996) and Keith N. Hylton, *The Law and Economics of Organ Procurement*, 12 *Law & Policy* 197 (1990). For a discussion of the economics of organ sales with an up-to-date empirical evaluation of the market for organs, see Gary Stanley Becker and Julio Jorge Elias, *Introducing Incentives in the Market for Live and Cadaveric Organ Donations*, forthcoming *Journal of Economic Perspectives*, available at http://home.uchicago.edu/~gbecker/MarketforLiveandCadavericOrganDonations_Becker_Elias.pdf. Probably the first article providing an economic analysis of the organ shortage and advocating a market for organs is Marvin Brams, *Transplantable Human Organs: Should Their Sale Be Authorized by State Statutes?* 3 *Am. J. L. and Medicine* 183 (1977). Several scholars have noted that a market for transplantable organs effectively exists today, although it is an unregulated black market. See, e.g., Michele Goodman, *Black Markets: The Supply and Demand for Body Parts* (Cambridge Univ. Press, 2006).

³⁸ More generally, P_w can be taken to represent the monetized value of the reduction in lifetime utility that results from giving up an organ. The reduction in lifetime utility may include effects from a reduction in work-life and also effects from a reduction in the capacity to enjoy recreational activities as well.

experiences disappointment from knowing that his effort provided little help to anyone in the end.³⁹ Under these assumptions, A 's minimum asking price is

$$P_{Ask} = P_o + P_w + P_s .$$

A medical ethicist, or gatekeeping physician, presumably would object to the proposal on ethical grounds if he observes that the price demanded by the donor exceeds his out-of-pocket expenses ($P_o < P_{Ask}$). The ethicist presumably would say that there is nothing ethically objectionable about A having his costs covered, receiving a price sufficient to compensate A for his out-of-pocket expenses. But the ethicist would object to this particular transfer if it appears to provide a "profit" of $P_{Ask} - P_o$ to the donating party A . This conclusion could easily be wrong on ethical grounds, because of the ethicist's limited information. A 's decision to donate imposes unobserved costs on him equal to the sum of reduced lifetime earnings and subjective costs ($P_w + P_s$). Allowing the transaction to take place at a price of P_{Ask} would result in no gain in welfare to A and a gain in welfare to B of $P_{Offer} - P_{Ask}$. In other words, even if we accept the proposition that earning a profit would corrupt A 's offer on ethical grounds, such a complaint would be inapplicable in this example.

Generalizing slightly on this example, what are the characteristics of the type of organ donation transaction that the gatekeeping physician will approve? He will approve a transaction when it appears that the donor's demand price (P_{Ask}) is just sufficient to cover the donor's out-of-pocket expenses (P_o). Since the donor's demand price is equal to the sum of out-of-pocket, lifetime earnings, and subjective costs, this is equivalent to saying that the gatekeeping physician will approve transactions only when the sum of the lifetime-earnings and subjective components is equal to zero ($P_w + P_s = 0$). When will this occur? The most likely scenario is when the subjective component is substantial and negative, which means that the donor experiences a large subjective benefit from donation. This will be observed largely when the donor is giving the organ to a family member. But why should the transaction with a family member be privileged relative to one in which the donor demands a larger price because the subjective cost component is positive rather than negative?

As this example illustrates, the gatekeeping physician's limited information leads to a result in which he enforces rules that fail to bear a strong relationship with the underlying ethical norm. The underlying ethical norm is to deny organ donation transactions that produce a gain, advantage, or profit to the donor. This leads the gatekeeping physician to deny transactions in which the demand price significantly exceeds the donor's out-of-pocket expenses and to otherwise approve the transaction. But the transactions between live donors and potential recipients that are approved,

³⁹ The expected cost of disappointment is a subjective cost at the time of the transaction only to the extent it is foreseeable to the organ provider. More generally, the subjective cost includes any perceived cost that cannot be described as an objective expense (such as medical costs or wage loss). For example, the perceived cost of violating religious norms may fall under this category. The low rate of donation by minorities may reflect the perceived cost of violating religious norms or a fear that they may be exploited.

largely donations to family members, are also instances in which the donor experiences a real gain and therefore appear to violate the underlying ethical norm.

Consider the following numerical example. Assume two potential organ donors, Sam and Al, would each experience out-of-pocket expenses (P_o) of \$200 and expected future-earnings losses (P_w) of \$500 in connection with the donation of an organ. However, Sam's subjective cost is, translated into monetary terms, \$0, while Al's subjective cost is -\$1000. Al's subjective cost is negative and large (in absolute value) because he is donating to a relative. If Sam demands a price of \$700, his proposed transaction will be rejected because he would appear to the gatekeeping physician to be gaining a profit of \$500 (\$700 price less \$200 out-of-pocket expenses). However, Sam's real profit is \$0 in his proposed transaction. Suppose Al, on the other hand, demands a price of \$200. His proposed transaction would be accepted by the gatekeeping physician because he would not appear to be gaining a profit, since his demand price of \$200 would be just sufficient to cover his out-of-pocket expenses. Al's real gain, however, would be equal to \$500 (the demand price \$200, less out of pocket expenses of \$200, less expected future losses of \$500, less the subjective cost of -\$1000). In this example, the more altruistic of the two donors is Sam. However, Sam's proposed transaction is the one most likely to be rejected as unethical.

