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Death, Ethics, and the State

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> *[T]his case presents novel issues of fundamental importance that should not be resolved by mechanical reliance on legal doctrine.*
>
> —*Superintendent v. Saikewicz*[1]

The state has an interest in "maintaining the ethical integrity of the medical profession."[2] The U.S. Supreme Court recognized this proposition in its recent landmark "assisted suicide" decision, *Washington v. Glucksberg*.[3] Unfortunately, the Court did so in a way that could undermine the ethical integrity of the medical profession in this country, in cases ranging from the right to refuse treatment to assisted suicide, abortion, and the death penalty.

As discussed in this Article, the interest in the ethical integrity of the medical profession (EIMP for short) has been widely recognized by courts. These courts typically have done so in difficult cases at the margins of medical practice, where the powerful themes of death, ethics, and the powers of the state intersect. EIMP is a reasonable goal, and most citizens would probably agree that there is a state interest in ensuring that doctors maintain high standards of ethical conduct. Stated in that form (as what I will call the Societal Goal), EIMP is vitally important, and this Article discusses ways in which our courts and society at large can take steps to ensure it. But is this what the courts mean by EIMP? And how are states and courts supposed to maintain EIMP? Surprisingly, there are no clear answers to these questions; none of the dozens of jurisdictions that have asserted a state interest in EIMP have ever really explained what EIMP means or what would protect it.

What makes this ironic is that, as a result, EIMP—in the sense defined in the last paragraph—has not been maintained

1. Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 422 (Mass. 1977) [hereinafter *Saikewicz*].

2. *Id.* at 425.

3. 521 U.S. 702, 731 (1997) ("The state also has an interest in protecting the integrity and ethics of the medical profession.").

but rather has been threatened by these court decisions, regardless of their outcome. Instead of explaining what EIMP means, courts simply have cited earlier cases asserting a state interest in EIMP. The cited cases themselves do the same thing. The trail ultimately leads back to the landmark right-to-die case of *Superintendent of Belchertown State School v. Saikewicz.* However, the court in that case (whose self-conscious judicial activism was quoted above) simply made EIMP up out of whole cloth.

And so it goes. Judges make things up and their successors cite them blindly, even in cases involving the most serious matters of life and death. With EIMP, this combination of improvisation and mimicry has the effect of twisting courts' words until they achieve the opposite of what they say. The result—degrading doctors' standards of ethical conduct—is very dangerous indeed. This Article is an attempt to shine a light on this line of case law, and to suggest new and more effective ways to ensure that we as a society maintain high standards of medical ethics.

I. INTRODUCTION

The story of EIMP begins in 1977 with *Superintendent v. Saikewicz,*[4] the Massachusetts 'right to refuse treatment' case that introduced EIMP as part of a state-interest calculus. Despite the Massachusetts Supreme Judicial Court's warning, quoted above, against "mechanical reliance on legal doctrine," many courts facing treatment-refusal and other life-and-death issues have blindly adopted the *Saikewicz* state-interest formula, including EIMP. Eventually, EIMP's path led to the Supreme Court in *Glucksberg.*

This Article has three themes. I first examine the origins, application, and consequences of the EIMP standard. Ironically, I contend, the articulation of a state interest in maintaining the "ethical integrity of the medical profession" has served to undermine the medical profession's ethical integrity.[5]

4. 370 N.E.2d 417 (Mass. 1977).

5. The question of one's right to die is a complex and emotional one, and has already been discussed extensively in the literature. Therefore, I do not focus on the extent to which patients have the right to forge their own destinies. Instead, I explore, among other things, the ways in which Americans and their judges might

The second theme of this Article, subtler but just as important, is the tendency of courts to 'mechanically rely on legal doctrine' rather than carefully scrutinize sources and their applicability.[6] As this Article traces the spread of EIMP into other jurisdictions as well as into other areas of law, the background of the analysis reveals how a single act of judicial activism (or judicial creativity, depending on one's point of view) can mushroom, distorting (or informing) an entire area of case law for decades.

The third theme, also subtle but significant, concerns courts' use of multi-factor balancing tests. When a factor like EIMP is part of a balancing test that includes weighty interests such as privacy and life, EIMP can easily get lost in the shuffle. Also, factors placed on the losing side of the balance are often ignored in making policy determinations when courts conceptualize justice as "scales." A better solution, I argue, is to attempt to maximize the sum of *all* relevant interests, what we might call "Justice as Optimizer."

Part II is a brief prologue, examining the *Saikewicz* case at its origins—the probate court—and highlighting the ironically questionable ethics of the doctors, lawyers, and judge in the case. This examination provides the background for Part III, where I take a detailed look at the murky origins of the ethical integrity standard in the Massachusetts Supreme Judicial Court's *Saikewicz* decision. In Part IV, I chronicle EIMP's application in dozens of death cases[7] in the two decades since *Saikewicz*. In Part V, I examine the use of the standard and its analogues in the areas of abortion, assisted suicide, and the death penalty. Part VI is devoted to analyzing the Supreme Court's decision in *Glucksberg*, in the context of the rest of this

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make such choices in ways that more effectively safeguard medical ethical integrity.

6. Conventional theories of jurisprudence tend to describe judicial decision-making as either "realist" and ad hoc, or "formalist" and rule-based. Neither model really explains the case of EIMP, in which a "rule" is recited blindly (thus not realist), but it is never defined and is often ignored (thus not formalist). Obviously, this characterization is based on gross simplification of the formalist and realist camps. *See generally* NEIL DUXBURY, PATTERNS OF AMERICAN JURISPRUDENCE (1995) (providing detailed and nuanced analysis of these competing themes). A full treatment of EIMP in the context of various theories of jurisprudence is a project for another day.

7. I use the term "death cases" as a catch-all for "right to refuse treatment" cases, including patients with curable and incurable, treatable and untreatable, and terminal and non-terminal diseases.

Article. In Part VII, I conclude with some proposed solutions to the outlined problems with EIMP and the judicial decision-making process. I will argue that EIMP should embody what I call the "Societal Goal," meaning it is important that we, as a society, guarantee that our doctors maintain high standards of ethical conduct, in part by ensuring broader societal input into defining what "ethical conduct" entails.

II. *SAIKEWICZ* IN THE PROBATE COURT—ETHICAL INTEGRITY PROLOGUE

On April 19, 1976, Joseph Saikewicz was diagnosed with acute myeloblastic monocytic leukemia.[8] Saikewicz's prognosis was for a relatively painless death, in a few months at the most. An alternative was for Saikewicz to undergo difficult and uncomfortable treatments of chemotherapy, which had a 30 to 50 percent chance of success (probably closer to the lower bound, given Saikewicz's age of sixty-seven). "Success" meant remission, which could last two to thirteen months, after which Saikewicz's leukemia would likely return. However, as the probate judge in Saikewicz's case found, the majority of people in Saikewicz's situation would have elected to receive chemotherapy. Nonetheless, on the urging of medical experts and Saikewicz's guardian ad litem, the probate court ordered that no treatment be administered to Saikewicz for his leukemia.

It was left to a probate judge to make this treatment determination because Saikewicz had an I.Q. of 10. He was unable to communicate, and he most likely did not understand his condition well enough to give anything resembling informed consent.

A. *Why Mr. Saikewicz's Life Was Not Prolonged*

The decision apparently turned on Mr. Saikewicz's mental deficiency. Two excerpts from the probate court transcript show that the decision was a close one:

> THE COURT: .... I feel that if I had a serious disease and with treatment I could live another five or eight years or ten years, whatever, I'd rather take the treatment than just take

8. The facts of the case presented here, unless otherwise cited, can be found in the appellate decision (*Saikewicz*, 370 N.E.2d at 419-22).

the chance of dying tomorrow or next week.

> MR. MELNICK [the guardian ad litem]: Let me say this, that that was my opinion, but . . . I was informed that the toxic effects from the treatment would be so great and with his inability to understand the pain, the chances of success are small to begin with, and he'd die comfortably if he didn't have any treatment. Your judgment is yours and mine is mine, but the toxic effects of the drugs would be very great in my mind. That is how I made my judgment, but I agree that a person that could make an informed consent would consent to it.[9]

Regardless of the fact that "a person that could make an informed consent would consent to it," the fact that chemotherapy would be painful and confusing to Mr. Saikewicz convinced the guardian ad litem that it was better to let him die painlessly.

The judge was not so sure:

> THE COURT: That is the choice I have to make.
>
> DR. DAVIS: That is it. I don't know. I don't have that deep knowledge.
>
> THE COURT: I am inclined to give treatment.
>
> DR. JONES: One thing that concerns me is the question about his ability to cooperate. I think it's been made clear that he doesn't have the capability to understand the treatment and he may or may not be cooperative, therefore greatly complicating the treatment process. . . .
>
> THE COURT: Dr. Davis, do you agree?
>
> DR. DAVIS: I think it's going to be virtually impossible to carry out the treatment in the proper way without having problems. You have to see him. When you approach him in the hospital, he flails at you and there is no way of communicating with him and he is quite strong; so he will have to be restrained and that increases the chances of pneumonia, to restrain him if he can't be up and around.
>
> . . . .

9. Appendix at 40, *Saikewicz* (No. 711) (Transcript, Hampshire, ss. Probate Court Proceeding before Jekanowski, J., *In re Saikewicz*, No. 45596, May 13, 1976).

THE COURT: Maybe I should change my judgment.[10]

The judge did change his judgment, and agreed to let the doctors withhold treatment from Mr. Saikewicz:

THE COURT: Do I have to form a written judgment?

MR. ROGERS: Yes, I will draft it.

THE COURT: After a full hearing with medical specialists and doctors being present and their testimony being taken, the Court determines and adjudges that chemotherapy treatment should not be given at this time.[11]

The court's findings, apparently written by Mr. Rogers, the staff attorney at the hospital, are worth quoting here at length:

. . . .

2. That said JOSEPH SAIKEWICZ is 67 years of age and is currently suffering from acute myeloblastic monocetic [sic] leukemia.

3. That the only available medical treatment therefor is the administration of various drugs, known as "chemotherapy".

4. That said JOSEPH SAIKEWICZ is profoundly retarded, with an I[.]Q. of 10 and a mental age of approximately 2 years and 8 months, and is unable to give informed consent to such chemotherapy.

5. That the majority of persons suffering from leukemia . . . choose to receive treatment in spite of its toxic side effects and risks of failure.

. . . .

13. That factors weighing against administering chemotherapy for said JOSEPH SAIKEWICZ are: (1) his age, (2) his inability to cooperate with the treatment, (3) probable adverse side effects of the treatment, (4) low chance [30–40 percent] of producing remission, (5) the certainty that treatment will cause immediate suffering, and (6) the quality of life possible for him even if the treatment does bring about remission.

14. That factors favoring administration of chemotherapy for said JOSEPH SAIKEWICZ are: (1) the chance that his life

10. *Id.* at 43–45.
11. *Id.* at 45.

> may be lengthened thereby, and (2) the fact that most people in his situation when given a chance to do so elect to take the gamble of treatment.[12]

Note that of all of the "con" factors, all but two seem to be canceled out by the second "pro" factor (i.e., that most people who could consent to the chemotherapy would do so). Regardless of whether "most people in [Mr. Saikewicz's] situation" would have been acting rationally in choosing to receive chemotherapy—despite their age and the pitfalls of treatment—it is nonetheless the choice that they would have made, and a choice that would have been obeyed. The decision to treat Mr. Saikewicz differently from "most people" therefore must have turned on other considerations. The only remaining "con" factors—presumably, then, the dispositive ones—are the second and the sixth: that Mr. Saikewicz could not cooperate with the treatment, and that he would have a poor quality of life even if the treatment brought about remission.

In the abstract, cooperation would seem to be a valid issue. One must wonder, though, if there really was no way to treat Mr. Saikewicz through sedating him or through making an intensive effort to calm him.[13] Certainly, no one asked that question. Perhaps it was not worth the effort, perhaps it would not have worked, but one wonders why the issue was not even raised by the court. The answer cannot be that it would somehow be unethical to sedate Mr. Saikewicz in order to lull him into cooperating with a treatment to which he could not consent—the whole purpose of this proceeding was to make Mr. Saikewicz's decision for him, to decide what was best for him notwithstanding his own reactions.

The best explanations that the Massachusetts Supreme Judicial Court ("SJC") could muster when validating the probate court's use of the cooperation issue were the following:

> The possibility that such a naturally uncooperative patient would have to be physically restrained to allow the slow intravenous administration of drugs could only compound his pain and fear, as well as possibly jeopardize the ability of

12. *Id.* at 47–48 (Order of Jekanowski, J., Hampshire, ss. Probate Court, *In re Saikewicz*, No. 45596, May 13, 1976).

13. This question is explored in detail in ROBERT A. BURT, TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS 157–58 (1979).

> his body to withstand the toxic effects of the drugs.[14]

The first explanation is unconvincing, as it suggests that sedating Mr. Saikewicz would have been, on balance, both difficult and painful. The second explanation is purely speculative. Notwithstanding these flaws, cooperation remains more convincing than any other factor proffered to support the decision to withhold treatment.

More troubling is the probate court's other main reason for withholding treatment: Mr. Saikewicz's diminished quality of life. The appellate court struggled to interpret this as a reference to the pains of chemotherapy, saying:

> The sixth factor identified by the judge as weighing against chemotherapy was "the quality of life possible for him even if the treatment does bring about remission." To the extent that this formulation equates the value of life with any measure of the quality of life, we firmly reject it. . . . Rather than reading the judge's formulation in a manner that demeans the value of the life of one who is mentally retarded, the vague, and perhaps ill-chosen, term "quality of life" should be understood as a reference to the continuing state of pain and disorientation precipitated by the chemotherapy treatment.[15]

This statement by the SJC is a bald-faced lie, albeit a creative one. It reads like a stinging rebuke to the probate judge, nicely veiled to say "you must have meant *X*, because you couldn't have meant *Y*." However, the probate judge meant exactly what the SJC firmly rejected as demeaning. The SJC had to know this—the probate judge could not have equated "quality of life" with the pain and disorientation of chemotherapy as the Supreme Judicial Court did, because the probate judge had already mentioned the latter in his third and fifth "con" factors (high probability of side effects and certainty of pain and suffering respectively).[16]

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14. *Saikewicz*, 370 N.E.2d at 432.

15. *Id.*; *see also* BURT, *supra* note 13, at 158.

16. Possibly, the probate judge also devalued Mr. Saikewicz's life because of his age, which was one of the reasons given for not proceeding with the chemotherapy. The SJC stated that age is "of course" immaterial to calculations of the value or quality of life and that it was only mentioned as a factor because Mr. Saikewicz's age lowered the probability of success of the treatment. *Saikewicz*, 370 N.E.2d at 432 n.17. This rationale would be redundant, though, given that the low probability of success is already mentioned as a "con" factor. Indeed, the prospect of success becomes dim only when one adds in the age factor (if then).

The SJC, then, had to recognize the deeply flawed basis of the probate court decision. It chose to ignore this fact and to rewrite the decision on what it perceived to be stronger ground. Regardless of the SJC's approach, it affirmed the probate court's decision, which allowed Mr. Saikewicz to die because he did not merit the same treatment that a competent person would choose. The court's opinion thus suggests that the life of an old retarded person is less worthy of protection than that of an ordinary person with the same condition.

This is an ethically troubling decision. The judge was responsible for it, but the doctors encouraged and supported him. Left to his own devices, the judge apparently would have ordered treatment. The decision here, if unethical, reflects as much on the medical profession as the judiciary.

B. *Who Decides?*

Professor Robert Burt raises the question of "who decided" Mr. Saikewicz's fate in the course of making a larger point about the unwillingness of the parties in such situations to enter into a "direct struggle";[17] i.e., to interact with a dying person:

> Most fundamentally, this . . . reflected everyone's unwillingness to enter into sustained interaction with Joseph Saikewicz . . . . The trial transcript shows this if we attempt to identify from it *precisely who decided to withhold treatment from Saikewicz—the doctor or the judge.* The judge claimed power to decide, to which the doctor deferred on the ground that he lacked "that deep knowledge"—until the judge suggested that his decision would require the doctor to treat. The doctor then objected . . . . The judge had thus succeeded in obtaining a highly explicit recommendation from the doctor and then encircled his decision with the rhetorical flourishes "after a full hearing with medical specialists and doctors being present and their testimony being taken, the Court determines and adjudges . . . ." Who then was responsible for this decision?[18]

At the appellate level, this question was answered decisively, once again in a way that rewrites the basis of the lower court's decision:

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17. BURT, *supra* note 13, at 155, 157.
18. *Id.* at 157-58 (emphasis added).

