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Prologue: The politics of smoking has emerged once again as a leading topic of news coverage and health policy. Not since former Health, Education, and Welfare Secretary Joseph Califano hammered away at the evils of smoking more than a decade ago has the subject gained such notoriety. The recent attention has come largely as a consequence of the antismoking onslaught of the current secretary, Louis W. Sullivan, who recently excoriated RJR Nabisco, Inc., for its announced intention to market a new cigarette targeted at the black community. Sullivan has also delivered his antismoking message in a variety of other ways that reflect the many dimensions—economic, political, and social—of the subject. In this conversation, Tom Schelling, Lucius N. Littauer Professor of political economy at Harvard University’s John F. Kennedy School of Government, discusses some of these dimensions. The description of Schelling as “an errant economist” is taken from the subtitle of a 1984 book (Harvard University Press) of essays he wrote that reflect the intellectual breadth of the man. In his varied and distinguished career, Schelling has studied a diversity of subjects, many of which turned on questions of bargaining, conflict, and strategy as they applied to international security, but also seemingly more simple matters: the ways people maneuvered in traffic jams, negotiated with children, confronted demands for ransom, filed suit, or designed agendas for meetings. He also has studied the circumstances of dying, because, as he once explained, “Relations between physician and patient, especially a terminally ill or hopelessly wretched patient, involve negotiation, strategic withholding of information, a need to authenticate asserts, and conflict of interest within small groups.” Almost seventy, Schelling is retiring from his Harvard professorship but is far from abandoning his many pursuits. He will soon take up academic residence at the University of Maryland.
Q: Professor Schelling, you are recognized as a leading thinker on the subject of human behavior, particularly as it applies to smoking. Our readers would be interested to know how a professor of political economy got interested in this subject in the first place and the lessons you have learned about why humans behave as they do.

A: I spent twenty-five or thirty years of my career mainly working on theories of bargaining and conflict, looking at how people try to influence the behavior of others—making threats and promises, striking bargains, providing incentives, and things of that sort. Early on, it occurred to me that the ways that people try to influence somebody else’s behavior are not altogether different from the ways they try to influence their own. They try to make promises to themselves that they can keep, to arrange threats to punish their own misbehavior, and to arrange rewards for good behavior. They even try to devise arrangements so that if they commit a fault, they can pay an appropriate price and get back on board.

This was an almost purely theoretical interest until I became involved with a committee of the National Academy of Sciences concerned with substance abuse and addictive behavior. That committee must have met a total of at least fifty days over a six-year period (1976–1983). In this context, I had an opportunity to examine whether people who have obesity problems, drinking problems, a heroin habit, or a smoking habit could do something to help themselves. Most of the members of the committee dealt professionally with these behaviors, and most of them seemed to feel that there wasn’t much these people could do for themselves. People needed to get professional help. I tried to argue that there were ways in which people could discipline their own behavior, both successfully and unsuccessfully. The committee finally challenged me to write something on the subject, and I did. As I wrote some more, I began to get more seriously interested. Eventually, when we had an opportunity to start an institute at Harvard concerned with smoking behavior, I was ready to take it on in a much more practical, professional way.

Q: I take it, when you gathered with this committee of experts, many of whom, as you’ve said, were engaged professionally in this subject, you really were challenging the conventional wisdom regarding behavior, at least as expressed by those experts.

A: Yes, I argued that there was an important area of behavior that they were overlooking, namely, the ways that people can cope with their own misbehavior. I remember that they argued, especially with respect to heroin addiction, that there was very little that individuals could do for themselves. But as I listened to them describe relapse, I remembered a description of a reformed heroin addict who took a bus through town. The bus happened to stop at the very place where he had previously met...
with others to shoot up heroin. He began to get withdrawal symptoms, and before he’d gone very far, he’d gotten off the bus, walked back, looked for his old friends, and was soon back on heroin. And I thought, well now, there’s a piece of advice you could give an addict, namely, don’t take the bus that goes past the place where you’re likely to succumb to the physical urge to seek out the heroin. This seemed to me a simple thing that one could do for oneself: avoid the friends, places, or other cues or stimuli associated with one’s old habit. So I began to observe the things that people do or try to do in disciplining their own behavior,

It’s an important field, because, with respect to smoking, most people who try to quit get no help. They try on their own. With eating problems, there are many diets that people can try and much advice in newspapers and books about finding foods that taste good without too many calories, and so forth. There’s very little advice about smoking available anywhere. You can get more advice on how to train a puppy not to wet the floor than on how to help your husband stop smoking.

