

# APA Newsletters

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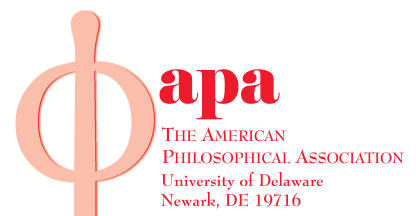
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APA NEWSLETTER ON

# Philosophy and Law

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Theodore Benditt, Editor

Fall 2005

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## FROM THE EDITOR

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### Theodore Benditt

*University of Alabama at Birmingham*

The topic for this issue of the *Newsletter* is *Ethics, Health Policy, and Law*, with Professor Samuel Gorovitz of the Department of Philosophy at Syracuse University serving as guest editor.

This is the last issue I will be editing. I have enjoyed my term as editor and want to thank everyone who worked on the *Newsletter*, including contributors, the APA Publications Office, and the members of the APA Committee on Philosophy and Law. I also want to welcome the new editor, Professor John Arthur of Binghamton University of the State University of New York. Professor Steven Scalet, also at Binghamton, will serve with John as co-editor.

### Future Issues of the *Newsletter*

Topics and editors for upcoming issues of the *Newsletter* are:

#### Spring 2006 – LEGAL POSITIVISM

Submission Deadline: January 9, 2006

Editor: Kenneth Einar Himma

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#### Fall 2006 – OPEN ISSUE

Submission Deadline: June 15, 2006

Editor: John Arthur

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Papers on any topic related to Philosophy and Law will be considered.

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## FROM THE GUEST EDITOR

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### *Ethics, Healthy Policy, and Law*

#### Samuel Gorovitz

*Founding Director, Renée Crown University Honors Program; Professor of Philosophy, The College of Arts and Sciences, Syracuse University*

The law—as one among many public sector instruments that influence choices about health-related matters—powerfully affects peoples' lives. We have seen in the recent case of Terri Schiavo how a complex interplay of law, medicine, politics, religion, emotion, opportunism, misunderstanding, and duplicity commanded center stage as this multiply tragic case lurched toward its bitterly contested conclusion. In this sorry saga, it was vividly clear both that the relevant laws were crucially important and also that many other factors beyond the laws were also crucial to the case. Part of the dispute concerned the legitimacy of case-specific legislation in the context of a complicated battle over who should get to decide what about whom.

Questions at the intersection of law, ethics, and health policy occupy a domain within which jurisdiction is typically contested. One may ask what the law is or what it ought to be about a specific kind of controversial decision, but in the background there is typically the logically prior question of whether and why such decisions should be thought of as a matter of law in the first place. In *Quinlan*, the court famously found that the decision about the patient's treatment was not the court's business. In *Schiavo*, the court found that the decision about the patient's treatment was not the legislature's business. In *Werneke*, on June 16 of this year, Texas Juvenile Court Judge Carl Lewis ruled that the medical care of twelve-year-old Katie Werneke was no longer her parents' business.

Each of the three essays that follow explores a question to which the law is relevant but about which one must also ask who should get to decide what. The first, by Courtney Cox, begins with the observation that there has been considerable controversy about the ethical permissibility of using data obtained by Nazi researchers in evil experiments on human subjects. Yet there is no controversy about using data obtained in evil experiments done in earlier times. Cox asks how the passage of time shapes our judgments about what is ethically permissible and then explores how her conclusions can be reflected in policies that can inform choices that remain for us to make as we seek to balance the claims of those who stand to benefit from the use of ill-gotten research results with the rights of those with a legitimate claim against the use of that information.

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The second essay, by Michael Gottlieb, considers the role of physicians in treating the mental illness of death row inmates whose executions are prevented only by that mental illness. His analysis of *Singleton v. Norris* has a broader goal, however: he argues in the end for legal protection of the integrity of roles, claiming that offenses such as those in Abu Ghraib are made more likely by inadequate attention to the conflict inherent when a professional occupies multiple roles.

The final essay, by J. Andrew West, focuses on a specific current question and considers it in light of actual and pending legislation in several states. Most people agree that a nurse who is opposed on moral grounds to abortion ought not be required to participate in performing one. Instead, a “conscience clause” would typically allow that nurse to be held safe, without penalty, from participating in it. But if that nurse steadfastly objected on grounds of conscience to, say, the use of bandages or to the administration of medications, most people would agree that this noncompliance would be grounds for termination of employment. So the question arises: Who should be allowed to decline, on grounds of conscience, from what kinds of actions that might otherwise be assigned as a professional responsibility? West examines the legal and ethical dimensions of this question and proposes model legislation that he argues avoids the deficiencies of legislation already enacted in several states.