> [S]uch questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent "the morality and conscience of our society," no matter how highly motivated or impressively constituted.[19]

Were it not for the vacillations of the probate judge; for the fact that the doctors testifying before him seemed to be leading him by the nose; for the fact that the doctors' lawyer wrote the opinion;[20] for the fact that the probate judge pulled an existential punch by deciding not that Joseph Saikewicz *would* not receive treatment, but only that he *should* not; were it not for all of these things (none of which are visible in the appellate decision), this declaration by the SJC would be inspiring instead of ironic.

Some irony would remain. The SJC said in *Saikewicz* that judges, not doctors (or the legislature) should make life and death decisions. This idea comports with the notion that the state has its own interest in maintaining the ethical integrity of the medical profession, rather than leaving doctors to their own ethical devices. It clashes, however, with subsequent courts' treatment of the ethical integrity standard, which has generally entailed passively deferring to the medical establishment.

Twenty-four years later, the case of Joseph Saikewicz seems an odd vehicle for positively asserting, and supposedly vindicating, a state interest in maintaining the ethical integrity of the medical profession. When they treated Joseph Saikewicz differently because of his mental incapacity—by withholding treatment that competent patients in his condition would choose to receive—the doctors in this case arguably compromised their ethical integrity. In a sense, then, *Saikewicz* is an appropriate place from which to consider EIMP as a cautionary example, not as a positive archetype. Unfortunately, the SJC used it as the latter, and over the next twenty years, judges in much of the rest of the country followed suit in applying the appellate decision.

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19. *Saikewicz*, 370 N.E.2d at 435.

20. This practice is not unusual, to be sure, but in this case it further dramatizes this judge's failure to exert control.

III. ORIGINS

The origins of EIMP in the death cases are murky. The *Saikewicz* case supposedly synthesized the standard from previous cases, but upon closer analysis we can see that it transformed and expanded the interest far beyond anything that had appeared before. To put it bluntly, the SJC made up EIMP, the same way it constructed a falsely ethical version of the probate court's decision. Compounding these problems, it made little effort to explain coherently what the EIMP standard was supposed to mean. Part III suggests that these chaotic origins are reflected in the lack of respect and the inconsistent treatment the *Saikewicz* standard has received. In other words, the carelessness with which the state interest in the ethical integrity of the medical profession was first asserted has led to its subsequent undermining.

A. *Forerunners*

Long before *Saikewicz* used it, the phrase "ethical integrity of the medical profession"[21] appeared in a series of pharmacy cases. An early and typical example is *Stadnik v. Shells City, Inc.*,[22] a 1962 case that struck down a law preventing pharmacies from advertising prescription prices. The ban had been intended to prevent doctors from deciding which drugs to prescribe based on price, but the court asserted that the ethical integrity of the medical profession could be relied upon to nullify any such market pressure.[23] Several cases in the 1960s and 1970s used comparable language in dealing with similar pharmacy advertising bans.[24] Before *Saikewicz*, then, the main use of EIMP language was to express confidence that doctors were motivated by science and ethics, not economic considerations.

Two other cases, closer to *Saikewicz* both in time and topic,

21. I use the term EIMP to cover similar phrases that appear in the case law, such as "ethical integrity of medical practice," and "integrity of medical ethics."

22. 140 So. 2d 871 (Fla. 1962).

23. *See id.* at 875.

24. *See, e.g.*, Terry v. California State Bd. of Pharmacy, 395 F. Supp. 94 (N.D. Cal. 1975); Maryland Bd. of Pharmacy v. Sav-a-Lot, Inc., 311 A.2d 242, 250 (Md. 1973); Supermarkets Gen. Corp. v. Sills, 225 A.2d 728 (N.J. Super. Ct. Ch. Div. 1966); Pennsylvania State Bd. of Pharmacy v. Pastor, 272 A.2d 487, 492-93 (Pa. 1971); Texas State Bd. of Pharmacy v. Gibson's Discount Ctr., Inc., 541 S.W.2d 884, 887-88 (Tex. Civ. App. 1976).

also referred to the ethical integrity of the medical profession. Like the prescription cases, they ruled that states' external attempts to regulate doctors were unwarranted given the profession's strong internal ethical integrity. In *Poe v. Menghini*,[25] an important pre-*Roe v. Wade* abortion case, a federal court deemed unnecessary a state's requirement that a three-doctor panel pre-approve abortions. One reason given was that the state interest in preserving the life of the unborn child could be served simply by relying on "the self-discipline and professional ethics and integrity of the medical profession" reflected in the judgment of the one doctor treating the patient.[26]

The second example was the trial court decision in the famous case of Karen Quinlan.[27] In holding that Ms. Quinlan should not be taken off of life support, the trial court argued that:

> The judicial conscience and morality involved in considering whether the court should authorize Karen Quinlan's removal from the respirator are inextricably involved with the nature of medical science and the role of the physician in our society and his duty to his patient.
>
> When a doctor takes a case there is imposed upon him . . . a higher standard, a higher duty, that encompasses the uniqueness of human life, the *integrity of the medical profession* and the attitude of society toward the physician, and therefore the morals of society. A patient . . . [expects] that he (the physician) will do everything in his power, everything that is known to modern medicine, to protect the patient's life. He will do all within his human power to favor life against death.
>
> The nature, extent and duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician. What justification is there to remove it from the control of the medical profession and place it in the hands of the courts?[28]

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25. 339 F. Supp. 986 (D. Kan. 1972).

26. *Id.* at 995.

27. *In re* Quinlan, 348 A.2d 801 (N.J. Super. Ct. Ch. Div. 1975), *modified*, 355 A.2d 647 (N.J. 1976).

28. *Id.* at 818 (emphasis added) (footnote omitted). One commentator sums up this part of the trial court's decision in this way:

This decision displays a subtle difference from the pharmacy cases and *Poe*. As in the previous cases, the *Quinlan* trial court said that the medical profession was a better guardian of medical-ethical standards than the state. However, where the other cases had placed such confidence in individual doctors and their "self-discipline," the trial court in *Quinlan* spoke of ethics as if they were an external duty "imposed" on doctors simply by their membership in the medical profession.[29]

The New Jersey Supreme Court continued this trend toward viewing ethics at a professional rather than individual level in the appellate *Quinlan* decision.[30] The excerpt from the lower court opinion quoted above was included almost verbatim in the appellate decision, but, significantly, the language about the integrity of the medical profession was neatly excised. The supreme court rejected the lower court's notion that doctors, not the courts, should decide the fate of patients like Ms. Quinlan.[31] The court held that the lower court could reasonably defer to Quinlan's doctor's pro-life decision,[32] but it articulated a new standard to be applied to future cases. Henceforth, it said, hospital ethics committees should decide what to do with such patients. Such committees could screen out the self-interested motives of patients' families and, importantly, of doctors.[33] Despite such deference to ethical boards, the court gave Quinlan's hospital a specific criterion on which to base its decision.[34] Regardless of whether a court or a hospital committee decided what was ethically acceptable, individual doctors no longer received the same level of deference as in previous cases.

> The trial court judge said he could not order the ventilator removed because no doctor was willing to testify that it was consistent with medical ethics to take Karen off of the ventilator. This was shocking because ventilator removal was consistent with medical ethics, even though the physicians would not say it in public.

George J. Annas, *Facilitating Choice: Judging the Physician's Role in Abortion and Suicide*, 1 QUINNIPIAC HEALTH L.J. 93, 97–98 (1996) (footnote omitted).

29. *Quinlan*, 348 A.2d at 818.

30. *See* 355 A.2d 647 (N.J. 1976).

31. *See id.* at 665.

32. *See id.* at 666.

33. *See id.* at 669.

34. This criterion reflected the court's strong holding recognizing a privacy-linked right to die for people in Quinlan's condition. *See id.* at 671 ("If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a *cognitive, sapient state*, the present life-support system may be withdrawn . . . ." (emphasis added)).

Perhaps this result reflected the waning of America's former deification of doctors. The god-like status of doctors has fallen in the past few decades at the same time, paradoxically, as doctors' powers to sustain life have increased. When doctors were less able to prevent our deaths, they were revered.[35] Now they can sustain life beyond our wildest former expectations, but once patients realize the hollowness of such mechanical life, those patients who want to die sue their doctors. Alternatively, perhaps the court's decision reflected the higher stakes and publicity of *Quinlan*. At a minimum, it foreshadowed the approach in *Saikewicz* and *Glucksberg* of taking ethical decisions out of the hands of individual doctors and putting them into the hands of courts, which then (paradoxically) purport in their decisions to represent the ethical sensibilities of the medical profession.

B. Saikewicz *at the Appellate Level*

1. *The Case*

In one sense, the result in the *Saikewicz* case was unsurprising —Saikewicz was old and terminally ill and so, realistically, he was not going to have the same value placed on his life as a young woman in stable condition like Karen Quinlan. On the other hand, he had a potentially treatable condition, and even though the treatment would only prolong life and not cure the disease, most competent patients would have opted for it regardless of the wisdom or rationality of such a choice. Because Saikewicz was severely retarded and his family took no interest in his case, the decision rested entirely on the shoulders of the state.[36]

The *Saikewicz* opinion's preliminary discussion cited to "[t]he current state of medical ethics," in part as it was described by "one commentator," an author in the *Journal of the American*

35. *See* DAVID J. ROTHMAN, STRANGERS AT THE BEDSIDE 148–49 (1991) (discussing coterminousness of rise in technology with decline in trust of doctors); *see also* Robert J. Dzielak, Note, *Physicians Lose the Tug of War to Pull the Plug: The Debate About Continued Futile Medical Care*, 28 J. MARSHALL L. REV. 733, 736–39 (1995) (noting that "[u]ntil fairly recently, a patient did not control medical treatment decisions. Rather, a physician provided medical treatment which he felt was in the patient's best interests" and the patient complied).

36. Saikewicz had two sisters who chose not to concern themselves with their brother's case. *Saikewicz*, 370 N.E.2d at 420.

Medical Association in 1968.[37] That author wrote that "extraordinary means of prolonging life or its semblance" should be avoided when the patient will not be able to recover and live "without intolerable suffering."[38] On this basis, the court felt that its decision was in line with "the current medical ethos."[39]

Turning to the legal ruling itself, after a substantial discussion of individual-rights issues such as privacy and informed consent, the court considered countervailing state interests.[40] To do so, it surveyed a large sample of recent analogous cases in order to arrive at some common principles: "As distilled from the cases, the State has claimed interest in: (1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; (4) *maintaining the ethical integrity of the medical profession.*"[41]

2. *The Creation of the Ethical Integrity Standard*

The court singled out three cases as providing the precedential basis for EIMP:[42] *Georgetown College*,[43] *Kennedy Hospital*,[44] and *United States v. George*.[45] In *Georgetown College*, a Jehovah's Witness in need of a transfusion for her bleeding ulcer refused to consent to it. The hospital faced a difficult choice: if it treated the woman against her will, it exposed itself to civil or criminal liability for assault; if it let her die it exposed itself to liability for malpractice. In an opinion written after the transfusion was performed, the D.C. Circuit held that a patient could not place a doctor in this dilemma.[46] While this opinion never explicitly mentioned ethics and the integrity of the

37. *Id.* at 424.

38. *Id.* (citing H. P. Lewis, *Machine Medicine and Its Relation to the Fatally Ill*, 206 JAMA 387 (1968)).

39. *Id.* The court did not discuss what this might mean in the context of the majority of competent patients, whom the lower court noted would have chosen to undergo the treatment notwithstanding "the current medical ethos." *Id.*

40. *See id.*

41. *Id.* at 425 (emphasis added).

42. *See id.* at 425-26.

43. *In re* President and Dirs. of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964).

44. John F. Kennedy Mem'l Hosp. v. Heston, 279 A.2d 670 (N.J. 1971). This case was overruled by a subsequent decision by the New Jersey Supreme Court. *See In re* Conroy, 486 A.2d 1209, 1224 (N.J. 1985).

45. 239 F. Supp. 752 (D. Conn. 1965).

46. *Georgetown College*, 331 F.2d at 1009.

medical profession in those terms, the *Saikewicz* court rightly understood the general sense of the case to mean that doctors performing their professional obligations adequately should not be exposed to liability.[47] I restate this goal as "doctors should not have to worry about getting sued for doing the right thing, whatever the right thing is," or, for short, the "Liability Goal."

In *Kennedy Hospital,* another Jehovah's Witness would not consent to a transfusion, here for her unconscious adult daughter who had been in a car accident. The mother even signed a release freeing the hospital from liability.[48] The court held that the patient had no right to die, regardless of religion. The staff members of the hospital, who were "consecrated to preserving life," would commit malpractice if they did not perform the transfusion, no matter what the patient said.[49] More to the point, it was unfair for the patient to request partial treatment in a way that required the medical staff to violate its own standards. "When a hospital and staff are thus involuntary hosts and their interests are pitted against the belief of the patient," the court wrote, "we think it reasonable to resolve the problem by permitting the hospital and its staff to pursue their functions according to their professional standards."[50] In other words, to the *Kennedy Hospital* court, the ethics of the medical profession trump the ethics and beliefs of patients.

I restate this goal as, "the doctor's job is to care fully for you, to 'consecrate life'; you cannot ask her to treat you with one hand tied behind her back." I will call this the "Full Treatment Goal" for short. The *Saikewicz* court's reading was again accurate, with one departure.[51] *Kennedy Hospital* unambiguously cast this goal as the interest of the medical staff, separate from the state's interest in preserving life.[52] The *Saikewicz* court did not pretend otherwise,[53] but transformed the doctor's interest into a part of the state's interest without

47. *See Saikewicz,* 370 N.E.2d at 425 (citing *Georgetown College*).
48. *See Kennedy Hospital,* 279 A.2d at 671.
49. *Id.* at 672.
50. *Id.* at 673.
51. *See* 370 N.E.2d at 425.
52. *See* 279 A.2d at 674.
53. *See* 370 N.E.2d at 425.

explaining why or how.

The third case, *United States v. George*, dealt with another Jehovah's Witness who refused a life-saving transfusion. As in *Kennedy Hospital*, the court's emphasis was on the Full Treatment Goal. In this case, too, a patient "submitted" to the doctors' care, then asked for a course of treatment that would constitute malpractice.[54] The court held that "the doctor's conscience and professional oath must . . . be respected," and that a "patient may knowingly decline treatment, but he may not demand mistreatment."[55] Of the three cases, this one comes the closest (though not in the portions just quoted) to explicitly dealing with ethical considerations, yet *Saikewicz* gives this case the least discussion.[56]

It is striking that none of the three cases that formed the basis for EIMP articulate anything resembling it. The Liability Goal, while worthy,[57] is neither directly a state interest nor ethical in its scope. The Full Treatment Goal, while more directly concerned with medical standards (ethical and otherwise), sounds in these cases more like an individual doctor's interest, rather than one inhering in the profession as a whole or in the state.

The years between these three precursor cases and *Saikewicz* saw a transformation from respecting medical ethics on an individual level to treating it as an "institutional consideration"[58] and giving the state a voice in constructing such ethics (as in *Quinlan*). *Saikewicz*, then, reflected this trend. The case combined the Liability and Full Treatment Goals, made them collective and professional rather than individual, and made them a state interest.[59] To be sure, doctors and

54. *See George*, 239 F. Supp. at 754.

55. *Id.*

56. *See* 370 N.E.2d at 425.

57. *But see* Annas, *supra* note 28, at 107. Annas argues strenuously that courts' protection of doctors from liability has given doctors a "blank check," which they have "used . . . to act irresponsibly," leaving "no strong medical ethics core to the medical profession." Without the strong ethical core, Annas contends, the medical profession is subject to unseemly market forces. In addition, without its ethical core, the medical profession is beginning to be treated as technicians for hire for such previously unacceptable duties as assisted suicide. *See id.* at 109.

58. *Saikewicz*, 370 N.E.2d at 427.