The Decline Of Smoking In America

Q: On the smoking question, clearly millions of Americans—and, for that matter, people all over the world, I suppose—have demonstrated a capacity to quit smoking. How have they been able to do that? You say little advice is available. How has it happened that, over this twenty-five-year period since the surgeon general’s first report on smoking in 1964, millions of people have abandoned this addictive habit?
A: You’re right. Close to fifty million people have given up smoking (Exhibit 1). What is remarkable about this dramatic abandonment of such a ubiquitous, life-threatening behavior is that people’s quitting was entirely voluntary. And, interestingly enough, nearly everybody who quit had to try more than once. Surveys indicate that, on the average, successful quitters needed at least three or four tries before they succeeded. The relapse rate is very high. From what records there are, it looks as though among people who seriously try to quit, only 10–15 percent or so make it through a year or two. But if one tries at least four times, there is a fifty-fifty chance one will make it. It may be that people get better each time; they may learn something from the experience of relapse about what to avoid next time. So the main thing is, as some billboards in this area have begun to say, “If at first you don’t succeed, quit, quit again.”

Besides trying several times, people do a lot of standard, simple things to stop smoking. One is to pick an important ceremonial time, like a birthday, New Year’s Day, the first day on a new job, or the first day of a
big vacation, so that it’s not just another day. A lot of people appear to benefit from writing out a contract with themselves that indicates, among other things, what penance they must do if they break down and smoke. One of the most serious problems—and on this, I think the advice is sometimes wrong—is coping with relapse. Nearly everybody relapses. Being able to anticipate the circumstances and to avoid them is important. For example, many people discover that they relapse when they’ve had a few drinks, which I think is perfectly understandable. Well, if you have a smoking problem but not a drinking problem, maybe giving up drinking, or at least drinking in circumstances where you might smoke, eliminates a precursor to relapse.

Q: Has smoking become a socially unacceptable behavior among most population segments in American society?

A: Very nearly so, at least in middle-class society. This development has occurred within the past seven or eight years. Smoking, despite the glamorous advertisements, is no longer fashionable in middle-class society. Smoking has nearly disappeared from television except for old movies. Surveys among corporate employees indicate that even smokers believe there should be some explicit regulation of smoking in the workplace.

Q: Does that mean, to put it in the context of corporate America, that in the future it would be unusual for a corporation like IBM, AT&T, or Exxon to hire a promising college graduate who smokes? Will it go that far, or has it already, so that smoking has become a criterion for not employing a person?
A: I think it is becoming that way in two respects. One is that in many big corporations, especially at corporate headquarters, smoking is disappearing because of worksite antismoking rules, many of them reflecting city ordinances that require restrictions on smoking at the worksite. Many corporations are going completely nonsmoking and are offering therapy to their employees to encourage them to quit. When it comes time to hire a new person, they must inform the prospective employee that if you work here, you can’t smoke on the job. That sends a powerful signal to the person. It’s also becoming a widespread notion that smoking is unsightly, a disagreeable habit, and incompatible with gentlemanly and ladylike virtues. I have noticed, for example, that many people now claim that cigarette smoke gives them physical symptoms. Their eyes water, their heads ache, and they may become nauseated. This is a recent phenomenon in my experience. I think part of what has happened is that people have become so conditioned now to thinking of cigarette smoke as unhealthful that psychosomatically they have become physically sensitive to it and do develop symptoms. Therefore, it’s going to be very hard for a young law school graduate to interview for a job at a law firm and smoke in front of the person who interviews him or her.

The Role Of The Federal Government

Q: Let me ask you about your view of smoking in relation to the federal government, which represents all segments of our society. Given the wealth of evidence that documents smoking is detrimental to one’s health, should we expect more of our federal government in helping people to stop smoking, possibly through reducing subsidies of one sort or another that promote smoking?

A: Well, it is interesting that except for requiring warning labels on billboards and cigarette packages and banning television advertising of cigarettes in 1970, the federal government did virtually nothing about this until very recently. The surgeon general indeed did, but his budget was tiny—just about large enough to put out an annual report and to call a single press conference. One secretary of health and human services (or health, education, and welfare, as it was called at the time), Joe Califano, tried hard to make an issue of smoking. But his president didn’t go along with him. In the 1980s) C. Everett Koop as surgeon general became the most recognizable person, aside from the president himself, in the federal government, taking every opportunity to appear on television dressed in his Public Health Service Commissioned Corps uniform so that he had a powerful moral suasion effect.

