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THE INTEGRITY OF DEATH: RESOLVING DILEMMAS IN MEDICINE

Larry I. Palmer

The U.S. Supreme Court's declaration three years ago that there was no constitutional right to physician-assisted suicide¹ has not ended the public debate over, or media attention to, the so-called right to die. Proponents of the right to die have simply shifted the debate to the political arena, as evident in the recent ballot initiative in Maine seeking to establish by legislation the right of a terminally ill patient to a physician's help in dying.

The Court's decision this past term declaring unconstitutional a particular statute prohibiting so-called partial birth abortion² will not end the political or moral debate over the "right to life." The controversy about the legal parameters for terminating pregnancy spills over into political rhetoric about the appropriate uses of reproductive technologies and the meaning of "family." The persistence of those acrimonious debates over the role of medicine raises this question: Should courts, the political process, or families control the intimate matters of who should live and who should die?

Faith in medical progress has created the public dilemmas about both the beginning and the end of life. The collective search for meaning in our large and complex society fails to acknowledge the influence of several basic social institutions (family, religion, science, medicine, and law) in shaping intimate concepts of meaning. Too often people have turned to one of those institutions, law, and particularly to the U.S. Supreme Court, to provide guidance in their search for community. Science also appears to offer guidance. Belief in scientific progress and its alliance with medicine has raised the question of whether individuals—in collaboration with health care professionals in their service—should create life or control death.

A CONSTITUTIONAL RIGHT TO DIE

As we consider whether there is a constitutional right to die, we must remember that a decade ago—before the debate began over a constitutional right to physician-assisted suicide—the justices had already answered no in *Cruzan v. Director, Missouri Department of Health*.³ The fact that even so-called conservative justices within the institutional constraints of the U.S. Supreme Court used different methods of reasoning to arrive at their respective nos indicates that judges

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have different conceptions of the Court's role in institutional life. Those different conceptions are evident from the different questions each raises about the relationship of legal institutions to the institution of medicine. Underlying all the justices' questions is a fundamental assumption that legislatures, as opposed to courts, are the primary forum for determining the degree of legal control there should be over modern medicine.

Legislatures provide a process that adjudication cannot provide. The question about dying that legislatures at the state level have consistently addressed over the past twenty-five years is whether a patient is terminal. Through court-developed doctrine and legislative ratification, nearly every state has in place the legal means of removing or withholding medical treatment from terminal patients with few, if any, possible legal ramifications for physicians. During the past decade, however, Jack Kevorkian, with the assistance of the national media, has transformed the public question about the terminally ill by assisting in the death of many patients most of us would categorize as chronically ill. There is in fact no legal or legislative definition of "chronically ill," but Kevorkian's rhetoric has forced us to consider if legal definitions of "terminally ill" will suffice in a world in which most of us will die of chronic, as opposed to acute, illnesses.

In contrast to medicine, law in general is slow in adapting to social, economic, and ethical changes. The decade-long battle by Michigan prosecutors to convict Kevorkian for his assistance in more than 130 deaths should remind us what "due process" of law means. Law is a rather clumsy process, constrained in our system by its reliance on the past, what lawyers call precedents, and some traditions, such as the

requirement of proof beyond a reasonable doubt, before lay jurors are authorized to convict anyone of a crime.

People like Kevorkian, with resources to acquire lawyers and garner media attention, can take advantage of technicalities in the pure novelty of the issues they present. Kevorkian's ability to escape conviction until recently must be seen against the backdrop that application of criminal laws to modern physicians is already fraught with uncertainty. In dealing with the withdrawal or withholding of treatment, the legislature in Michigan and elsewhere has been vigilant in

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protecting physicians from legal liability. In other words, physicians run less risk of criminal conviction than most defendants charged with homicide.⁴

The institution of medicine has begun to play an important part in our construct of death. It should come as no surprise that lay jurors had difficulty convicting Kevorkian until prosecutors had new tools—new laws about assisted suicide, technological evidence such as the videotape of Kevorkian injecting a patient, more control over admissible evidence, and perhaps a shift in public attitudes after the defeat of the initiative to legalize physician-assisted suicide. In any event, convicting a physician, even a defrocked one, for his alleged acts of mercy, acts that symbolize the idea of medical and social progress, is a difficult task for a jury consisting of past and future patients.

WHO WILL DECIDE?