59. Whatever transformation occurred in the meaning of "ethical integrity," the state interest was simply an overlay; the court spoke of "the integrity of the medical profession, the proper role of hospitals in caring for such patients . . . [and] the State's interest in protecting the same." *Id.* at 426-27.

hospitals still had an interest in avoiding liability and aggressively treating their patients, but now the state had an interest in preserving the doctors' interest, and it was only the state's interest that countervailed the patient's right to refuse treatment.[60]

Unfortunately, the *Saikewicz* court distilled this standard in a manner that lost something in the translation. The confusion is evident from an examination of the plain meaning of EIMP. Declaring a state interest in the ethical integrity of the medical profession sounds like saying "as a society, it is important that we guarantee that our doctors maintain high standards of ethical conduct," a concept that I call the "Societal Goal."

The Liability Goal does not say this—it worries about letting doctors do their jobs without having to make a *no-win* choice about lawsuits. In the three cases discussed in *Saikewicz*, the doctors faced a dilemma of letting a patient die and committing malpractice on one hand or overriding a patient's non-consent and committing assault and battery on the other. As such, the situation posed no threat to the ethical integrity of the profession; such a threat would have come only from a choice in which only the more ethical of the two medical options exposed the doctor to liability. In such a case, a doctor would either have to expose himself to a lawsuit *or* be unethical. If rational actors would choose the latter, the ethical integrity of the profession would be undermined.

The Full Treatment Goal is much closer to the Societal Goal, but it too loses something in the translation. In the case law leading up to *Saikewicz*, the Full Treatment Goal prevented patients from tying doctors' hands, but the very holding in *Saikewicz* makes it clear that "new" medical ethics might allow, or even require, less-than-Full Treatment. As the *Saikewicz* court put it, "[t]he force and impact of this interest is lessened by the prevailing medical ethical standards . . . [which do not] demand that all efforts toward life prolongation be made in all

60. It is certainly possible that one reason for the transformation of EIMP into a state interest is that the *Saikewicz* court and others like it found it unseemly to be weighing doctors' interests directly against those of their patients. Ideally, doctors' and patients' interests would be aligned on the same side, and even if these cases already represented a failure of that ideal, courts understandably might wish to avoid constructing a legal standard that drives this wedge in further.

circumstances."[61] The Full Treatment Goal thus is transformed into an "*Appropriate* Treatment Goal": "you can ask a doctor to treat you less than fully, but only if such scaled-down treatment is consistent with medical ethics." As we will see, this Goal has been transformed (or, some might say, watered down) even further in the cases applying *Saikewicz*.[62]

In sum, the ethical integrity standard was improvised from three Jehovah's Witnesses cases that reached opposite results from *Saikewicz*, had very different versions of "ethical integrity" (indeed, they never used the phrase), and did not assert their versions of "ethical integrity" as a state interest.

3. *The Application of the Ethical Integrity Standard*

The discussion of EIMP in *Saikewicz* is necessarily incomplete without considering the court's application of the rule. Examining the application surely should lend some guidance as to the court's interpretation of the interest. Unfortunately, even though the standard sounded relatively straightforward when first mentioned, the court applied it in a manner that greatly complicated matters. Some courts treat precedents and their language as rigid rules; others treat them as representing results to be harmonized. Either way, *Saikewicz* represents an unacceptable precedent; a court applying *Saikewicz* must choose between using the plain meaning (such as it is) of a rule constructed out of thin air and left unexplained, and using a standard confusingly and incoherently applied in the very case that created it.

In examining the *Saikewicz* court's application of its EIMP rule, quoting the court in full offers the best overview (the emphasized portions in the quotation will receive special attention below):

> As distilled from the cases, the State has claimed interest in: (1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession.
>
> . . . .

61. *Saikewicz*, 370 N.E.2d at 426.
62. *See infra* Part IV.

> The last State interest requiring discussion is that of the maintenance of the ethical integrity of the medical profession *as well as allowing hospitals the full opportunity to care for people* under their control. *The force and impact of this interest is lessened* by the prevailing medical ethical standards. Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather, as indicated in *Quinlan*, the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of *the right to refuse necessary treatment* in appropriate circumstances is consistent with existing medical mores; such a doctrine *does not threaten* either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State's interest in protecting the same. It is not necessary to deny a right of self-determination to a patient in order to recognize the interests of doctors, hospitals, and medical personnel in attendance on the patient. Also, if the doctrines of informed consent and right of privacy have as their foundations the right to bodily integrity, and control of one's own fate, then *those rights are superior to the institutional considerations.*
>
> . . . [T]he [interest in] protection of the ethical integrity of the medical profession was *satisfied on two grounds.* The probate judge's decision was in accord with the testimony of the attending physicians of the patient. The decision is in accord with the generally accepted views of the medical profession, as set forth in this opinion.[63]

Each of the italicized portions represents a significant discontinuity in the application of the rule.

The court's application of its new rule suggests that it was blazing its own trail in creating EIMP; thus, looking to the three precursor cases provides an incomplete guide to the meaning of the new standard. But, the court fails to either explain this activist transformation or to define the new trail in careful or consistent terms. Examining these discontinuities shows the frustrating incoherence in the *Saikewicz* standard and foreshadows the main themes developed in the rest of this Article.

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63. *Saikewicz*, 370 N.E.2d at 425–27 (citations and footnotes omitted) (emphasis added).

a. *"as well as allowing hospitals . . ."*

When the *Saikewicz* court first mentions EIMP as one of four state interests, EIMP is simple and unadorned with subclauses, but in its application of the rule the court inexplicably adds, "as well as allowing hospitals the full opportunity to care for people under their control."[64] This reference undoubtedly identifies the Full Treatment Goal from *Kennedy Hospital* and *United States v. George*. By mentioning this goal alongside and separately from the ethical integrity standard, the court seems to be suggesting that the latter does not encompass the former, but the ethical integrity standard was formed from the Full Treatment Goal and the Liability Goal. Separating out Full Treatment leaves only Liability, and this result simply could not be what the *Saikewicz* court meant by "ethical integrity of the medical profession."[65] So if "ethical integrity" does not mean Full Treatment, and it does not mean Liability, what does it mean? Because the formal listing of the four state interests only mentions "ethical integrity," without the Full Treatment subclause, should applications of *Saikewicz* include the subclause or not? The court gives absolutely no guidance.

A further point: it is unclear how the hospital's interest functions in the middle of a state interest. Protecting the interests of innocent third parties is its own, separate prong of the state-interest test; perhaps the hospital's and doctor's interests represent a specialized version of this interest, handed over to the state for convenience (although the hospital is actually a named party here).[66] If the court intended this meaning, the state-interest test would then basically translate as: (1) preservation of life—people shouldn't die; (2) protection of innocent third parties—people shouldn't die if third parties will be harmed; (3) prevention of suicide—people shouldn't die at their own hands; (4) maintaining the ethical integrity of the medical profession—people shouldn't die at the hands of doctors. The last point would then be bifurcated: (a) if doctors

64. *Id.* at 426. The court also subdivides the standard later in the paragraph, speaking of "the integrity of the medical profession, the proper role of hospitals in caring for such patients[, and] . . . the State's interest in protecting the same." *Id.* at 426-27.

65. Although the Liability Goal is relatively unimportant in *Saikewicz* (as it is relegated to a footnote in the case), it is still part of the calculus. *See id.* at 427 n.12.

66. *See supra* note 60.

"kill" people it undermines the ethical integrity of the medical profession; (b) doctors should have rein to treat people as fully as they are capable. These two prongs implicate, roughly speaking, the Societal Goal and the Full Treatment Goal. This test would apply the rule fairly coherently, relatively consistent with underlying precedent and the plain meaning of the court's words. Unfortunately, the court never states its meaning clearly, and maddeningly, the court proceeds to confuse matters further as its application of the rule continues.

b. "[t]he force and impact of this interest is lessened . . ."

Which interest does the court mean by "this" interest? It has just listed two: "straight" EIMP and the Full Treatment subclause. The obvious reading is that the lessened interest is Full Treatment, because the rest of the paragraph discusses it. Indeed, this portion of the *Saikewicz* opinion marks the formal transformation ("lessen[ing]") of Full into Appropriate Treatment. The other reading, that prevailing standards of medical ethics have lessened the importance of maintaining the ethical integrity of the medical profession, does not sound like something the court intends, but it is not an illogical reading. After all, the formation of hospital ethics boards and the shift toward greater accommodation of patient choice, exemplified by *Quinlan* and *Saikewicz*, could be seen as making the maintenance interest—specifically the portion that says "doctors shouldn't go around 'killing' people"—less urgent. It is also conceivable that the court meant this statement to apply to both Full and Appropriate Treatment as two halves of a single interest. Again, the court's lack of clarity leaves the meaning indeterminate.

c. "[t]he right to refuse necessary treatment . . . does not threaten . . ."

The presumption by the court—that allowing some patients to refuse treatment is consistent with medical ethics—is not particularly controversial.[67] What is harder to accept, and what the court glosses over, is the presumption that because allowing treatment-refusal is consistent with medical ethics, it

67. In this particular case, the presumption is controversial, or at least should be. *See supra* Part II.

does not threaten the ethical integrity of the medical profession.

It is difficult to evaluate whether or not this is the case, in large part because it is unclear what the court means by maintaining "ethical integrity." But if we assume that the court means that the state has an interest in maintaining trust and confidence that doctors consistently act ethically,[68] it is at best optimistic, and at worst dangerous, to leave it completely up to the profession itself to define its standards. To take an obvious (if extreme) example, just because Nazi doctors had no ethical qualms about human experimentation does not mean that the ethical integrity of Nazi doctors did not suffer.[69] Indeed, it means exactly the opposite, especially when EIMP is expressed as the interest of the State, not the doctors. Although there are valid policy reasons for having doctors and not judges define medical ethics, such an approach has definite "agency costs" as well, costs that the *Saikewicz* court did not consider. The dangers of allowing any group—particularly a group with power over life and death—to police itself and define the moral bounds of its own conduct are clear. This discontinuity is discussed in greater length in the final portion of this Article.[70]

d. ". . . those rights are superior to the institutional considerations."

On the whole, the contribution of *Saikewicz* to American jurisprudence was not its articulation of a catchy state-interest calculus but its strong statement in favor of the right to refuse treatment. The *Saikewicz* court effectively concluded that, whatever the basis and extent of the ethical integrity state interest, the patient's personal rights trump it. Moreover, the holding of the case states: "Finding no State interest sufficient to counterbalance a patient's decision to decline life-prolonging medical treatment in the circumstances of this case, we conclude that the patient's right to privacy and

68. *Cf.* 7 OXFORD ENGLISH DICTIONARY 1066 (2d ed. 1989) (defining integrity as: "The condition of not being marred or violated; unimpaired or uncorrupted condition; original perfect state; soundness," and "Soundness of moral principle; the character of uncorrupted virtue, esp. in relation to truth and fair dealing; uprightness, honesty, sincerity.").

69. *See* Ptolemy H. Taylor, *Execution of the "Artificially Competent": Cruel and Unusual?*, 66 TUL. L. REV. 1045, 1063 n.125 (1992).

70. *See infra* Part VII.

self-determination is entitled to enforcement."[71]

The primacy of the patient's right to refuse treatment exposes a weakness in the *Saikewicz* approach. If the patient's right prevails, the "institutional considerations" are set aside. Only if the patient's right does not prevail (as in the three precursor cases from which *Saikewicz* constructed EIMP) do the institutional considerations matter. The court takes no interest, then, in preserving the ethical integrity of the medical profession in those cases where the patient is allowed to die. That is, the law makes no attempt to maximize the sum of the patient's and state's interests. Instead, it merely measures the two elements, with the larger of the two winning all. As shown below, some subsequent courts confronted this problem and began (wisely, I argue) to take the sum-maximization approach; "Justice as Optimizer," rather than "Justice as Scales."[72] But *Saikewicz* itself did not. As a result, the very case that created EIMP strongly stated that the interest did not matter very much.

e. ". . . satisfied on two grounds . . ."

The preceding sections were more of a discussion of the ethical integrity interest than an application of it. When the court finally applies the standard explicitly, it cites two reasons to conclude that EIMP is satisfied. First, the lower court's decision to let Mr. Saikewicz die was consistent with the opinions of the doctors attending him. Second, the decision was consistent with medical ethics in general.

The first factor is truly baffling. Nowhere in the previous statement and discussion of the ethical integrity standard were the wishes of attending physicians mentioned. Another unexplained facet of EIMP is thus introduced, because neither the Full Treatment nor the Liability Goal fits here. Perhaps the court meant that the lower court decision was validated by the attending physicians' expert recommendation against

71. *Saikewicz*, 370 N.E.2d at 435. The court's reference to "a patient's decision" applied to Mr. Saikewicz even though he was incapable of making a decision, because the court had earlier made clear that the right to refuse medical treatment extended to incompetent patients (via "substituted judgment") as well as competent ones. *Id.* at 427, 430-31.

72. *See infra* Part IV.

chemotherapy.[73] Perhaps the court meant that EIMP entails not forcing doctors to act in contravention of their own personal interpretation of medical ethics. There is no way to know for sure.

One interpretation of this new interest would say that EIMP is not a matter of the individual treating physician's interpretation of medical ethics, but rather a matter for that physician's conscience. This distinction is subtle, but important. Medical ethics, a court would say under this view, is the province of ethical boards and the profession as a whole. Individual doctors cannot speak for medical ethics, but only for their own beliefs. That said, however, respecting those individual beliefs is important. I would restate this interest as saying, "a doctor should not have to violate her conscience in acceding to a patient's request and a court's enforcement of that request," and call it the "Individual Conscience Goal."

As discussed above, the ethical integrity standard was transformed in *Saikewicz* into a professional, "institutional concern," and part of a state interest. Individual Conscience is presumably a state interest only in the sense that the state is representing third-party interests in general in these proceedings.[74] It is an institutional interest only insofar as integrity of the profession as a whole rests on respecting the rights of its individual practitioners.

Whatever the *Saikewicz* court meant by this, the significant point is that the court saw the opinion of Mr. Saikewicz's doctors in favor of letting him die as a reason to dismiss the state interest in maintaining the ethical integrity of the medical profession, instead of seeing it as a reason to subject it to extra scrutiny. This disturbing dismissal recalls the earlier Nazi analogy.

The second ground that the court found to satisfy the ethical integrity interest was that withholding treatment from Saikewicz was consistent with medical ethics in general.[75]

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73. *See Saikewicz*, 370 N.E.2d at 419.

74. *Cf.* Matthew S. Feigenbaum, *Minors, Medical Treatment, and Interspousal Disagreement: Should Solomon Split the Child?*, 41 DEPAUL L. REV. 841, 858 (1992) (arguing that interest of ethical integrity is a general concern of medical profession, but that the state is the proper vehicle for asserting it).

75. This ground touches on the Liability Goal, though very obliquely and only implicitly; one might presume that a doctor following the ethical dictates of the professional authorities would be less susceptible to an adverse judgment in a

Notably, as with the first ground on which the ethical integrity interest was satisfied, society has no protection against medical ethics gone awry. If medical ethics agree with the "desires" of a patient (here, a patient with no means of expressing any desires), the state assumes that the ethical integrity of the profession is protected. Once again, the specter of the Nazi doctor looms, and society is protected only by a weak assessment of the patient's intent. Such a result contravenes the Societal Goal—the plain meaning of EIMP—very directly.

All of these analytical threads most likely reflect a pragmatic (perhaps results-oriented) approach by the court. The liberty interest is relatively new and powerful here; indeed, its forceful application is the reason that *Saikewicz* (like *Quinlan*) was a significant case. Having already decided that this powerful individual right trumps the "most significant" state interest, the interest in preserving life,[76] it was highly unlikely that the court would determine that a poorly defined and less weighty interest would tip the balance in the other direction. Unfortunately, taking this approach prevented the court from providing a proper explication of the ethical integrity standard, even as it wrote that standard into law.

4. *Conclusion*

The legacy of *Saikewicz* is a confused one. In asserting a state interest in maintaining the ethical integrity of the medical profession, the SJC affirmed the ethically questionable decisions made by the doctors and judge below; it found precedent for EIMP in cases that did not assert anything like the standard and did not use any similar words; it stated and applied the standard in multiple puffs that were frustratingly inconsistent in content and phrasing; it made absolutely no effort to explain what EIMP was supposed to mean; and it stated that the standard had little if any weight that the court was bound to respect.