However, the federal government, until recently, continued to provide cigarettes in the field rations of soldiers and to tout duty-free, tax-free
cigarettes as PX privileges. It was only about four years ago when Defense Secretary [Caspar] Weinberger appointed an advisory committee that recommended getting rid of all kinds of drugs, including nicotine, in the armed services. He banned smoking in U.S. Army buildings and vehicles and imposed tight restrictions in the Air Force and Navy. In another set of important federal actions, the General Services Administration negotiated with the American Federation of Government Employees to impose strict controls on smoking in federal buildings under its jurisdiction. Finally, Congress banned smoking on airlines. This is a very impressive piece of symbolic education as well as a prohibition. But the federal government was behind states and cities, not to mention Canada and Northwest Airlines. As early as four or five years ago, a number of major cities—including Cambridge, Massachusetts; Cleveland, Ohio; Rochester, New York; San Francisco; and Seattle—adopted severe ordinances against smoking in public places and in the workplace. Minnesota’s clean air act, passed a decade ago, was way ahead of everything the federal government did in this regard.

Q: What other steps could the president take, in your opinion, to slow the spread of smoking to the next generation?

A: First, it’s interesting that fifty million people have quit smoking, and another fifty million who might have smoked don’t. The federal government seems to have had very little to do with that, with the exception of the surgeon general’s annual report and Koop’s exhortations while in that office. There is no question that the president could take more decisive action, primarily in symbolic educational areas. It would be very significant if a president or a first lady would get as interested in what smoking does to an unborn fetus as in what alcohol does to an unborn fetus. What has been holding them back, really, is the political power of a very few senators and representatives, who have been losing their political clout more than perhaps presidents have realized.

Of all the presidents we’ve had, Ronald Reagan perhaps best understood the way he could personally affect America’s values. At some time, he must have looked at the television screen and seen his own surgeon general taking this very, very seriously. When the surgeon general alleges publicly that more than 1,000 people are dying prematurely every day because they have smoked cigarettes, a president would have to be pretty insulated not to realize that it is a devastating habit. On further reflection, the president or the president’s spouse might well take it on as a project and raise the consciousness of people about their own smoking and that of their spouse, their children, and their parents. They might make a special case of targeting, say, pregnant women, just to dramatize even more clearly the effects of smoking and the responsibility for not smoking
if an unborn child is depending on you. It is very hard to see why every president from Jimmy Carter to George Bush has been so utterly inactive with respect to this remarkably devastating, self-destructive habit.

Smoking and Tax Policies: The California Experience

Q: As an economist, what is your view of the role the excise tax should play in the smoking question? Should it be raised as a way to dampen demand, or is that an ineffective way to deal with that question?
A: The federal excise tax on cigarettes was allowed to wither away through inflation. In 1951, when cigarettes cost less than twenty cents per pack, the federal tax of eight cents represented almost 75 percent of the pretax price. The tax went unchanged for thirty-one years, while the pretax price of cigarettes increased sixfold, so that in 1982 the tax was only 12 percent of the cigarettes’ price. In that year, it was doubled to sixteen cents, but its impact on the price of cigarettes is about one-third of what it was three decades ago.

We are soon going to have more evidence of the impact of excise taxes on demand, based on California’s approval in a statewide referendum in November 1988 of a twenty-five-cents-per-pack tax increase. The increase raised California’s tax to thirty-five cents per pack, one of the highest in the nation. Earlier studies to date have indicated that there is some, but not much, elasticity of demand—that is, some tendency of a higher price to be associated with less smoking. Primarily, the evidence is that the higher price may slow down the smoking of young people, presumably because young people have less money to spend.

There are two ways the question could be studied in the United States. One is to associate demand for cigarettes with price over time and examine whether demand has changed. That is a difficult approach, because cigarette prices don’t vary enough year by year to get good statistical correlations. The other approach is to study demand cross-sectionally, where different states have different excise taxes. The task under this approach is to examine whether, statistically, smoking appears to be less prevalent in states with higher excise taxes. But state excise taxes generally don’t differ enough to provide very striking differentials to study. And then there are the problems of people who cross state boundaries to buy cigarettes by the carton in the next state if the price is fifteen cents less per pack.