As we move into legislative debates about assisted suicide and adequate pain medication, we are reminded that law is itself a complex institution of courts, administrative bodies, commissions, and legislatures. We are now in a legislative era in which acrimony over “rights” in the abortion debate must be

replaced by a public discourse that respects our rich diversity. Although the religious conviction that life begins at conception quite properly did not prevail in the constitutional debate over abortion, that does not mean that the spiritual-ethical and religious position on assisted suicide and euthanasia—that suffering is a necessary part of human life—must be silenced in the legislative and regulatory debates on assisting death. Religion as an institution plays too important a role in American life to be ignored in the public debate over suffering that proponents of physician-assisted suicide have forced on us.

Proponents offer secular understandings of suffering that must compete with various religious understandings of suffering in the legislative debates. Although in polls Americans express favorable views towards legalizing some form of physician-assisted death, when they vote, they often vote against such proposals, as the 1998 Michigan vote overwhelmingly indicates. While some legal scholars suggest that church groups' assistance in defeating proposals to legalize physician-assisted suicide is somehow illegitimate or leads to voter irrationality,⁵ the views of those scholars are grounded in a vision of law as solely court-developed constitutional doctrine. Within institutional analysis it is impossible to remove the influence of religious beliefs from voter behavior, because those beliefs are intimately tied to individual conceptions of family and community.

When the proponents of physician-assisted suicide took their secular crusade to the U.S. Supreme Court, the Court gave an institutional response: If physicians are to have legal immunity for death-assisting activities, legislatures rather than courts must grant that immunity.

While the justices were divided on how they reasoned to that result, they posed these more-general questions for medicine and those who seek to regulate health care professionals: Should we view physicians as relievers and managers of pain, as determined scientifically rather than existentially? Should we in our public debates reject the metaphor of “physicians as relievers of suffering,” just as we rejected a previous generation's metaphor of physicians as the preservers of life and the fighters against death? A reliever-of-pain metaphor, as opposed to a reliever-of-suffering metaphor, encourages us to use all our institutional resources—science, medicine, law, family, and even religion—to assist those with the pain of chronic conditions or terminal illnesses to live and die well.

The U.S. Supreme Court's opinions on assisted suicide affirmed the right of any state to legalize assisted suicide and thus retroactively affirmed the constitutionality of the Oregon Death with Dignity Act. The problem remains whether Oregon provides the appropriate direction for other states that might consider the question. Oregon should not be the model, once we understand that legislatures are the appropriate fo-

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rum, and the rules of engagement for legislative change are very different from the rights-oriented discussions of the past.

Legislative change is a complex process, because medicine is already highly regulated by a combination of statutes, court decisions, and administrative regulations. Proponents of the Oregon approach will use a combination of personal tales of horrible deaths and data about the Oregon experience⁶ to argue for legislative change. My own prediction is that we will continue to agonize over the role of physicians in our dying but that few states will follow the Oregon example. There are many forces within the institution of medicine for limiting the widespread use of lethal doses of drugs even in Oregon, not the least of which is the question of whether pharmacists are willing or ethically bound to fill the prescriptions.⁷

Furthermore, once we recognize that legislatures are the appropriate forum for exercising social control over medicine, it is apparent that the rights view of the relationship of medicine to law is simplistic. For instance, to change the "law" in Michigan to allow physician-assisted death required voters to read and understand a 12,000-word document proposing many modifications of statutes rather than a simple yes or no vote on a slogan about rights. Michigan citizens voted against the changes, since their ramifications in relation to important concepts of family and the integrity of death, as well as life, were unclear.

LIFE AND DEATH

That, finally, is the crux of the matter. The constitutional debate over physician-assisted suicide has illustrated that we cannot deal with death without talking about life. That debate has also demonstrated the limitations of both law and medicine in providing us with the choices that lead to meaningful lives and peaceful deaths. What we must seek from both institutions is a matrix that supports choice as well as responsibility for individuals.

There are vast personal, social, and ethical issues involved in how we live and die. In a democratic and pluralistic society, many questions will have to involve political processes, with all their limitations. Medicine and law are social systems within a dynamic, fluid community. Neither medicine nor law can provide meaningful lives or graceful deaths, but they can provide choices that affirm for individuals who they are. It is within that matrix of choice that both beginnings and endings have value for each of us, as well as for our society.



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1. *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).
 2. *Stenberg v. Carhart*, 120 S. Ct. 2597 (2000).
 3. 497 U.S. 261 (1990).
 4. Larry I. Palmer, *Law, Medicine and Social Justice* 94-107 (1989).
 5. Ronald Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* 4 (1994).
 6. Arthur E. Chin et al. "Legalized Physician-Assisted Suicide in Oregon: The First Year's Experience," 340 *New Eng. J. Med.* 577-83 (1999).
 7. "Board of Directors Report on the Council on Legal and Public Affairs," 56 *Am. J. Health Sys. Pharmacists* 652-59 (1999).