It may be desirable still to block organ donation transactions in which the donor's demand price exceeds the donor's out-of-pocket expenses on the ground that the donor lacks sufficient information or the ability to evaluate the long-term consequences of his decision.⁴⁰ If the donor gives the organ for free or for a small price to a family member, he may perceive the donation as an act of sharing in the organ recipient's misfortune. If the donor suffers unexpected harmful consequences as a result of the donation, it may simply reaffirm his perception of sharing in misfortune. If the recipient is someone for whom he cares deeply, he may perceive sharing in the misfortune as a proof of the depth of his concern for the recipient's welfare. On the other hand, if the donor sells the organ for financial gain to a stranger, he may perceive severe *regret* if the long-term consequences are more harmful than he had anticipated. Because the likelihood of regret is so much higher in the case of a transaction with a stranger, it may be justifiable to have a rule that prohibits transactions that appear to generate a financial gain, largely on the ground that this rule effectively prohibits live donations to strangers.

The potentially severe subjective loss associated with regret would be a defensible ethical reason for adopting a policy of blocking organ donation transactions in which the price exceeds out-of-pocket expenses. However, it is fundamentally independent of the donor's likelihood of gaining financially. Evidence suggesting that the donor gained financially would serve under this rationale only as sign suggesting that the risk of regret is worryingly high. There would be nothing ethically troubling in itself with the evidence that the donor had received a price in excess of out-of-pocket expenses.

⁴⁰ An alternative reason to block the exchange is that the external harms imposed on bystanders who object to the sale are greater than the surplus to the contracting parties, see Calabresi and Melamed, at 1111-12. See also, Roth, Alvin E., "Repugnance as a Constraint on Markets", available at SSRN: <http://ssrn.com/abstract=943908>.

The other basis for preferring consensual transactions on ethical grounds is self interest. Self interest is a primitive fact. A sound ethical theory must assume that it exists and is a motivation for the decisions of all actors. Recognizing the existence of self interest, why should society prefer a method of social organization that grants a third party, himself motivated by self interest, the right to block consensual transactions on ethical grounds?

Because of self-interest, the gatekeeping physician may decide to block welfare-enhancing transactions because he perceives some payoff from doing so. Suppose the gatekeeping physician enjoys a payoff from developing a reputation for enforcing ethical norms. He may decide that the payoff to himself is more valuable than the empathetic disutility he feels for the parties whose transaction he has just denied. Returning to the concrete example just offered, suppose the gatekeeping physician perceives a payoff of P_r from being seen to enforce rules that he equates with ethical norms. One such rule is to deny a proposed organ donation when the donor also proposes a price that appears to exceed the observed cost to the donor. In the example above, welfare is enhanced by the denial only if $P_r > P_{Offer} - P_{Ask}$. Since the gatekeeping physician is not a party to the transaction, however, he will clearly deny the transaction whenever his perceived payoff is positive ($P_r > 0$). That will result in many denials that reduce social welfare.

Information disclosure is another issue that has long captured the attention of biomedical ethicists. *Biomedical Ethics* treats the law in this area as another illustration of ethical rules in operation. However, the information disclosure requirement that has developed in the common law is a byproduct of the recognition of bodily integrity as an entitlement protected by a property rule. Indeed, bodily integrity is also protected by a rule of inalienability: not only is it unlawful to invade someone's body without consent, but the law does not even give the individual the right to sell claims to his body. With this hard barrier of protection surrounding the entitlement to bodily integrity, it follows naturally that the law would develop rigorous disclosure requirements for invasive medical procedures. The disclosure requirements observed in the context of health care are a byproduct of the rules protecting underlying entitlements. Where mere property rules apply, disclosure requirements are governed by the common law of fraud and misrepresentation. Where the inalienability rule applies, as in the health care setting, the law requires a more complete disclosure that includes possible financial interests in the proposed invasive procedure.⁴¹

V. Conclusion

As cases such as *McFall v. Shimp* illustrate, the common law governing health care has developed in a pattern consistent with the property and liability rules framework of Calabresi and Melamed. In other words, where the costs of transacting are low, the common law has tended to recognize spheres of autonomy. The breach of such a sphere has been treated harshly. A physician who refuses to gain consent from the patient for an

⁴¹ See, e.g., *Moore v. Regents of the University of California*, 793 P.2d 479 (Cal. 1990) (under the informed consent law, physician must disclose financial interest in invasive medical procedure).

invasive procedure, where such consent could have been obtained with a reasonable effort, is guilty of battery, even though ethical norms might justify the physician's conduct.⁴² In addition, the physician who fails to properly disclose the risks associated with a medical procedure can be held liable for breaching his duty to the patient.⁴³

The introduction of the biomedical ethicist does no harm if he reaches conclusions that are entirely consistent with the common law, and with its most reliable underlying rationales. However, if the biomedical ethicist exists for the purpose of reaching conclusions that would be rejected by the common law, as Beauchamp and Childress suggest in their treatment of *McFall v. Shimp*, he is unlikely to improve social welfare. The common law has developed over time by examining precisely the sort of tradeoff questions considered by the biomedical ethicist, and it has developed decision rules that are for the most part defensible on welfare grounds. Reexamining the same tradeoff questions, the biomedical ethicist is unlikely to do better.

⁴² E.g., *Mohr v. Williams*, 14 N.W. 12 (Minn. 1905).

⁴³ *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).