Within several years, we may have a better idea of whether California’s tax increase made any difference in rates of smoking. I say several years, because if a state suddenly increased its price of cigarettes, it may be that the price itself discourages cigarette purchases only a little, but that the
noticeable increase has a kind of signal, attention-getting effect. This may be the time when a wife says to a husband, “The price of cigarettes has gone up another two or three dollars per carton. Isn’t this the time for you to quit?” On the other hand, we know how high the relapse rate is among quitters. If you watch and see how many people quit immediately after the California price went up, you may not know how many of them will still not be smoking a year or so later. So researchers will have to watch for at least a year to determine the impact of the increased excise tax on the incidence of smoking in California.

I am skeptical that smoking is very responsive to the price of cigarettes if only because, first, cigarettes are really a bargain to the consumer. A pack of cigarettes in most states costs about twenty minutes of work at the federal minimum wage. Even for adults, there are ways to economize by, for example, purchasing cigarettes not from machines, but rather by the carton at a local gasoline station or supermarket. On the other hand, if California’s experience demonstrates that a stiff hike in this tax actually deters smokers, then state legislatures should increase the tax as high as they can, another fifty to seventy-five cents a pack. Excise taxes are regressive, though, so as better-educated people with higher incomes quit, the tax burden will fall disproportionately on disadvantaged and lower-income people, whose smoking rates remain higher. It comes down to a political judgment because, like most policy issues, there are pros and cons that must be weighed.

**Future Antismoking Goals**

Q: Have we arrived at a point at which those who still smoke represent something of a hard core? Or, to put it another way, is the declaration of former Surgeon General Koop of a smoke-free society by the year 2000 a realistic goal?

A: If by realistic you mean attainable, no. Whether it is a good goal in terms of motivation, education, and so forth, yes, maybe it is. On the question of whether the fifty million who quit were the ones for whom it was easy and the forty or fifty million who still smoke are the hard core, we don’t know the answer. There are some indications that that is not so. For example, it took those who quit, on average, three or four attempts to do so. Moreover, half of all current smokers say they have tried to quit three or four times. So we can’t say whether we’re dealing with a hard core. It may be that the people who have quit are those who think more in terms of long life and life expectancy. As smoking becomes more of a habit of the underclasses, many of these individuals have shorter time horizons. If you look at the dreadful life-expectancy statistics for young black males in inner cities, it looks as if dying of lung cancer at age sixty-five is pretty
remote from their current calculations. So the problem may be that, in a social, cultural sense, these people, while not necessarily hard-core addicts, are going to be harder to reach and motivate.

Quitting was hard for those who succeeded; it’s also hard for those who are still trying. The reason is that nicotine is an addictive chemical substance. Its effect on the central nervous system, though less dramatic, is not unlike the effect of the opiates. The discomforts of withdrawal, including a craving for cigarettes, can last for days, weeks, or for some even months. Weight gain and loss of creativity are often mentioned as impediments to staying smoke-free.

**International Trends**

**Q:** What are the smoking trends abroad?

**A:** In Canada, the United Kingdom, and Scandinavia, we see something like what has been happening in the United States. In developing countries, however, we see more spending on cigarettes—including imported cigarettes—as incomes rise, and no significant tendency to respond to health warnings. Indeed, in most developing countries, the medical establishments have not mobilized any significant campaigns. Typically, a strong ministry of agriculture promotes tobacco for economic development, and a ministry of finance enjoys taxing a commodity that, like salt in the middle ages, is a “necessity” that can be officially declared a taxable luxury, while a weak ministry of health, which relies on epidemiological evidence from advanced countries, attempts to persuade chain-smoking senior officials to join an anticigarette campaign. Regrettably, the U.S. Office of Trade Representatives and the Department of State have been vigorously promoting the removal of barriers to American cigarette exports in developed Asian countries, such as Taiwan and South Korea, and in Third-World countries.

**The Harvard Institute For The Study Of Smoking Behavior**

**Q:** Let me ask you specifically about Harvard’s Institute for the Study of Smoking Behavior. Has the center achieved the goals that you set out for it six years ago?