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malpractice suit. It matches the Full Treatment Goal as well, though here too the connection is not made explicit and is somewhat tenuous. The connection is this: a doctor acting consistently with the ethical dictates of the professional authorities is presumptively providing full treatment, or at least appropriate treatment.

As mentioned before, the court had already diluted the Full Treatment Goal *sub silentio* (because of the recognition of the powerful liberty interest) into the Appropriate Treatment Goal. As we will see, this is the test that a sizable number of courts adopting the *Saikewicz* test have used.

76. *Saikewicz*, 370 N.E.2d at 425.

In the next Part, I will argue that this confusion is reflected in how *Saikewicz* has been applied. Subsequent courts have looked to *Saikewicz* to find the state-interest rule; finding it, they have had little basis for intelligible application of it. Instead of scrutinizing the language of *Saikewicz*, or re-evaluating its basis, most subsequent courts have simply applied it blindly, with a "mechanical reliance" that is surprising given the *Saikewicz* court's own self-conscious declaration of activism. All of these approaches have contributed to making the "ethical integrity standard" into a cipher, protecting nothing.

IV. APPLICATIONS

Before examining how the *Saikewicz* standard has been applied by other courts, it is useful to collect and re-analyze the various Goals that have appeared so far in the discussion.

1. Liability Goal: Doctors should not be exposed to liability for doing the "right thing" ethically.

This approach appeared in *Georgetown College.*[77]

2. Full Treatment Goal: The doctor's job is to fully care for patients; patients cannot ask doctors to treat them with one hand tied behind their backs, and the State will not force doctors to do so.

This approach appeared in *Kennedy Hospital* and *United States v. George.*

3. The Appropriate Treatment Goal: The doctor's job is to fully care for patients; patients cannot ask a doctor to treat them with one hand tied behind her back. But a patient has a right to refuse certain treatment, and "full care" does not have to include such treatment when withholding it is consistent with modern medical ethical principles.

This modification of the Full Treatment Goal was stated along with (though not clearly subsumed within) EIMP in the *Saikewicz* court's introduction to its discussion of the standard.

4. The Individual Conscience Goal: A doctor should not have to violate her conscience in acceding to a patient's request and a court's enforcement of that request.

I interpret this goal as appearing implicitly in the actual

77. The Liability Goal also played a role in the *Quinlan* decision, as highlighted in Annas, *supra* note 28, at 98–99.

application of the ethical integrity standard in *Saikewicz*, when the court said the standard was satisfied in part by the testimony of the attending physician supporting termination of treatment.

5. The Societal Goal: A society must guarantee that its doctors maintain consistently high standards of ethical conduct.

In the three cases from which the *Saikewicz* EIMP standard was derived, the right to die was not yet established, and so the Societal Goal was equated with the notion that it would be bad for society to have doctors "killing" people. As argued in this Part, subsequent courts have incorrectly read *Saikewicz*'s EIMP standard to refer to this older, "pro-life" version of the Societal Goal. As the pro-life approach to medical treatment decision has faded (due in large part to *Saikewicz*, *Quinlan*, and their progeny), courts now view the state interest in EIMP as having faded as well, and thus they have largely ignored it.

Nevertheless, the *Saikewicz* court's determination that the state has an interest in maintaining the ethical integrity of the medical profession is still relevant. Taken at face value—which my definition of the Societal Goal attempts to do—EIMP is not about protecting life at all cost, it is about having ethical doctors. Instead of ignoring EIMP, courts should seek effective ways to maintain it. One crucial aspect of any effort to maintain EIMP must be to foster a broader societal dialogue on medical ethics while refusing to allow the medical establishment to self-define its own ethical boundaries.

These five significant alternate interpretations define the concept of "maintaining the ethical integrity of the medical profession" for the purposes of evaluating the application of EIMP in subsequent cases. Dozens of these cases exist, and I have collected, generalized and organized these cases so as to highlight their distinctive themes.

Saikewicz has had a major impact on this nation's jurisprudence, simply by virtue of the number of state courts that have felt the need to cite it. In addition to the Supreme Court's discussion in *Glucksberg*, the *Saikewicz* state-interest test appears in the jurisprudence of twenty-one states, the District of Columbia, and several federal courts, in cases either citing *Saikewicz* directly or citing cases that cite *Saikewicz*.[78] Most of

78. *See, e.g.*, Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996)

these cases concern the right to refuse treatment, and most of the treatment-refusal cases involve life or death determinations. The ramifications of the use (and non-use) of the *Saikewicz* EIMP standard in other areas related to the medical profession (such as abortion, assisted suicide, and the death penalty) will follow, as will the culmination of EIMP's development: its adoption by the Supreme Court in *Glucksberg*.

The first striking attribute of the application of the ethical integrity standard is the frequency with which it is explicitly stated as part of the state interest, but then wholly ignored. For these courts, EIMP is worth mentioning, but does not represent a significant factor. Of the roughly 80 cases I have found that actually mention the standard, approximately 20 percent fit into this category, neglecting even to *pretend* to apply EIMP.[79] This high proportion of outright snubs of the standard supports my argument that the *Saikewicz* EIMP standard is essentially meaningless. I discern no pattern among this fifth of the cases that explains why those particular courts did not apply the standard.

One can only speculate as to why these courts ignored the ethical integrity standard even after quoting it. Two main possibilities present themselves. First, the cases involving the right to refuse treatment involve relatively weightier interests: (1) the right to privacy and to refuse treatment; and (2) the state's interest in preserving life, preventing suicide, and

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rev'd sub nom. Washington v. Glucksberg, 521 U.S. 702 (1997); McKenzie v. Doctors' Hosp., 765 F. Supp. 1504 (S.D. Fla. 1991); Deel v. Syracuse Veterans Admin. Med. Ctr., 729 F. Supp. 231 (N.D.N.Y. 1990); Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988); Tune v. Walter Reed Army Med. Hosp., 602 F. Supp. 1452 (D.D.C. 1985); Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979); Rasmussen v. Fleming, 741 P.2d 674 (Ariz. 1987); Thor v. Superior Ct., 855 P.2d 375 (Cal. 1993); Stamford Hosp. v. Vega, 674 A.2d 821 (Conn. 1996); *In re* A.C., 573 A.2d 1235 (D.C. 1990); *In re* Severns 425 A.2d 156 (Del. Ch. 1980); *In re* Browning, 568 So. 2d 4 (Fla. 1990); State v. McAfee, 385 S.E.2d 651 (Ga. 1989); *In re* E.G., 549 N.E.2d 322 (Ill. 1989); Mack v. Mack, 618 A.2d 744 (Md. 1993); *In re* Beth, 587 N.E.2d 1377 (Mass. 1992); *In re* Rosebush, 491 N.W.2d 633 (Mich. Ct. App. 1992); *In re* Torres, 357 N.W.2d 332 (Minn. 1984); Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988); McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990); *In re* Farrell, 529 A.2d 404 (N.J. 1987); Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986); State *ex rel.* Schuetzle v. Vogel, 537 N.W.2d 358 (N.D. 1995); Leach v. Akron Gen. Med. Ctr., 426 N.E.2d 809 (Ohio C.P. 1980); *In re* Fiori, 673 A.2d 905 (Pa. 1996); *In re* Grant, 747 P.2d 445 (Wash. 1987); *In re* L.W., 482 N.W.2d 60 (Wis. 1992); State *ex rel.* White v. Narick, 292 S.E.2d 54 (W. Va. 1982).

79. *See, e.g.*, Mack v. Mack, 618 A.2d, 744, 755 n.7 (Md. 1993); *In re* Beth, 587 N.E.2d 1377, 1381 (Mass. 1992); State *ex rel.* Schuetzle, 537 N.W.2d 358, 360 (N.D. 1995).

protecting third parties' interests. Adding an additional, "minor" state interest would complicate the calculus in ways that are only necessary if the larger interests are in relative balance. Moreover, because these particular cases are not close ones, the courts can simply disregard the ethical integrity standard.[80]

The second possibility is that it is unclear to courts just what the *Saikewicz* ethical integrity standard actually means. As discussed, *Saikewicz* took several background cases, transformed their principles beyond recognition to form EIMP, and then mangled the interest further by applying it incoherently. Given, again, the relatively light weight of the interest, a court might choose not to figure out the exact meaning of the interest, notwithstanding the duty of courts to explain their decisions in light of precedent. Perhaps the light weight of the interest also explains an additional 10 percent of these cases, in which the courts do not ignore the ethical integrity standard per se, but they simply declare that it does not affect the result without any application of the standard or explanation as to what it means.[81]

The most striking example of a court completely ignoring the ethical integrity standard comes in *People v. Kevorkian*,[82] a Michigan case that does not apply the *Saikewicz* standard. In dissent, one of the Justices cites the four *Saikewicz* state interests, which had been applied in an earlier Michigan Court of Appeals decision.[83] In its analysis of these interests, however, the dissent fails to discuss the ethical integrity prong.

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80. The examples cited in the previous footnote involve two species of cases that courts have found relatively easy to decide upon—people in vegetative states and prisoners—in contrast to more complicated cases involving children or patients with readily treatable conditions.

81. *See, e.g.*, Rogers v. Okin, 478 F. Supp. 1342, 1370 (D. Mass. 1979); *In re* A.C., 533 A.2d 611, 615 (D.C. 1987) (EIMP "not relevant here"); *In re* McCauley, 565 N.E.2d 411, 414 (Mass. 1991).

One particularly significant example of this is the *Cruzan* case. Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988). After reciting the state-interest litany, the Supreme Court of Missouri declared without explanation that "only the state's interest in the preservation of life is implicated." *Id.* at 419. As a result, EIMP was not at issue when *Cruzan* was appealed to the United States Supreme Court, where it became a landmark case concerning the rights of family members to discontinue life-sustaining treatment. *See* Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990).

82. 527 N.W.2d 714 (Mich. 1994).

83. *See id.* at 757 (Mallett, J., concurring in part and dissenting in part) (citing *In re* Rosebush, 491 N.W.2d 633, 636 (Mich. Ct. App. 1992)).

This failure is highly significant because physician-assisted suicide and Dr. Kevorkian's approach to it have so clearly implicated the ethical integrity of the medical profession. Perhaps this omission occurred because Kevorkian's medical license was suspended, and so he did not represent the medical profession, but if anything this *underlines* the threat posed by the issue to the medical profession's ethical integrity.

While a significant number of the cases I have examined (approximately 30 percent) recite the mantra of the *Saikewicz* EIMP standard without further discussion, in the majority of cases courts dutifully try to apply it. Nonetheless, they have not agreed on what EIMP means, and many of these courts explicitly say that it is the least important of the four state interests identified in *Saikewicz*.[84] Those courts that apply EIMP do so mechanically, citing the state-interest prongs with "talismanic regularity"[85] but with only the shallowest of analyses.[86] *None* of them have chosen the most self-evident textual interpretation, the Societal Goal. In a jurisprudential vicious cycle, no precedent supports the plain meaning interpretation, which is now buried under an accretion of other interpretations. For the most part, courts have chosen the Appropriate Treatment Goal (applied by determining whether or not the patient's preferred course of treatment is consistent with modern medical ethical principles), the Individual Conscience Goal (applied by determining if the doctor in question is able to opt out of performing the procedure in question), or both.

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84. *See, e.g., In re* Browning, 568 So. 2d 4, 14 (Fla. 1990) (EIMP is "least significant" state interest). One commentator, in tracing the descent of the EIMP standard into uselessness in Florida, cites *Browning*'s negative language as a significant turning point. *See* Lester J. Perling, *Health Care Advance Directives: Implications for Florida Mental Health Patients*, 48 U. MIAMI L. REV. 193, 213-14 (1993). *But see* Scott I. Davidson, *But, Why Do We Shoot Horses: An Analysis of the Right to Die and Euthanasia*, 12 N.Y.L. SCH. J. HUM. RTS. 115, 128-29 (1994) (arguing that EIMP is the "most justified" state interest even though it amounts to little, given that the current medical ethical consensus does not require full treatment).

85. Thomas William Mayo, *Constitutionalizing the "Right to Die,"* 49 MD. L. REV. 103, 112 n.45 (1990).

86. *See* Diane E. Hoffmann, *The Maryland Health Care Decisions Act: Achieving the Right Balance?*, 53 MD. L. REV. 1064, 1096 (1994) (noting that most courts pay "lip service" to EIMP); Michael R. Fuller, *Just Whose Life Is It?: Establishing a Constitutional Right for Physician-Assisted Euthanasia*, 23 SW. U. L. REV. 103, 126 (1993) (noting that despite the number of cases mentioning EIMP, "almost none have attempted to discuss the issue in depth").

A. *Appropriate Treatment*

The majority of the cases acknowledging the four *Saikewicz* state interests have held that the ethical integrity of the medical profession prong is satisfied when the act of allowing the patient to refuse treatment is consistent with current standards of medical ethics. *Wons v. Public Health Trust*,[87] a Florida case concerning a Jehovah's Witness who refused a transfusion, uses fairly typical language:

> Finally, as to the state's interest in maintaining the ethical integrity of medical practice, the court [in *Ramsey*, a similar case,] concluded that such interest could not justify the blood transfusion in this case. The court adopted its prior *Perlmutter* analysis on this question which in a nutshell holds that *it is consistent with medical ethics to recognize a patient's right to refuse medical treatment under appropriate circumstances.* It goes without saying, however, that the medical personnel who accede to the patient's wishes in refusing medical assistance in these circumstances, cannot, the court says, be held criminally or civilly liable for their conduct.[88]

The Court then went on to conclude, based on *Ramsey*[89] and *Perlmutter*,[90] that because this case presented no ethical dilemma, the state interest in maintaining the ethical integrity of the medical profession was "entirely absent."[91]

Two things are noteworthy here. First, the Liability Goal makes a (rare) appearance, though not as part of the ethical integrity standard itself.[92] Second, by affirming *Perlmutter* (the first case to apply *Saikewicz* in Florida),[93] the *Wons* court accepted a decisive and limited view of the ethical integrity standard. *Perlmutter* had adhered tightly to *Saikewicz*'s transformation of the Full Treatment Goal to the Appropriate Treatment Goal—the notion that medical ethics does not

87. 500 So. 2d 679 (Fla. Dist. Ct. App. 1987).

88. *Id.* at 686 (emphasis added).

89. St. Mary's Hospital v. Ramsey, 465 So. 2d 666 (Fla. Dist. Ct. App. 1985)

90. Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

91. *Wons*, 500 So. 2d at 687.

92. For a keen analysis of forced cesarean cases that argues for taking the Liability, Individual Conscience and Appropriate Treatment Goals into consideration (though not using my terminology), see Eric M. Levine, *The Constitutionality of Court-Ordered Cesarean Surgery: A Threshold Question*, 4 ALB. L.J. SCI. & TECH. 229, 276-77 (1994).

93. *Perlmutter*, 362 So. 2d at 163.

necessarily always equal life at any cost.[94] According to the Appropriate Treatment Goal, if current medical mores would allow patient choice in a case, the interest in maintaining the ethical integrity of the medical profession is not threatened, and the weight of the interest is "lessened" or even "entirely absent" in the calculus.[95]

Wons is a vivid example of just how empty the *Saikewicz* test has become as the right to refuse treatment has expanded.[96] Remember that the three cases from which *Saikewicz* derived the ethical integrity standard, like *Wons*, involved Jehovah's Witnesses who refused transfusions. In all three of those cases, however, the courts forbade refusal of treatment, while the *Wons* court allowed it. What had changed in the meantime is that, independent of EIMP, *Saikewicz* and *Quinlan* had elevated patient choice to a more respected status. However, unlike *Saikewicz* and *Quinlan*, in *Wons* the court faced a person who essentially rejected her ticket to a full and healthy life.[97] *Wons* is not unusual in holding that such people can nevertheless choose to risk (or embrace) death, notwithstanding the state's interest in EIMP, because the right to refuse treatment has substantially expanded.[98]

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94. *Id.* at 163-64 (quoting *Saikewicz*, 370 N.E.2d at 426-27).