Each of these essays began as a paper written for a seminar on *Ethics, Health Policy, and Law* taught in the fall term, 2004, under the auspices of Yale’s Interdisciplinary Bioethics Center. Each has since been revised for this *APA Newsletter*. Courtney Cox is a senior in the Ethics, Politics, & Economics program at Yale, where she is also completing a degree in Electrical Engineering. Michael Gottlieb is in his third year at Yale Law School; he has master’s degrees in linguistics, in psychology, and in public health. J. Andrew West is a first-year student at Duke Law School; he received a master’s degree in ethics from the Yale Divinity School this year. It has been a privilege to work with them.

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## ARTICLES

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### ***Only Time Can Tell: Unethical Research and the Passage of Time***

**Courtney Cox**

#### **Overview**

Experimentation on human subjects is, unfortunately, necessary for medical advancement. Given the risks associated with human experimentation and the importance of treating people as ends in themselves and not mere means,<sup>1</sup> certain ethical standards must be met. What happens, however, when ethical standards are violated or ignored? In some cases, the resulting data sets have been of great importance to the advancement of medical science—and the lives of many. Once the information has been obtained, is its use another violation of the victim—or may the data set be considered separate from the way in which it was discovered? Should the unethical means by which the data sets were acquired preclude their future use for the benefit of humanity?

Regardless of the answer to that question, unethically acquired data have been and continue to be used. In fact,

much of what is known today about medicine was learned over the centuries through experimentation on slaves, poorer communities, and stolen cadavers.<sup>2</sup> The entire field of modern gynecology is based largely on discoveries made by Dr. J. Marion Sims during his experiments on slaves and poor Irish communities in the mid-nineteenth century.<sup>3</sup> Around the same time, body-snatching was becoming commonplace as doctors scrambled to find cadavers for experimentation: Charlie Grant, a former slave, recalled for a WPA interviewer that he had once dug up the body of a recently deceased two-year-old in return for two dollars.<sup>4</sup> While the use of “unethical data”<sup>5</sup> is hotly contested in the case of more recent experiments, such as the Nazi data or some of the HIV data acquired from disadvantaged communities, it is barely questioned in temporally distant cases. Why is this?

To answer this question, I will employ the idea of a “moral claim.” The word “claim” signifies the existence of a moral right. The claim may be for or against a certain action, object, or treatment. For example, from a Kantian perspective, humans have intrinsic value and, as such, are to be treated as ends in themselves, never means only. Using the idea of a claim, this means that a person has a *claim* to being treated as an end in him/herself, or a *claim* against being treated as mere means. In other words, they have a *right* to be treated in this manner. If there exists a moral obligation on *X*’s part to help *Y*, then *Y* has a *claim* to *X*’s help. Claims may be divided into two groups: active claims and inactive claims. Active claims are fully tied to the time in which they exist: the individual making the claim must be alive and the object<sup>6</sup> of his or her claim must exist at that time. Inactive claims are somehow temporally distant from either the claimer or the claimed object. For example, an active claim against a violation becomes inactive once the violation has occurred and no longer has the possibility of recurring. When ethical questions arise, it is usually as a result of two or more claims coming into conflict. Their weights must then be compared in order to arrive at a decision.

*Prima facie*, the question of whether to use unethical data appears to be one of utility. However, it is not necessarily a question of maximizing the good but of how best to balance conflicting moral obligations. In this case, there are essentially two types of competing claims: the claim of those in need and the claim of those violated. The claim of those in need is a claim to information. After needed information has been learned, there usually follows an obligation to use it under the principle of beneficence. Barring reasons *against* using the information (such as the data being unethical), if one knew how to cure a child’s illness, one should help. This claim to existing, needed information, is called the “Need Claim.” The Need Claim also extends to unethical data insofar as it exists as information. This claim is active—that is, in effect—until the need is met or disappears.