**A:** When we began, we were more oriented toward research that we would undertake within the institute. We quickly recognized that since we were going to be a rather small institute, we would do better to focus our energy on serving as a meeting place and clearinghouse for people interested in research on smoking behavior. We wanted to be able to give advice to federal agencies, such as the National Cancer Institute, as to how they should deploy their funds and toward which target groups they
should orient their antismoking programs. We got especially interested in what could be done through both private and public policy. For the last three or four of the six years that we have been in business, we have been much more concerned with which kinds of policies seem to work, which are enforceable, and what the reaction to various policies is.

One project we undertook was a study of the city of Cambridge, which recently passed an ordinance against smoking. Under the Massachusetts constitution, such an ordinance cannot take effect for several months. So we had three months' notice before the ordinance went into effect. The W.K. Kellogg Foundation came through with a quick grant, so we could begin a before-and-after telephone survey of both smokers and nonsmokers; on-site observation of smokers in public places and in worksites; and looking to see whether no-smoking signs went up on schedule. We did some case studies of hotels, hospitals, a major corporation, and Harvard University itself, with the idea that the Cambridge experience might be useful to other cities that were considering such an ordinance. In particular, we explored such things as whether, three years later, the city council is glad that it passed the ordinance and whether people—smokers and nonsmokers—are satisfied with it as well. The general conclusion is essentially good news. The ordinance is not enforced much better than are most traffic laws, but smoking has virtually disappeared in most public places in Cambridge. An occasional person still smokes in the subway. But by and large, in stores, shops, offices, hotel lobbies, hospitals, and corporate worksites, smoking has diminished, if not disappeared, with remarkably little difficulty. Business firms with whom we've consulted by telephone indicate that either it makes no difference to them or they may have saved a little money. Almost nobody reports that workers are seriously dissatisfied or quit because they couldn't smoke at work. So I think the news is getting around, and more and more cities are discovering that their residents prefer smoke-free indoor public places.

Q: Is most of your funding derived from private foundations?

A: Almost all of it. We had a little bit of money from the National Cancer Institute and the National Institute on Drug Abuse. Otherwise, the major sources of funds were the Carnegie Corporation of New York; the W.K. Kellogg Foundation of Battle Creek, Michigan; and smaller amounts from the Cabot Family Charitable Trust, the Conrad N. Hilton Foundation, and two conference grants from the pharmaceutical firm that markets the nicotine chewing substance Nicorette. We didn’t depend on federal grants for two reasons. First, we didn’t want to depend on the federal government. We believed it was much better to be collegially involved with the deputy director for prevention and control of the National Cancer Institute than to be soliciting support from that office.
Also, we were reluctant to establish our priorities based strictly on federal priorities. It made more sense to try to influence the priorities of the National Institutes of Health (NIH) than to seek federal support based on NIH’s research priorities.

Q: Upon your retirement from the Kennedy School, what will happen to the center? Will its work continue? Will it relocate?
A: I was hoping that some part of it could move into Harvard’s School of Public Health. The School of Public Health is establishing a new department concerned with behavior and health, which would include not only the bad behavior we’ve been talking about—drugs, alcohol, and tobacco—but also nutrition, injury prevention, prevention of child and spouse abuse, exercise, and almost any kind of behavior pertinent to health. It looks as if that program may not get up and running in time to absorb much of my institute. So we may simply gracefully go out of business.

Federal Health Promotion Goals

Q: On another subject, the federal government has over the past decade or so established a vast number of goals for society that deal with health promotion and disease prevention. In keeping with our pluralistic society, it is not a highly directed federal exercise. In that context, is a more directed or more active federal government on behalf of the broad goals of disease prevention/health promotion a realistic prospect, given the values of our society?
A: I do not take terribly seriously the promulgation of goals, partly because there is very little the federal government can do to help people achieve these goals. It may be also that the federal government itself is a little unimaginative. I would think, for example, it could be more influential with respect to its own employees, both civilians and military. I’ll just give you one example. My impression is that the people who prepare institutional food in corporate and government cafeterias and dining rooms are exceedingly backward with respect to diet and health. They’re concerned with taste, and the way to make food taste good is to use plenty of butter, fat, and sugar. Very often, employees wish for something more compatible with a healthy heart and proper body weight. Here at the Kennedy School, it turned out that quite a number of people did not like the food in our faculty dining room because it appeared to be loaded with saturated fat and calories. A few of us got together and talked with the catering service that provides the meals in the faculty dining room. Their response was very good. Within two months, they developed an entirely new menu in which everything was within American Heart Association standards, except for a few items that had a black asterix beside them.
The interesting thing was, most people thought the food tasted better. I have been hoping that the caterer, which serves about fifty different corporate employers in the Boston area, would sell that scheme to other large organizations. I have also discovered that the people who provide food for students in the Harvard dining halls have been equally slow to change to more healthy menus.