95. *Id.*; *see also* Kristi E. Scrode, *Life in Limbo: Revising Policies for Permanently Unconscious Patients*, 31 HOUS. L. REV. 1609, 1666 (1994) (arguing that EIMP is overridden in cases involving permanent-vegetative-state patients because medical ethics is consistent with death, and individual rights trump the four state-interest prongs).

96. As argued above, the EIMP standard was empty from its beginning in *Saikewicz*. Perhaps it was the *Saikewicz* court's intent to assert EIMP in this hollow form, so as to make clear that notions of medical ethical integrity should never stand in the way of personal autonomy and the right to refuse treatment. Regardless of the court's intent, however, the plain language of EIMP held the potential for future courts to assert the Societal Goal.

97. Thus, cases of incurable, terminal patients who wish to forego some sort of treatment are less controversial, and application of this sort of analysis leads more easily to a conclusion that EIMP is not implicated.

98. Many such cases involve adult Jehovah's Witnesses refusing treatment for themselves. *See, e.g.*, McKenzie v. Doctors' Hosp., 765 F. Supp. 1504 (S.D. Fla. 1991); Stamford Hosp. v. Vega, 674 A.2d 821 (Conn. 1996); *In re* E.G., 549 N.E.2d 322 (Ill. 1989); Norwood Hosp. v. Munoz, 564 N.E.2d 1017 (Mass. 1991). Nonetheless, numerous cases involve non-religious-based requests by competent, curable adults to withhold treatment. *See, e.g.*, Singletary v. Costello, 665 So. 2d 1099 (Fla. Dist. Ct. App. 1996) (involving a prisoner on hunger strike); Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978) (involving a gangrene patient refusing life-saving amputation). Other cases involve discontinuing life support for quadriplegics whose only "illness" is that they need a respirator or other life-sustaining assistance. *See, e.g.*, State v. McAfee, 385 S.E.2d 651 (Ga. 1989); McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990).

That the right to refuse treatment was quickly extended to curable people is no surprise to anyone who has followed this area of the law even casually. In this context, it shows that the purpose of the ethical integrity test was turned completely inside-out *without any explanation*. EIMP originated as a reason —a weight on one side of the scale—to require people to accept treatment; the state had an interest in not having doctors let people die. When medical ethics changed, allowing doctors to let people die in some situations, EIMP became either a weight on the other side of the scale or a nullity.[99] In other words, maintaining the ethical integrity of the medical profession means only that doctors have to act according to the current acceptable standards of medical ethics, as defined by courts that typically defer to the medical establishment. If they do so, the ethical integrity of the profession is supposedly not threatened.

However, in these Jehovah's Witness forced-transfusion cases, and in treatment-refusal cases in general, can one really accept that maintaining the ethical integrity of the medical profession requires an opposite result today from what it required thirty years ago? What has changed, apparently, is respect for patient autonomy and, perhaps, for religious freedom.[100] But, according to the *Saikewicz* line of cases, showing this shift from the Full Treatment to the Appropriate

99. Interestingly, the cases do not agree precisely on which side of the scale to place the interest in maintaining the ethical integrity of the profession. Most courts have held that the ethical integrity interest is not "in conflict" with the patient's right to refuse treatment. *See, e.g.*, Thor v. Superior Ct., 855 P.2d 375, 386 (Cal. 1993); *In re* Doe, 583 N.E.2d 1263, 1270 (Mass. 1992). In many cases permitting forced treatment, ethical integrity weighs in on the winning side, adverse to the patient's right to choose. *See, e.g.*, Rockville Gen. Hosp. v. Mercier, No. CV-90-44838-S, 1992 WL 335218 (Conn. Super. Ct. Nov. 9, 1992) (requiring forced treatment for psychiatric patient); *In re* McCauley, 565 N.E.2d 411, 414 (Mass. 1991) (requiring forced transfusion for child with leukemia, contrary to Jehovah's Witness parents' wishes). *But see In re* Doe, 632 N.E.2d 326, 334 (Ill. App. Ct. 1994) (holding ethical integrity forbids forcing woman to have cesarean section). Similarly, a handful of courts have placed ethical integrity along with the rest of the state interests, adverse to and outweighing the patient's interest. *See, e.g., In re* Browning, 543 So. 2d 258, 270 (Fla. Dist. Ct. App. 1989); *In re* Torres, 357 N.W.2d 332, 340 (Minn. 1984). While the ethical integrity standard has been both on the winning side and losing side, as well as held to not matter, it has never been a dispositive factor in any case.

100. Perfect autonomy and religious freedom have limits; people may not refuse transfusions on behalf of their small children. *See, e.g., In re* McCauley, 565 N.E.2d 411, 414 (Mass. 1991) (preventing Jehovah's Witnesses from withholding a transfusion from a child; mentioning but not applying EIMP).

Treatment Goals, (1) to let the Jehovah's Witness in need of a transfusion die before would have been adverse to the ethical integrity of the medical profession; and (2) to do so now would not be adverse. Leaving aside which position is ethically superior, how can this be logically consistent?

Two possible answers may reconcile these propositions, but neither has been offered by any of the courts in these cases. Perhaps maintaining the ethical integrity of the medical profession requires doctors to act consistently with officially promulgated medical ethics. Stated more weakly, perhaps it requires doctors to act in ways that are not inconsistent with the views of a significant portion of the medical ethical establishment. In some courts' views, then, the ethical integrity interest is not implicated in cases like *Wons*, because medical ethics no longer clearly requires forcing transfusions (regardless of whether a religious interest is involved).

This answer has some merit to it, although it might then be more accurate to recast EIMP as maintaining the ethical *consistency* of the medical profession. Still, merely following the medical ethical establishment has another serious flaw as a basis for EIMP. While maintaining this consistency makes sense in a vacuum, it does not make sense when we consider its use in practice. If the patient's preferred course of action is to refuse treatment, and this does not contravene medical ethics, the doctor must obey the patient.[101] But whatever the patient wants, and whether or not the doctor agrees, the doctor cannot outwardly act in contravention of medical ethics in a life or death situation without being disciplined or losing her license.[102] As such, it is unclear what *extra* is accomplished by grounding EIMP entirely on the dictates of the medical ethical establishment.

Viewing this point from another angle is instructive. It is highly unlikely that a court would allow the patient's rights to

101. In some of these cases, the doctor is not an adverse party. In *Wons* and many other cases, however, the doctor is. The question of the doctor's interest is explored below and includes an examination of holdings that refuse to force a particular doctor to perform the procedure in question if a willing practitioner can be found.

102. *Cf.* Sugarman v. Board of Registration in Med., 662 N.E.2d 1020, 1023 (Mass. 1996) (noting authority of medical registration board to sanction doctors for "conduct which undermined public confidence in the integrity of the medical profession").

trump the state's interest in preserving life (or vice versa) if doing so clearly contravened established medical ethics, because no certified doctors would be available to perform the procedure in question. This is evident from the fact that none of the cases passing the "consistency with ethics" test have ruled in favor of forced treatment, except in areas where doctors have traditionally treated the unwilling.[103]

If the court were to allow patients' rights to trump established medical ethics, a court would essentially be forcing a change in the establishment. Presumably the medical establishment would respond to a court's decision, which effectively moots the purpose of looking to formal medical ethical dictates in evaluating EIMP. Whether or not it realized it, the court would be an actor in shaping medical ethics. In practice, though, the law has lagged behind developments in medical ethics,[104] reluctant to allow all of the new permutations that modern ethicists have approved and that the medical establishment will allow.

Consistency with medical ethics is thus a *necessary* condition of any decision, not a factor that can be balanced against the patient's liberty interest. Furthermore, and not meant to be understated here, it is not a sufficient condition, because history has shown that letting doctors define their own rules is not always wise.[105]

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103. *All* of the exceptional cases, in which medical ethics require treatment despite the wishes of the patient, involve curable children (i.e., the parents' wishes are contravened) or prisoners, two cases in which the liberty/privacy/choice interest is diminished. *See, e.g.*, Polk County Sheriff v. Iowa Dist. Ct., 594 N.W.2d 421, 428 (Iowa 1999) (involving a pre-trial detainee refusing dialysis); Commissioner of Correction v. Myers, 399 N.E.2d 452, 458 (Mass. 1979) (involving a prisoner refusing dialysis); *In re* Custody of a Minor, 379 N.E.2d 1053, 1066–67 (Mass. 1978) (involving curable child patient); Commonwealth v. Kallinger, 580 A.2d 887, 892–93 (Pa. Commw. Ct. 1990) (involving a prisoner attempting a hunger strike).

104. *See, e.g.*, Todd David Robichaud, *Toward a More Perfect Union: A Federal Cause of Action for Physician Aid-in-Dying*, 27 U. MICH. J.L. REFORM 521, 537–39 (1994).

105. *See* Daniel Robert Mordarski, *Medical Futility: Has Ending Life Support Become the Next "Pro-Choice/Right to Life" Debate?*, 41 CLEV. ST. L. REV. 751, 775–76 (1993) (noting that deferring to medical ethics as defined by doctors is itself a threat to ethical integrity of medical profession); *see also* Katherine A. Taylor, *Compelling Pregnancy at Death's Door*, 7 COLUM. J. GENDER & L. 85, 110 (1997) (warning against ceding to doctors state's power to define ethical obligations); J. BERLANT, PROFESSION AND MONOPOLY 64–68, 97–120 (1975), *cited in Developments in the Law: Medical Technology and the Law*, 103 HARV. L. REV. 1643, 1669 n.186 (1990) [hereinafter *Developments in the Law*] (noting that medical ethical standards

Another potential way that the evolution in the application of the ethical integrity standard could be justified is to say that maintaining EIMP requires doctors to act in accordance with the contemporary norms of society as a whole. Because society had reached a consensus in favor of greater patient autonomy, the argument would go, it would contravene the ethical integrity of the profession to resist patients whose requests were within the limits of that consensus.

This argument ignores the fact that no such broad societal consensus exists. Second, tying the ethical integrity of the profession to whatever society believes on that day robs the medical ethical establishment of purpose. This is dangerous given that we want doctors to contemplate specially the ethical implications of their work,[106] even if society does not trust them to have the last word. Third, in actual practice the courts in these cases generally defer to the medical ethical establishment, not to what society or the legislature thinks.

The ethical integrity of the medical profession cannot function as a part of the state interest if it is tied solely to the ethical dictates of society or, alternately, tied to the ethical dictates of the medical establishment. The ethical integrity test should reflect the *Societal* Goal: the *general* public interest in having an ethical medical profession, as opposed to merely having doctors conform to a *particular* code of ethics.

The Appropriate Treatment Goal does little to consider the "social meaning of medical decisions,"[107] or to safeguard the ethical integrity of the profession. To the extent that the Appropriate Treatment Goal does protect the profession, it does so redundantly; institutional mechanisms ensure that doctors follow the ethical dictates of the profession, and democratic ones (legislation and regulation) ensure that doctors follow the ethical dictates of society.

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further medicine's monopoly). Well-known examples include the Nazi doctors discussed previously; forced sterilizations of prisoners and the mentally retarded in the United States and Europe; and the infamous Tuskegee syphilis experiments on African-Americans. For an interesting analogy between deferring to the medical profession and deferring to administrative agencies, see David L. Katz, Note, Perry v. Louisiana*: Medical Ethics on Death Row: Is Judicial Intervention Warranted?*, 4 GEO. J. LEGAL ETHICS 707, 723 (1991).

106. *See generally* Edmund D. Pellegrino, M.D., *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47, 66-68 (1993) (asserting need for medical ethical establishment existing independently of social convention).

107. *Developments in the Law, supra* note 105, at 1669.

Unfortunately, courts usually employ the Appropriate Treatment Goal in considering end-of-life care cases. If EIMP only means that doctors ought not let people die, given that such death is not always objectionable, EIMP will usually be irrelevant. Even when this version of EIMP was weightier, the state interest in life was generally sufficient to trump the individual's right. So, in its most typical applications, EIMP is generally irrelevant to the law. Because the Societal Goal better furthers these relevant considerations, courts should take it—and through it EIMP—more seriously.[108]

B. *Individual Conscience*

A second interpretation of the ethical integrity test has been used by a handful of courts. This interpretation focuses on the interest of doctors in not acting contrary to their personal ethical standards: the Individual Conscience Goal.[109] This goal is distinct from the Liability Goal and the Full/Appropriate Treatment Goal, but it relates tangentially to the Societal Goal insofar as it is in society's interest[110] for doctors to practice in ethically comfortable situations. Doctors may be, to borrow from the parlance of law and economics, the "least-cost avoiders" in terms of ethics.

A leading case applying this goal is *Brophy v. New England Sinai Hospital*,[111] which held that "so long as we decline to force the hospital to participate . . . there is no violation of the ethical integrity of the medical profession."[112] Importantly, *Brophy* discussed the Individual Conscience Goal both as the hospital's interest and the state's, though future cases mechanically applying the ethical integrity test have not always bifurcated the treatment of Individual Conscience in this way.[113]

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108. *See infra* Part VII.

109. For a reading of EIMP as coextensive with the Individual Conscience Goal, coupled with an aggressive defense of the Goal in the face of judicial activism, see James J. Murphy, Comment, *Beyond Autonomy: Judicial Restraint and the Legal Limits Necessary to Uphold the Hippocratic Tradition and Preserve the Ethical Integrity of the Medical Profession*, 9 J. CONTEMP. HEALTH L. & POL'Y 451 (1993).

110. Society's interest is not inherently incompatible with being part of a state interest because the state is supposed to represent the interests of unrepresented third parties.

111. 497 N.E.2d 626 (Mass. 1986).

112. *Id.* at 638.

113. *See id.* at 627–39; *In re* Doe, 583 N.E.2d 1263, 1270 & n.17 (Mass. 1992); *see also In re* A.C., 573 A.2d 1235, 1246 & n.13 (D.C. 1990). The *A.C.* case is

Such protection of the hospital's and the state's interests furthers a worthy goal, but it has no basis in the *Saikewicz* definition of EIMP. In *Saikewicz*'s application of the ethical integrity test, the court did look to the opinions of the attending physicians, but it did not treat these decisions as matters of personal conscience. Individual Conscience arguably could function as a moral version of the Liability Goal, but no court decisions explicitly draw this connection. If courts believe that the state has an interest in protecting the interests of doctors and hospitals, they should say so in appropriate language (e.g., "the state has an interest in maintaining the ethical *autonomy* and integrity of *individual members* of the medical profession"), not by adapting the ill-fitting language of *Saikewicz* and its progeny without explanation.

In addition, courts that cite the Individual Conscience Goal as a purpose of EIMP have not used it to prevent the carrying out of patients' wishes. Here, too, the ethical integrity of the medical profession is not really safeguarded from a societal or a professional standpoint. These courts refuse to force *individual* doctors to act against their principles, but so long as some doctor somewhere is carrying out the patient's wishes, the impact on the ethical integrity of the *profession* remains.

The most problematic cases are those where the court recognizes the doctor's interest in acting in accordance with his conscience, but forces the doctor to comply if within a certain amount of time he cannot find another institution willing to perform the procedure.[114] In other words, if a procedure is troubling ethically, but only minimally, so that another doctor can easily be found to perform it, the original doctor can opt out. But for the procedures that are so ethically problematic that no other willing doctors can be found, the original doctor is forced to act. This leads to the ironic result that an

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particularly troubling; it dealt with a terminally ill pregnant woman forced against her will to have a cesarean section. The doctor's right to choose was vindicated, while the woman's was on the losing side. The court's treatment of EIMP is strikingly ironic.

114. *See, e.g.*, Elbaum v. Grace Plaza, Inc., 544 N.Y.S.2d 840, 848 (N.Y. App. Div. 1989); *see also* Kathleen M. Boozang, *Death Wish: Resuscitating Self-Determination for the Critically Ill*, 35 ARIZ. L. REV. 23, 50-51 & n.146 (1993) (citing such cases, including some that did not cite the EIMP interest); *cf.* MD. CODE ANN., HEALTH-GEN. § 5-611 (protecting physician's right not to perform ethically questionable procedures, but limiting right if willing care provider cannot be found).

individual doctor's right to follow her conscience is left unprotected in precisely those cases where that right is most seriously implicated.

None of this is to say that the rights of individual doctors should not be protected, even at the cost of allowing for greater ethical division among doctors.[115] Indeed, Part VII will address that very concern. The use of EIMP to provide such protection, however, both further obfuscates the *Saikewicz* standard and appears not to work anyway.

C. *Conclusions*

When *Saikewicz* introduced EIMP, it was unclear what the standard was supposed to mean. It was distilled from the Liability and Full Treatment Goals. The former goal was ignored in *Saikewicz* and by most of the courts applying it. The latter goal was dead on arrival because the strong deference given to the liberty interest in *Saikewicz* meant that Full Treatment was no longer always appropriate.

What was left? Nothing, necessarily. *Saikewicz*, after all, culled state interests from old cases whose foundations it simultaneously tore down. For future courts, all that *Saikewicz* left of the state interest in EIMP was the need to ensure that current institutional medical ethics were indeed consistent with the action to be taken in the case at hand. Yet, this concern would never really need to be balanced; a court would not order a procedure that was medically unethical, because no doctor would be available to perform it. This fact has been ignored by courts, which have "resolved" the issues in the cases before them "by mechanical reliance on [*Saikewicz*'s] legal doctrine," in ironic disregard of that case's warning.[116]

The only room for conflict left by these courts is the interest of individual doctors in not violating their own consciences. Even if fulfilling a patient's request is consistent with medical

115. This sort of division could be argued to have a negative impact on the ethical integrity of the profession, as it causes fragmentation and prevents accountability to a unitary ethical authority, something that patients may rely upon. On the other hand, society may also value a profession composed of people who are individually accountable, provided that their individualism is communicated to the patient, who can then get an "second ethical opinion." As a practical matter, though, these ethical opinions are typically not sought by patients, but by doctors.

116. *Saikewicz*, 370 N.E.2d at 422.

ethics, individual doctors (who often bring these lawsuits to flout the patient's wishes,[117] not just to avoid liability) might be unhappy about being required to refrain from performing a life-saving procedure. If the court already is balancing ethics, and these uneasy doctors are before the court, it is fairly simple to consider the Individual Conscience Goal as part of the ethical integrity test.

The Societal Goal has not been analyzed under the EIMP test as applied. Neither the *Saikewicz* court nor any subsequent court has made a systematic effort to fulfill this goal along with the personal interest in liberty and the state interest in preserving life. As with most balancing tests, the court views its role as weighing the concerns of each party. This role makes sense when the court must balance the mutually incompatible interests of a patient in death and the state in life. It makes less sense when medical ethics issues are implicated. After Part V examines how the Societal Goal has been used and ignored in related areas of the law, Part VII looks at ways to maximize the sum of life, liberty, and the interests expressed in the Societal and Individual Conscience Goals.

V. ANALOGUES: ABORTION, ASSISTED SUICIDE, AND THE DEATH PENALTY

Strikingly, while EIMP has been mechanically and blankly applied in treatment-refusal cases, it has received relatively little attention in other cases that raise even more difficult questions about the medical profession's proper ethical role.[118] However, the U.S. Supreme Court's decision in *Glucksberg* likely means an end to this trend and an expansion of EIMP, with all of its flaws, into other highly charged areas at the margins of medical ethics.[119]

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117. *See supra* note 102.

118. *Cf.* Taylor v. Kurapati, 600 N.W.2d 670, 676 (Mich. Ct. App. 1999) (ignoring EIMP in "wrongful birth" case and noting that the *Saikewicz* factors are "consider[ed] to be inapplicable or shunt[ed] aside" in similar cases).

119. Despite the danger of importing the flawed EIMP jurisprudence into other areas, at least one scholar who sees the potential for EIMP's expansion also views EIMP more or less in the context of the Societal Goal. *See* Jill R. Radloff, Note, *Partial-Birth Infanticide: An Alternate Legal and Medical Route to Banning Partial-Birth Procedures*, 83 MINN. L. REV. 1555, 1582–83 (1999) (applying *Glucksberg/Saikewicz* analysis to "partial-birth infanticide" paradigm, and stating that "because the performance of both physician-assisted suicide and partial-birth infanticide may lead the public to question the medical profession's ethics and integrity, a state

This Part examines abortion, assisted suicide, and death penalty cases in which EIMP or something resembling it has been applied.[120] The attention (or lack thereof) given to EIMP is an accidental result of our common-law system's reliance on precedent. Treatment-refusal cases often look to *Saikewicz* and cite its language. However, EIMP has largely been ignored in these other areas because cases of similar or greater weight in these fields (for example, *Roe v. Wade*[121] in abortion law) do not contain such language. Nevertheless, even when boiled down to its simplest and weakest formulation—"the job of doctors is (usually) to heal"—the interest in maintaining the ethical integrity of the medical profession is deeply important to a correct resolution of cases in these other areas. Ideally, with *Glucksberg* as precedent, EIMP will be considered more carefully than it was in the cases discussed below.[122]

A. *Abortion*

As discussed previously, an early, important abortion case, *Poe v. Menghini* mentioned the "ethics and integrity of the medical profession," in the context of preventing a state from interposing the judgment of an outside medical panel in the decision to perform an abortion.[123] Significantly though, *Poe* does not assert a state interest in EIMP. Subsequent landmark abortion cases like *Roe v. Wade* dealt at great length with medical ethics, but these cases contained no strong statement of a state interest in maintaining EIMP and turned instead on the balancing of the interests of the mother, the fetus, and the

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has an interest in preventing the erosion of public faith in the medical community").

120. The issues discussed here are those that have generated significant case law in the past, but as technological capabilities continue to skyrocket in the next decade, innumerable other medical/ethical/legal issues will likely arise in which EIMP will be a factor (and likely will be mishandled—i.e., treated as the Appropriate Treatment Goal—as it has been to date). *See, e.g.*, Michelle L. Brenwald & Kay Redeker, Note, *A Primer on Posthumous Conception and Related Issues of Assisted Reproduction*, 38 WASHBURN L.J. 599, 612 n.49 (1999) ("[T]he United States Supreme Court will likely give deference to physicians and their ethical guidelines if a posthumous conception issue ever arose, as '[t]he State also has an interest in protecting the integrity and ethics of the medical profession.'") (quoting Glucksberg v. Washington, 521 U.S. 702, 731 (1997)).

121. 410 U.S. 113 (1973).

122. The *Glucksberg* Court did improve somewhat on EIMP's flawed interpretive history. *See infra* Section VI.A.

123. 339 F. Supp. 986, 995 (D. Kan. 1972).

state.[124]

The language of *Saikewicz* did appear in one abortion case: *Moe v. Secretary of Administration and Finance*.[125] This was a Massachusetts case, which likely explains why *Saikewicz* was on the judges' precedential radar screens.[126] In *Moe*, three women challenged a Medicaid restriction that limited funding abortions to cases in which the mother's life was in danger. All three women had medically indicated abortions, but their lives were not endangered per se. The court held in their favor, and looked to *Saikewicz* and one of its descendants[127] for help in assessing the state interest: "Although we do not regard it as decisive, we note that placing physicians in the position of choosing between their livelihood and the preservation of the health of a patient for whom abortion is a medical necessity cannot be thought to foster the ethical integrity of the profession."[128]

Avoiding this dilemma for the physician resembles the Liability Goal, although the liability here was merely administrative, rather than civil or criminal. The opinion mentions nothing resembling the Societal or Full Treatment Goals, both because the interests in life and privacy outweighed EIMP and because it was settled by *Roe v. Wade* that, as far as lower courts were concerned, abortion was not inconsistent with medical ethics. Also, because *Moe* mainly concerned public funding rather than, for example, the ethics of a new abortion procedure, the ethical integrity of the profession as developed in *Saikewicz* could not be fully implicated in any meaningful way.

Should not the ethical integrity of the medical profession be of concern to judges deciding cases at the margins of the abortion debate? While *Roe* dealt at length with medical ethics, subsequent cases such as *Webster v. Reproductive Health Services*[129] and *Planned Parenthood v. Casey*[130] did not. They

124. *See generally Roe*, 410 U.S. at 129-66.

125. 417 N.E.2d 387 (Mass. 1981).

126. *See id.* at 403 ("Rather than mechanically accepting [*Roe v. Wade*'s] result, however, we prefer to test these enactments [restricting abortions] by the balancing principles which we have developed in our own recent decisions.").

127. Commissioner of Correction v. Myers, 399 N.E.2d 452 (1979).

128. *Moe*, 417 N.E.2d at 404 n.22.

129. 492 U.S. 490 (1989).

130. 505 U.S. 833 (1992).

certainly did not address EIMP. However, more than a few doctors have been murdered by people who felt that abortion was inconsistent with the proper ethical role of doctors in our society.[131] While one might argue that abortion cases concern titanic interests in life and privacy, leaving EIMP with little weight in the balance, recent cases involving parental consent,[132] partial-birth abortions,[133] and other such important issues on the ethical margins clearly implicate EIMP. Furthermore, the unlikelihood that EIMP would ever be dispositive does not mean that it is unimportant to consider in constructing workable solutions to these knotty issues. After all, abortion cases involve the interests of the would-be mothers, the unborn, would-be fathers, would-be grandparents, abortion providers, the state, and others; there is ample room for the consideration of, and respect for, a multitude of varying interests (*Roe* is a classic, if obsolete, example). Here, then, is a promising candidate for an approach to the state interest in ethical integrity that seeks to maximize its sum with other interests, rather than merely weighing and discarding it if it is on the light side of the scale.

B. *Assisted Suicide*

In the Ninth Circuit's en banc decision in *Compassion in Dying v. Washington*,[134] reversed by the Supreme Court in *Glucksberg*, Judge Reinhardt's opinion for the court predicted that, just as the legalization of abortion had not negatively impacted the ethical standing of the medical profession (a debatable proposition), the legalization of physician-assisted suicide would similarly have no detrimental effect on the integrity of the medical profession.[135] According to Judge Reinhardt's somewhat bold approach, EIMP dictates "prohibiting physicians from engaging in conduct that is at odds with their role as healers," and is compromised not by assisted suicide,

131. *See* Shelby A.D. Moore, *Doing Another's Bidding Under a Theory of Defense of Others: Shall We Protect the Unborn with Murder?*, 86 KY. L.J. 257, 263 (1998).

132. In contrast to abortion cases, minors in treatment-refusal cases are generally not given their own voice, but instead have the state represent their interests. *See supra* note 100.

133. *See* Radloff, *supra* note 119.

134. 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom.* Glucksberg v. Washington, 521 U.S. 702 (1997).

135. *See id.* at 829–30.

but by statutes that forbid the practice.[136] Thus, for Judge Reinhardt, society's interest is served by having compassionate doctors.

Whether or not one agrees with Reinhardt's analysis, it brings to the forefront important questions that should be considered in the other cases discussed in this Article. What are the effects on the medical profession's ethical integrity from physicians assisting in suicides, letting otherwise healthy patients refuse life-saving treatment, performing certain types of abortion, or assisting in the execution of convicted murderers? Perhaps even more important is the question of how we as a society and a legal system are supposed to answer that question.

Part VII offers some possible answers. Judge Reinhardt's answers are in his opinion, and unlike all of the other major assisted suicide cases, the opinion discusses how to meet the Societal Goal.[137] A faithful reading of *Saikewicz*'s treatment of

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136. *Id.* at 827. The dissent not unexpectedly disagreed with this assessment, claiming that assisted suicide contravenes medical ethics. *Id.* at 855 (Beezer, J., dissenting). Contrast the majority opinion in *Compassion in Dying*, 79 F.3d 790 (9th Cir. 1996), to the decision of the Michigan Supreme Court in *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), which did not even mention the ethical integrity of the medical profession in the majority opinion, even though its more conservative approach to the assisted suicide question certainly could have benefited from such an analysis.

137. Within the context of physician-assisted suicide, some have called for the same sort of bland application seen in the Appropriate Treatment Goal cases, looking only to the contemporary state of medical ethics (which are usually cited with artificial clarity) and in any event looking mostly to the strong individual interest for a basis of decision. *See, e.g.*, Joan W. Dalbey Donahue, Note, *Physician-Assisted Suicide: A "Right" Reserved for Only the Competent?*, 19 VT. L. REV. 795, 806-11 (1995).

I did find one other court that has looked at EIMP with (relative) subtlety: the Circuit Court of Oakland County, Michigan, where Dr. Jack Kevorkian has been tried several times. Following is an excerpt from a decision accompanying an injunction against Kevorkian:

> The final State interest which is implicated is the maintenance of the ethical integrity of the medical profession. There is substantial evidence on the record in this case as to the unacceptability of Dr. Kevorkian's proposed practice. Prevailing medical ethical practice rejects physician-assisted suicide; the goal of causing death is contrary to the goal of medicine to promote health and life. Doctors testified as to *the threat of this practice to the existence of the medical profession* in view of the potential for error or abuse and the lack of capability of a precise measurement of pain and incurability, consent and voluntariness. The Court finds that the proposed practice of physician-assisted suicide is outside of the realm of acceptable medical practice and threatens the ethical integrity of the medical profession.

Honorable Alice Gilbert, *The Legal Response to Assisted Suicide*, 20 OHIO N.U. L.

EIMP indicates that Judge Reinhardt is not in accord with that case and its progeny, and yet (ironically, considering his activist, non-textual approach) Judge Reinhardt is the first judge to attempt to do justice to the plain meaning of EIMP. Furthermore, however *Saikewicz* is interpreted, EIMP is an important consideration ignored by too many courts who apply the standard as if all that matters is preventing doctors from helping people die, except in a few well-defined situations. These courts have implied that if medical ethics permit a death, the ethical integrity of the medical profession remains unharmed. By applying EIMP in a case where *not* permitting a death is purportedly a threat to the ethical integrity of the profession, the Ninth Circuit has shown that ethical integrity is more complex than "preserving life with a few exceptions." Regardless of whether Judge Reinhardt answered the question correctly (I would argue that he did not), he was asking the question suggested by the plain meaning of EIMP—the Societal Goal question.

In the case of assisted suicide, there is no decisive public or medical consensus on the proper role for doctors, which makes it more urgent to determine the correct outcome by considering the implications for the ethical integrity of the medical profession.[138] Not everyone agrees with Judge Reinhardt; many commentators worry that physician-assisted suicide would undermine the bond of trust between doctors and their patients.[139] The ethical integrity of the medical profession is "damned if it does and damned if it doesn't." Perhaps EIMP requires a single standard; or a legislative statement (more on this later); or the maximization of patient and doctor choice. The point is that looking to and arguing over the dictates of the medical ethical establishment will do little to tell us what effect a given course of decision will have on the ethical integrity of

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REV. 673, 706-07 (1994) (reprinting decision in People v. Kevorkian, Case No. 90-390963-AZ (Mich. Cir. Ct. Feb. 5, 1991)) (emphasis added). While Gilbert initially focuses on a standard application of standard medical ethics, she elaborates by including such issues as potential for error or abuse, consent and voluntariness, issues which provide a more nuanced view of EIMP than just whether or not it is socially acceptable for doctors to help people die.

I should disclose that, coincidentally, I worked for Judge Gilbert in the summer of 1995, but I did not do work related to the issues discussed here.

138. *See* Note, *Physician-Assisted Suicide and the Right To Die with Assistance*, 105 HARV. L. REV. 2021, 2035 (1992).

139. *See, e.g.*, Neil Milton, *Lessons from* Rodriguez v. British Columbia, 11 ISSUES L. & MED. 123, 129 (1995).

the profession. The contentious nature of the assisted suicide debate shows that *Saikewicz*'s version of the EIMP state interest, as applied to this issue, is nearly useless.

C. *The Death Penalty*

Finally, death penalty cases implicate EIMP, but again with less vigor than treatment-refusal cases. There are two separate issues here. First, many states require that a doctor be present at executions (perhaps to lend an aura of clinical precision and *faux* compassion to the killing of prisoners) but this role is incompatible with the doctor's usual societal role. Second, because it is generally unconstitutional to execute medically incompetent prisoners, an ethical dilemma is inherent in treating psychotic death-row prisoners who will be killed as soon as they are cured (or at least drugged into stabilization).