There may be things that the federal government could do to encourage, maybe even assist, institutional food services to provide food of the kind that is continually being studied by the National Research Council at the request of the Department of Health and Human Services. I have here in my office a big book produced by the National Research Council, Diet and Health. Books like that are wonderful repositories of information, but they have very little influence. I think that is because the government has not thought about how, within a voluntaristic, pluralistic society, it could at least assist people in promulgating, especially within the corporate workplace, more healthful food and activity.

**Physicians And Disease Prevention Activities**

Q: As an economist and a student of human behavior, are you of the view that physicians should be assuming a larger role in helping their patients to curb excessive eating or to stop smoking? Or is that an unrealistic expectation?

A: Most of the health care industry and especially physicians know very little about prevention. The very name of the industry is a misnomer. It is really a sickness industry that pays little attention to promoting health. One interesting exception is dentistry, which has promoted healthier teeth through fluoridation and other helpful steps. The downside for dentists, of course, is that they seem to be putting themselves out of business, to some extent. Physicians are not trained to think about prevention. They don’t know how to help their customers—their patients—change their lifestyles or whatever is needed.

Smoking has been a conspicuous example. Until recently, physicians rarely tried to get patients to quit smoking—for a very good reason: Physicians don’t know how to help. A physician could say to me, “Tom, I notice you’re still smoking. You know, that really isn’t good for you. I wish you would quit.” And I would respond, “Doc, I’ve tried three times. I’ve had it. I can’t quit.” What can the doctor say? He can tell me to try again. I would say, “Okay, Doc, I’ll try again.” And then I would either try and fail or not even bother to try. What the physician may not realize is that if he takes five minutes with every patient, maybe one out of twenty or thirty will take the physician seriously and quit smoking. One out of thirty is a very poor score, from the point of view of the physician. If you
get thirty sick people and twenty-nine die, it is so discouraging you don’t even want to try to treat them. But if five or ten minutes per patient will get one out of thirty to quit, that’s actually an immense result. Thus, if you spend two or three hours of your time and you get somebody to quit, in cost/benefit terms, that’s terrific. But it doesn’t appeal to physicians; it’s not their business. I think the same is true with diet and exercise. Also, we read a lot about how physicians can ignore signs of such things as child abuse. They must believe, essentially, that it’s not their business. And there is no major, well-organized profession with direct access to people that is in the prevention business, unless it’s the school system. But the school system is always dealing with people whose futures are a long way off, making it hard to appeal to those people in terms of lifestyle.

Q: Do Americans have an unrealistic notion about the value of medical care?  
A: Yes, I think Americans are brought up with the notion that the medical profession can perform miracles. It learns how to combat the most horrendous kinds of diseases, ailments, maladies, and injuries. The American people watch with interest and pride as medicine becomes more and more able to save the lives of people who appear to be hopelessly ill and to rescue people, whether they are premature infants or elderly nursing home patients, from the brink of death. It is very hard with this value system to rescale the priorities toward—I’m almost afraid to say it for fear that I will violate the current value system—trying to prolong the lives that are genuinely worth prolonging and to relinquish prolonging lives that are so wretched, so painful that if they were our lives we wouldn’t want them prolonged. The medical profession itself must endure a wrenching ordeal to stop thinking that the prolongation of life has absolute value, beyond every measure of cost and of quality of life.

Former Surgeon General C. Everett Koop (whom I admire immensely), in a symposium on this question, simply answered with a rhetorical question: “How am I to know whose life is of such low quality that we shouldn’t prolong it?” My answer to him would be, sooner or later you’re going to have to become responsible for thinking about it. You can’t forever take refuge in the notion that you’re playing God if you try to think about that question. You’re playing God either way; if you’re going to play God, play it right. That means you can’t turn your back on the question of whether some people’s lives are essentially hell before death. From the patient’s point of view, I believe that more and more people will sign living wills to avoid putting themselves through these hellish scenes. I would expect—not too confidently, but I think it quite likely—that within the decade a few states will have experimented with legislation allowing physician-assisted suicide for people who are wretchedly and hopelessly if not terminally ill.