A handful of cases have recognized these dilemmas, and some have even evaluated the effect of executing prisoners on the ethical integrity of the medical profession, but none have explicitly cast EIMP as an interest to be weighed or have made it a dispositive factor in the decision.[140] Still, the courts in some of these cases have taken the ethical integrity of the medical profession seriously, even if they have not been able to fashion subtle results. This lack of subtlety exists because, as in abortion and treatment-refusal cases, the result is either life or death, and the court is unlikely to look much beyond those two weightiest of outcomes.

In the seminal case of this genre, *State v. Perry*,[141] the Louisiana Supreme Court held that it was unconstitutional to forcibly medicate psychotic prisoners just so that they could be executed.[142] While the focus was on the rights of the patient/prisoner, the court duly noted that readying a patient for the slaughter "inherently conflicts with medical ethics."[143] The court cites this conflict only as evidence of societal standards of decency, not as an interest to be weighed in

140. For discussion of these issues, see Katz, *supra* note 105, especially at 721; Rochelle Graff Salguero, Note, *Medical Ethics and Competency to Be Executed*, 96 YALE L.J. 167, especially at 183-86 (1986).

141. 610 So. 2d 746 (La. 1992).

142. *See id.*; *see also* Singleton v. State, 437 S.E.2d 53 (S.C. 1993) (reaching similar conclusion on grounds of right to privacy, with current medical ethics (but not an interest in EIMP) "reinforc[ing]" the conclusion).

143. *Perry*, 610 So. 2d at 769; *see also* Taylor, *supra* note 69, at 1063.

resolving the case. Indeed, medical ethics are opposed to the state interest here, not part of it. This subtlety was not recognized in any of the treatment-refusal cases, in which all the state-interest prongs have either been weighed against the patient's privacy interest or held not to matter, but have almost never been added to the patient's side of the scale.[144] The *Perry* court's placement of EIMP on the patient's side probably does not reflect any deep reflection on this subtle distinction between treatment refusal and the death penalty; more likely, it stems from the fact that EIMP is equated with life in both contexts, and in death penalty cases life is the patient's interest, not the state's.

Later in the *Perry* opinion, medical ethics enters more directly into the prisoner's interest. Because doctors cannot be forced to contravene their professional ethical standards, the prisoner is left with no possibility of obtaining proper medical treatment. Attempting to force treatment ironically leads to deprivation of treatment, and contravenes the prisoner's interest.[145]

Still later, the *Perry* court comes very close to expressing the Societal Goal (its mere evaluation of the ethical *consistency* of treatment having only expressed the Appropriate Treatment Goal). While it does not appear to factor into the ultimate weighing of interests, the court notes in some detail that forced treatment in this case denigrates the social interest in keeping medical care as an "unambiguously beneficent healing art."[146] This language of "interests," however, is mere dicta. The so-called interest leads only to the conclusion that forced treatment in this case should be classified as part of the process of executing the prisoner, not as medical treatment.[147] No real societal interest in ethical integrity is weighed explicitly against the state interest in executing the prisoner. No personal interest of the doctors weighs into the calculus at all.

The Delaware case of *State v. Gattis*[148] is less promising than *Perry* in its consideration of the ethics of the medical profession. Gattis, facing execution, claimed that Delaware's

144. *See supra* note 99.
145. *See Perry*, 610 So. 2d at 752.
146. *Id.* at 753 (citing Katz, *supra* note 105, at 724).
147. *See id.*
148. No. IN90-05-1017, 1995 WL 562254 (Del. Super. Ct. Aug. 24, 1995).

lethal injection provision violated constitutional standards of decency because it required a doctor's participation, in violation of medical ethics.[149] The court rejected this claim for procedural reasons, but it added that Gattis would not have won anyway, because contravention of medical ethics did not necessarily render the death penalty morally or constitutionally impermissible.[150] This holding missed the point of Gattis's claim, which was not that to kill him was unacceptable per se, but that to have a doctor present when doing so was unacceptable. The *Gattis* court thus missed a golden opportunity to at least comment on the implications for the ethical integrity of the medical profession of requiring doctors to participate in executions, especially given that members of the medical ethics establishment, such as the American Medical Association ("AMA"), proscribe it.[151]

In the death penalty context, as in the assisted suicide and abortion contexts, the ethical integrity of the medical profession is implicated but not discussed. Furthermore, unlike the treatment-refusal cases, EIMP is not formally recognized, even superficially, as an interest to be weighed in determining whether the prisoner-patient should live or die. But, the fact that courts are willing to force death-row prisoners to receive treatment does not mean that courts should blithely force doctors to provide it. Nevertheless, even though the Individual Conscience Goal should be an important consideration in death-penalty and other prisoner forced-treatment cases, courts have completely slighted it.

The interest of society in having doctors with ethical integrity is more complex than the narrow question of when doctors should be allowed to help people die. Decisions and procedures surrounding death can and should be shaped to minimize the damage to the integrity of the profession.

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149. *See id.* at *21.

150. *See id.*

151. The *Gattis* court cited *State v. Deputy*, 644 A.2d 411 (Del. Super. Ct. 1994), for this proposition. The *Deputy* court had noted opposition by the AMA, the American Nurses Association, the American College of Physicians, and the American Public Health Association to participation in executions of prisoners, but it held that this opposition was not convincing evidence of contemporary standards of decency. *See id.* at 421. Yet, the claim in *Deputy* only extended to this question of decency, while the claim in *Gattis* directly concerned actual doctor participation.

Few, if any, of the EIMP cases actually look toward promoting the profession's ethical integrity; they instead focus on guarding against its infringement. These cases typically do so by deferring to contemporary medical ethics, a maneuver that does nothing to help safeguard EIMP. The final Part of this Article suggests simple ways in which the law may take EIMP seriously while protecting the individual rights of both patients and doctors. But first, Part VI discusses the most significant milestone in the history of EIMP: its discussion by the U.S. Supreme Court.

VI. WASHINGTON V. GLUCKSBERG

Judge Reinhardt's opinion in *Compassion in Dying*, discussed above, was appealed to the Supreme Court, which reversed the Ninth Circuit. In doing so, the Supreme Court enshrined EIMP as a state interest in assisted suicide law. Despite not being bound by the precedents of lower courts, the Supreme Court adopted the language of EIMP with the same sense of automaticity that has characterized EIMP in lower courts. As a result, the Court's use of EIMP suffers from some of the same flaws described at length above. Encouragingly, however, the Court did move somewhat closer to the Societal Goal: using EIMP to protect the value to society of having ethical doctors.

A. *The Majority Opinion*

The majority in *Glucksberg* mentioned EIMP in its discussion of whether Washington's ban on assisted suicide was rationally related to legitimate government interests:[152]

> The State also has an interest in *protecting the integrity and ethics of the medical profession*. . . . [T]he American Medical Association, like many other medical and physicians' groups, has concluded that "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer." And physician-assisted suicide could, it is argued, undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming.[153]

Superficially, the biggest difference in the Court's use of EIMP

152. Washington v. Glucksberg, 521 U.S. 702, 728 n.20 (1997).

153. *Id.* at 731 (emphasis added) (second alteration in original) (citation omitted) (quoting American Medical Association, Code of Ethics § 2.211 (1994)).

here (besides a slight shift in phrasing) is that the state interest is on the winning side for a change. But, while results are important, the Court's method of analysis has even more significance.

The Court noted that it was lifting its catalog of state interests from the lower court and the parties' briefs.[154] Unlike the *Saikewicz* court, the U.S. Supreme Court did not purport to make a definitive list of state interests; rather, it surveyed the interests cited by the parties and acted only to determine whether or not those interests were legitimate and rationally related to the state's actions.[155]

This distinction does not, however, let the Court completely off the hook. The readiness of courts in jurisdictions outside of Massachusetts to adopt the *Saikewicz* state-interest test verbatim, without analysis, has already been shown.[156] It seems likely that the U.S. Supreme Court's citation of EIMP will carry even more weight with these courts, since its rulings (unlike those of the Massachusetts SJC) are binding on them.[157] Unfortunately, just as courts around the country have recited *Saikewicz*'s list of state interests without adjustment or analysis, these same courts are likely to regurgitate the *Glucksberg* analysis rather than deconstruct it and make optimal use of it.

Moreover, even though the Court only mentioned EIMP because the parties used it, it still has a responsibility to give a reasoned explanation of what EIMP means and how it should be applied. As quoted above, however, the Court notes only that the AMA believes that assisted suicide is incompatible with the physician's role as healer, and that assisted suicide therefore threatens the doctor-patient relationship.[158]

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154. *See id.* at 728.

155. *See id.* at 728 n.21.

156. *See supra* Part IV.

157. Lower courts around the country thus may also be more likely to apply the analysis in *Glucksberg* to contexts outside assisted suicide than they were to apply *Saikewicz* outside of treatment refusal cases. *Cf. supra* note 127 and accompanying text.

158. The Supreme Court's citation to and reliance on the AMA raises the interesting issue—one which this Article leaves for another day—of what exactly constitutes the "medical ethical establishment." In this Article I have often mentioned the AMA and the "medical ethical establishment" almost interchangeably. This is an oversimplification. Yet, it is true that the AMA, its *Journal*, and its well-developed Code of Ethics loom large in any discussion of what is ethically acceptable. They certainly do in *Saikewicz*, 370 N.E.2d at 424 (relying on three *JAMA* articles as basis of "current state of medical ethics"), and

It would probably be unreasonable to expect the Court to have embarked on an extensive analysis of the origins and meaning of EIMP. Nevertheless, it would not have been too difficult for the Supreme Court, which has the last word on the meaning of EIMP, to reflect carefully on what it was interpreting EIMP to mean, and on the implications of that choice.

Fortunately, however, the Court seems to have gotten it right, albeit briefly and cursorily. The Court did not merely cite the AMA Code as evidence of the medical ethical consensus and conclude that, because the profession does not accept assisted suicide, the practice necessarily compromises EIMP. Certainly the Court does imply this,[159] but it continues by noting that the "the societal risks of involving physicians in medical interventions to cause patients' deaths is too great." [160] In particular the Court was concerned that physician-assisted suicide would "undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming."[161]

Admittedly, the Court's discussion is short and relies heavily on the AMA and the congressional testimony of Dr. Leon Kass. But like Judge Reinhardt below, the Court has done something unusual in the annals of EIMP: it has included in its application of EIMP a discussion of *why* assisted suicide creates a problem for society *vis-à-vis* its need for doctors to maintain ethical integrity. Instead of using the same threadbare logic of so many previous courts, the *Glucksberg* Court added some detail.

The point should not be overstated. The Court's holding

Glucksberg, 521 U.S. at 731 (relying heavily on AMA).

159. Specifically, the Court noted that the AMA had stated in its amicus brief that "[p]hysician assisted suicide is fundamentally incompatible with the physician's role as healer." *Glucksberg*, 521 U.S. at 731 (quoting American Medical Association, *Code of Ethics* § 2.211 (1994)).

By contrast, the Florida Supreme Court, in a case decided only a few weeks later, goes no further than a recitation of the medical ethical establishment's objection to assisted suicide. The case, *Krischer v. McIver*, 697 So. 2d 97, 103-04 (Fla. 1997), essentially uses the same sources and reaches the same result as the *Glucksberg* Court regarding EIMP, but it does not rely on *Glucksberg* for its conclusions.

160. *Glucksberg*, 521 U.S. at 731 (citation omitted) (quoting Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229, 2233 (1992)).

161. *Id.* (citing *Assisted Suicide in the United States: Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary*, 104th Cong., 355-56 (1996) (testimony of Dr. Leon R. Kass) ("The patient's trust in the doctor's whole hearted devotion to his best interests will be hard to sustain.")).

amounted to little more than an application of the Appropriate Treatment Goal, but with a conclusion that this "treatment" was *not* appropriate. The Court also did not state specifically that the real meaning of EIMP is the Societal Goal. Perhaps most significantly, the Court did not really engage in a discussion of medical ethics, or of the best way for society to define it in these cases. Finally, the Individual Conscience Goal is nowhere to be found, but its absence is no particular surprise because the Court's decision does not force doctors to act.[162]

Nevertheless, in its discussion of the dangers of inappropriate treatment, the Court did more than any court before it to re-focus the EIMP discussion on the value to society of having doctors conform to a standard of ethics. That said, Justice Stevens's concurrence highlights the deficiencies of the Court's approach and underscores the need for the more nuanced approach outlined in this Article.

B. *Justice Stevens's Concurrence*

Justice Stevens disagreed with the majority's assessment of EIMP, phrasing it somewhat differently, but he agreed that it was part of the equation:

> The final major interest asserted by the State is its interest in *preserving the traditional integrity of the medical profession.* The fear is that a rule permitting physicians to assist in suicide is inconsistent with the perception that they serve their patients solely as healers. But for some patients, it would be a physician's refusal to dispense medication to ease their suffering and make their death tolerable and dignified that would be inconsistent with the healing role. . . . Furthermore, because physicians are already involved in making decisions that hasten the death of terminally ill patients—through termination of life support, withholding of medical treatment, and terminal sedation—there is in fact significant tension between the traditional view of the physician's role and the actual practice in a growing number of cases.[163]

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162. To the extent that individual conscience requires some doctors to assist in suicide, of course, the Court's decision does implicate this Goal. By maintaining the status quo, though, the Court does nothing to prevent the actions of doctors who, for centuries, have discreetly helped their patients die. *See* Stephanie Graboyes-Russo, *Too Costly to Live: The Moral Hazards of a Decision in* Washington v. Glucksberg *and* Vacco v. Quill, 51 U. MIAMI L. REV. 907, 913–14 (1997).

163. *Glucksberg*, 521 U.S. at 748–49 (Stevens, J., concurring) (emphasis added)

Justice Stevens's point is similar to that of Judge Reinhardt:[164] medical ethics are not so simple that courts can say that assisted suicide will always find itself on the wrong side of EIMP. Justice Stevens also challenged the Court's facile assumption that the role of physician as healer can feasibly be maintained as an absolute. He concludes this section of his concurrence by noting that, AMA Code aside, a majority of doctors support some form of helping terminally-ill patients die.[165] I have deliberately avoided taking sides on this matter in this Article. The point is that when courts honestly evaluate the effect on EIMP solely on the basis of the consensus of a medical ethical establishment, they are bound to find that no real consensus exists. Furthermore, even if there is a consensus, there is no guarantee that writing this consensus into law protects the state interest in EIMP.

Finally, Justice Stevens's concurrence highlights one remaining deficiency in the majority's approach. Even though the Court discusses the implications for EIMP of assisted suicide in a way that suggests the Societal Goal, in the end the Court engages in balancing. It evaluates the effect of the procedure at issue, determines that it is incompatible with EIMP, and ends the discussion. Justice Stevens, however, suggests that the majority might have it wrong, and that future cases might require re-evaluation of the calculus.[166] I would suggest that an even better approach would be to avoid the balancing approach altogether; to avoid placing EIMP inexorably opposite from the personal privacy interest; and to avoid forgetting about EIMP in those cases when the individual interest wins. The best approach is to seek to maximize EIMP and thus protect society from a repeat of the "Nazi doctor" problem, by finding ways to protect EIMP even in those cases where the "state interests" are trumped by

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(citations omitted). Stevens concluded that other legitimate state interests might suffice even without the interest in preserving the medical profession's integrity.

164. Justice Stevens did not agree with Judge Reinhardt that the state interests in this case would always be outweighed by the personal privacy interest, but he disagreed with the majority's equally rigid conclusion that they never would be. *See id.*

165. *See id.* at 749 n.12.

166. *Cf.* T. Alexander Aleinikoff, *Constitutional Law in the Age of Balancing*, 96 YALE L.J. 943, 948 (1987) (discussing efforts by some courts not just to establish balancing tests but to establish permanent assessments and calculations of the factors).

individual rights.

C. *Post-Script*

It is too early to say for sure how lower courts will treat the *Glucksberg* Court's use of EIMP. One judicial clue comes from the Illinois Court of Appeals. In *In re Fetus Brown*,[167] decided on the last day of 1997, the court gave the most detailed and incisive treatment of EIMP since *Saikewicz* in the process of allowing a pregnant woman to refuse treatment that would have benefited her viable fetus.

First the court noted the Supreme Court's approval of the tired old *Saikewicz* state-interest test:

> Generally courts consider four State interests—the preservation of life, the prevention of suicide, the protection of third parties, and the ethical integrity of the medical profession—when deciding whether to override competent treatment decisions. *Application of the President & Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1006-07 (D.C. Cir. 1964); *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 425 (1977). *See also Compassion in Dying v. State of Washington*, 79 F.3d 790, 816 (9th Cir. 1996) (finding six state interests, cited with approval on writ of certiorari, *Washington v. Glucksberg*, 117 S. Ct. 2258, 2271-72 n.21 (1997)).[168]

When the court applied EIMP, the court explained it as follows:

> This interest seeks to protect the role of hospitals in fully caring for their patients as well as to promote the prevailing medical ethical standards. *Saikewicz*, 370 N.E.2d at 426. Although some hospitals have sought judicial determination of their role in these matters, the American Medical Association Board of Trustees generally recommends that "[j]udicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus." H. Cole, *Legal Interventions During Pregnancy*, 264 JAMA 2603, 2670 (1990). Accordingly, this interest does not provide a definitive solution.[169]

Admittedly, this discussion is not particularly expansive. It also does not draw upon the Supreme Court's use of EIMP in

167. 689 N.E.2d 397 (Ill. Ct. App. 1997).
168. *Id.* at 402 (citations omitted).
169. *Id.* at 403 (alteration in original) (citations omitted).

Glucksberg, though this is understandable because the Court in that case made no effort to explain what EIMP means, and because this case does not involve an assisted suicide.

Interestingly, the court in *Brown* uses the language of Full Treatment, not the watered-down language of Appropriate Treatment seen elsewhere. This usage is significant, because the court nevertheless allows a patient to refuse treatment and forbids doctors to care fully for either the mother or the fetus, both of whom would die without treatment.[170]

Finally, as in most previous cases, the court determines the effect on EIMP by examining the medical ethical establishment's current consensus. In doing so, though, it explicitly states that EIMP requires this examination. Indeed, it says that the court's role in the EIMP process is to maintain the status quo, or "prevailing medical ethical standards."[171] The Illinois Court of Appeals moves EIMP even farther down the wrong path discussed in this Article, both by embracing the Full/Appropriate Treatment Goal over the Societal Goal, and by deferring completely to the medical ethical establishment's view of what is appropriate. It does so, for the first time, with a citation to a Supreme Court opinion. Hopefully, this is not a harbinger of things to come.

VII. A PROPOSAL FOR REFORM: TAKING ETHICAL INTEGRITY SERIOUSLY

So what should be done with the state interest in maintaining the ethical integrity of the medical profession? What respect is due to an underexplained and underanalyzed precedent? Has it been so trivialized that it should be eliminated?[172] Should the entire list of state interests be overhauled and replaced with a "longer and more precise list"?[173] Or should EIMP be reasserted on firmer ground? It is my contention here that the latter is the best course of action, because the Societal Goal is a worthy one. I propose to address

170. *See id.* at 399. In this case, the question happened to be moot because the doctors performed the transfusion against the mother's will. *See id.* at 400.

171. *Id.* at 403.

172. *See* Daniel R. Gordon, *The Right to Die:* Public Health Trust v. Wons, 7 N.Y.L. SCH. J. HUM. RTS. 40, 97-98 (1990).

173. *In re* Guardianship of Browning, 543 So. 2d 258, 266 n.11 (Fla. Dist. Ct. App. 1989).

two issues here: first, achieving the Societal Goal—ensuring that our doctors are playing a proper ethical role—while still protecting a right to privacy and autonomy among patients; and second, carving out an area of ethical autonomy for doctors as well.

On its face, *Saikewicz*'s declaration of a state interest in maintaining the ethical integrity of the medical profession would seem to answer the Societal Goal once and for all. That is, it would seem to say that as a society we have an interest in the ethical responsibility of our medical community. As seen above, however, the courts applying EIMP have deferred to the ethical dictates of the profession itself in determining the proper role of doctors. While the opinions of doctors are certainly valuable ones to consider, this approach does nothing to protect the Societal Goal in those instances where the medical profession is divided on the ethical implications of a practice, or, more dangerously, when the profession is generally in agreement, but it is wrong.

Does society have an interest resembling the Full Treatment Goal in having a group of professionals who are committed to preserving life at all costs? Presumably not, given the trend over the past three decades in respecting patients' choices and in recognizing that heroic and extreme efforts at prolonging life are not always the most appropriate treatment. Nevertheless, might it not be worthwhile to remove doctors from these sorts of decisions; to let doctors remain as life-savers and leave the welcoming of death to some other branch of health-care institutions such as hospices? I do not purport to engage this question thoroughly here. I raise it only to assert the possibility that what is best for the patient is not necessarily what is best for the ethical integrity of the medical profession, but that potential alternatives may keep these two interests from working at cross-purposes.

The best approach takes EIMP out of the state-interest balancing test and places it instead into an interest-maximization test. Currently, courts examine contemporary medical ethics as part of the state interest that is weighed against the patient's liberty/privacy interest. When medical ethics support the patient's side, they are just written out of the equation. This is an artifact of the pre-*Quinlan* analysis in which life was on one side, death was on the other, the

"winner" would necessarily "take all," and the ethical integrity of the medical profession clearly was attached to the interest in life. Now that this is no longer the case, it might make sense to place EIMP on the patient's side, or, better yet, to take it off of the scales altogether.[174] The problem with balancing tests is that they dictate the same result for cases that are close as for cases that are not. By maximizing the sum of interests, or maximizing them individually in some lexical ordering, courts could go further towards vindicating all interests simultaneously.

In doing so, litigants and courts could begin looking for proper *complete* solutions rather than just proper outcomes. Instead of simply letting a patient discontinue treatment and forcing doctors to help, a court could first determine if treatment should be continued or not (looking to the other parts of the *Saikewicz* test, if it so chooses) and then, if treatment is to be discontinued, look for ways to do so that do not place the medical profession in problematic ethical postures. In areas like the death penalty, a solution could be to recognize that executions are not medical procedures, and forbid states to pretend that they are. In the context of treatment refusal or physician-assisted suicide, a solution might be simply making it clearer to doctors and patients well ahead of time what their rights are, and encouraging a wide social dialogue as to the correctness of these rights. In all cases, it might be sufficient just to use an Appropriate Treatment goal, measured with the same sort of ethical consistency analysis that most courts have used, but to define what is ethically appropriate based on the recommendations of a state medical ethics commission that is not monopolized by doctors.[175]

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174. *Cf.* Keith Shiner, Note, *Medical Futility*, 53 WASH. & LEE L. REV. 803, 806 (1996) (discussing patients' requests for futile treatment that doctors ethically do not wish to perform: "A 'turf battle' has now developed and some physicians . . . believe that patient autonomy has intruded too far into physician integrity—both as a matter of professional judgment and professional ethics.") (footnote omitted).

175. Some states currently have state medical licensing boards that are composed of members of the public as well as medical professionals. *See, e.g.*, MICH. COMP. LAWS ANN. § 333.17021 (West 1999) (establishing board comprising nineteen members, of whom eight are "public members"). If the state legislature mandated that a similar sort of board, rather than a random collection of tomes on medical ethics found in the courthouse library, were to be the source of courts' assessments of proper medical ethics, it would have moved closer to a democratic, systematic, and principled resolution of the Societal Goal.

These latter two solutions sound more statutory than judicial, but nothing prevents the legislature or an independent state commission from supplanting the courts as guardian of the medical profession's ethical integrity. Some states have attempted to do just that, though without mentioning EIMP per se.[176] Those states that do mention EIMP explicitly have simply written the state interest in EIMP into statutes without bothering to explain what EIMP means.[177] It is thus crucial to involve legislatures in the enterprise of taking ethical integrity more seriously by setting up institutions to protect it.[178] What the courts and legislatures should do, then, is recognize that *Saikewicz* was right in asserting that we have an interest as a society in the ethical integrity of our doctors, but recognize further that *Saikewicz* and its progeny have done a poor job of protecting it. Furthermore, EIMP should be protected in all legal-medical contexts, not just those treatment-refusal cases that fortuitously follow *Saikewicz.*

Unfortunately, even if society were to rely on legislative and democratic solutions, courts have already weakened the ethical standing of doctors. The lack of regard courts have given to maintaining the ethical integrity of the medical profession has been evident in case after case in which the courts newly allowed people to die or be killed. I would defer to the uncertain vicissitudes of popular consensus, not to vindicate democracy, but to prevent courts from doing further damage. I do not purport personally to have either the definitive answer for how to maintain EIMP, or an effective mechanism for writing it into law, absent the participation of political bodies working through democratic processes.

Currently, the state interest in EIMP has become a near

176. Maryland and Virginia, for instance, have statutes that protect physicians from being forced to perform a procedure that the physician personally feels is ethically inappropriate. *See* MD. CODE ANN., HEALTH-GEN. § 5-611; VA. CODE ANN. § 54.1-2990.

177. *See, e.g.*, FLA. STAT. ANN. § 765.102(1) (West 1997) (asserting in advance directive law state interests in life and ethical standards of medical profession); MO. REV. STAT. § 459.055(1) (listing protecting ethical standards of medical profession as one purpose of life support regulation declaration); NEB. REV. STAT. § 20-402 (listing *Saikewicz* prongs as state interest in cases dealing with the terminally ill).

178. I would be more forceful in urging a role for the legislature, based on my personal beliefs about the proper role of the judiciary, but I have bowed in this Article to the fact that courts follow precedents, however ill-defined, and I have attempted to find the best possible way to repair one particular precedent.

nullity because courts have found a consensus on when it is ethically acceptable to allow a patient to discontinue treatment. This consensus ignores the complexity of the ethical integrity of the medical profession, the many angles from which it is subject to erosion, and the fact that there will always be cases that need to be addressed at the margins of consensus. The following are some specific questions that we must have our guarantors of medical ethics address: Are doctors healers, life-savers, comforters, or some combination? What are the best ways to vindicate a patient's right to refuse treatment? (Presumably, lawsuits such as those surveyed in this Article are a poor way, given their repetition.) What is the proper role, if any, of doctors in assisting suicide? What should the bounds of such participation be? Of performing abortions? Of attending executions? More abstractly, but no less threatening to the ethical integrity of the medical profession, under what circumstances should patients be told of genetic abnormalities in themselves or in their children? When are anencephalics considered legally dead so that their organs may be harvested?[179] What about assisted reproduction,[180] genetic manipulation, and cloning? The list is potentially endless, and given the increasing speed with which medical technology is advancing, there is no time to lose in forming principled methods of determining safeguards for the ethical integrity of the medical profession that are independent of determinations of patients' rights in individual cases.

In the meantime, courts should avoid the path they have taken since *Saikewicz*, in which they define ethics rather than apply them. The ethical integrity of the medical profession can be threatened just as much by the actions of courts in rewriting the rules of medical ethics as by the actions of doctors working along the margins of technology. While I call here for a democratic determination of what is ethically acceptable, I also believe that maintaining the status quo until there is such a determination is the best way to maintain EIMP. Absent

179. *See* Lisa E. Hanger, *The Legal, Ethical, and Medical Objections to Harvesting Organs from Anencephalic Infants*, 5 HEALTH MATRIX 347, 356-57 (1995) (arguing that harvesting organs from anencephalic infants would harm the ethical integrity of the medical profession).

180. *See supra* note 120.

constitutional considerations,[181] a *court* has no reason to push a shift in medical ethics. If a court suddenly and newly allows doctors to, say, assist in suicides, preside at executions, or clone a sheep, it stacks the deck. If the court maintains the status quo, it gives the democratic machinery a chance to resolve the question itself. The ethical integrity of the medical profession rests on defining ethics by true societal consensus, not judicial fiat.

Finally, courts are an immediate threat to the ethical integrity of the medical profession when they force medical practitioners to perform (or not perform) procedures based on a view of contemporary ethics that those doctors do not share. If doctors stop objecting, society has a problem. Even though society may not want to leave medical ethics completely in the hands of doctors, neither does it want doctors left out of the dialogue and placed at the mercy of the courts' predilections. The immediacy of this threat to the ethical integrity of the medical profession is apparent from those troublesome cases in which doctors object but must nevertheless obey courts.[182]

Separate, but still significant (indeed, perhaps more so) is the effect that forcing doctors to act has on the individual doctors themselves. The title of one law review article on the topic sums this up well: *I Have a Conscience Too: The Plight of Medical Personnel Confronting the Right to Die.*[183] In other contexts, like forced sterilization and abortion, federal legislation specifically protects the rights of medical professionals to not participate.[184] It is worth debating the extension of these sorts of protections to medical professionals in the treatment-refusal or assisted-

181. The *Ashwander* doctrine suggests that courts should avoid these constitutional considerations. *See* Ashwander v. TVA, 297 U.S. 288, 341-56 (1936) (Brandeis, J., concurring) (discussing canon of avoiding constitutional questions that are not necessary to decide the case). These kinds of cases present a highly charged example of why the Constitution should be left out of moral, legislative decisions: a failure to do so enshrines morally questionable results as being compelled by higher law.

182. *See supra* note 114.

183. Irene Prior Loftus, 65 NOTRE DAME L. REV. 699 (1990).

184. *See id.* at 721. An interesting and fast-growing analog to forced sterilization is the chemical castration of criminal sex offenders; several states have considered allowing physicians to refuse to perform the procedure, and at least one state has written such an opt-out provision into its chemical castration law. *See* Robert D. Miller, *Forced Administration of Sex-Drive Reducing Medications to Sex Offenders: Treatment or Punishment?*, 4 PSYCHOL., PUB. POL'Y, & L. 175, 196 (1998).

suicide contexts,[185] at least with the goal of spurring greater awareness and notice of medical ethical standards and options available to patients and to doctors.

Whether our intent is to aid further in maintaining the ethical integrity of the medical profession, or to vindicate the rights of medical practitioners, the solution is the same. As in the previous section, the answer is to maximize, not balance. Instead of determining that the patient's right trumps the doctor's, and then leaving the doctor out in the cold, courts can tailor their rulings to vindicate both sets of rights. Some courts, though not all, have done this.[186]

Obviously, these suggestions are ambitious ones. They would require a fairly radical departure from the spirit (though not the letter) of *Saikewicz* as it has been interpreted, and they would also require action by legislatures that have little immediate pressure being placed on them. Still, the language of *Saikewicz* and its progeny give space for courts to assert the Societal Goal, and the U.S. Supreme Court in *Glucksberg* took a tentative step in that direction. The ethical integrity of the medical profession is important, and courts and legislatures have shown some interest in protecting it. They can do it better.

VIII. CONCLUSION

When *Saikewicz* established a state interest in maintaining the ethical integrity of the medical profession, observers might have thought that EIMP would be an important factor as American courts moved through the tangled ethical issues that come with modern medicine. This belief might have seemed (superficially) vindicated by the inclusion of EIMP language by the Supreme Court in *Glucksberg*. But in reality, the effective use of the EIMP standard was over before it even started. Courts have construed medical ethics as supporting whatever outcome they would have reached anyway, and while considerations of ethics might have informed these decisions, *there has been no case* in which the consideration of the ethical

185. *See* Boozang, *supra* note 114, at 50 n.144 (citing states in which medical professionals have such protection in the context of the withdrawal of treatment).

186. *See id.* at 50-51 & nn.144-46 (citing cases in which courts have allowed doctors to opt out, but also citing cases in which courts have not).

integrity of the profession made any difference in the outcome.

In the meantime, however, the medical profession has undergone drastic changes, and ethical debates remain inextricably linked with the legal questions raised by issues such as treatment refusal, abortion, assisted suicide, and the death penalty. The ethical integrity of the medical profession needs to be safeguarded, and the *Saikewicz* state-interest test is not going to do it.

It is time for courts to think about the effect of their decisions on the ethical integrity of the medical profession. Courts making these determinations should use authorities other than just the medical establishment itself. Legislatures should foster dialogue on medical ethics that is not limited to doctors, and that provides courts with a clearer picture of what ethical requirements society has for its doctors. Courts should then apply *these* ethical standards, rather than defining their own. The courts must also recognize that the ethical integrity of the medical profession requires some ethical autonomy for medical practitioners. Finally, courts should seek to maximize the sum of these interests—patients', doctors', and society's—rather than respecting only the one perceived to be weightiest in the case at hand. It is time to take the maintenance of the ethical integrity of the medical profession seriously.