The second type of claim is the traditional one—the claim of those violated by the unethical experiment. This claim may be divided into two separate claims: the “Experiment Claim” and the “Use Claim.” The Experiment Claim is a claim against being used as mere means by an unethical experiment. Though it is a fundamental one, never justifiably violated, once it has been violated, the information exists. The Experiment Claim thus moves from being active to inactive and, as a result, decreases. There remains, however, an additional concern as to the harm that might be inflicted on the victims by use of the data. Subjects of human experimentation must consent to *both* data collection and data usage. This claim to deciding the data’s use is the Use Claim, which applies after the data have been collected. However, given that the data have already been collected, this additional harm is small in comparison to the initial violation.<sup>7</sup> Indeed, the capacity to do further harm

to the victims through the use of the data, as will be shown, seems to decrease over time. This may be what underlies the natural inclination to allow the use of unethical data at temporally distant points from the experiment itself.

A useful starting point is to analyze the nature of virtue and vice over the course of time. According to the recursive account of virtue and vice, when analyzing responses to good and evil, an appropriate response is good and an inappropriate response is bad.<sup>8</sup> This is similar to the idea of claims as weighing for or against an action. Thus, framing the discussion in such a way lends greater clarity to balancing the competing claims. I will show that as time passes, the value of hating the evil—the unethical experiment—decreases. Since the claim of the living to life remains constant, there will come a point when the value of using the data will outweigh the value of not using it.<sup>9</sup> This indicates that far out enough in time will come a point when data usage is not only permissible but also obligatory. For most cases, this point will occur after the death of the last victim involved.<sup>10</sup> Before this point, a similar comparison of values relates the nature of the initial ethical problem to the significance of the claim of those in need. Once the conditions of the use of unethical data have been established, instrumental concerns of deterring future creation of unethical data can then be addressed. Finally, I will discuss the resulting legal implications of this framework, as well as other instrumental concerns.

### The Framework

In beginning the discussion of the use of unethical data, the two primary claims that come into conflict must be established. The first is that of the victims of the unethical experiment. Their claim—to not being used as mere means to an end—is certainly substantial. Pure deontologists maintain that regardless of potential utility, the claim against being used as mere means must never be violated. The debate over the use of this unethical data, however, is not a comparison of utility. Rather, there is a competing *claim*, a right to health—even life—on the part of those who would benefit from this information.

How might this be established as separate from utility? First, consider a case in which a data set exists that has the potential to save one person's life. There are no ethical problems with the way in which the set was acquired, or with its intended use. This person should be saved—even if only for the added utility. What if there were a situation, however, where saving this person actually caused a decrease in utility? For example, the one person that would benefit is an orphan in an extremely impoverished community. While his survival would not cost anyone else her life, it would further tax an already ailing group—“just another mouth to feed.”<sup>11</sup> The decrease in well being that it would cause to the other members of the community is greater than the added well being to the orphan.<sup>12</sup> On a pure utilitarian analysis, it would be better *not* to save the child. This cannot be right. It fails to take into account the child's intrinsic value as a human being, placing the comfort of society above his survival; it is culpable negligence. The child has a right to life. If information were known that could potentially save lives, the principle of beneficence dictates a moral obligation to use it.<sup>13</sup>

Hence, this is not simply a matter of deontology versus utilitarianism. Two competing claims—respect for persons versus beneficence—must be balanced. However, the analysis of the second claim—the right to the information—needs to be taken a step further. Can a claim to the use of unethical data possibly be legitimate? If the data are evil, then perhaps they are best ignored, as though they had never existed at all. This does not seem plausible. It is not the numbers that are

evil; it is the way in which they were collected. *The information exists as information*. Therefore, the claim to it as information is possible. The concern over its use then extends to the harm that might be done apart from the initial violation.

Once the existence of these two competing claims has been established, the analogy to virtue and vice over time may be drawn. For this to be done, the base-level goods and evils, or claims, must first be considered in greater detail. The initial problem begins with the experiment itself. The subjects, being human, have intrinsic value. They are ends in themselves, not to be treated as mere means.<sup>14</sup> The nature of the experiment violates this. This is an evil occurring at time  $t_0$ . As would be expected, valuing their claim against this particular exploitation, or, more simply put, hating this evil, has intrinsic value at  $t_0$ .

The claim at  $t_0$  against being used as mere means by an experiment is the “Experiment Claim.”<sup>15</sup> As time passes, its value diminishes. This can be readily shown by considering a similar experiment taking place later at time  $t_1$ . The two experiments are equally “bad” within their respective timeframes.<sup>16</sup> If one existed at time  $t_1$ , the evil taking place at  $t_1$  is more proximate. As a result, the value of hating this evil is higher than hating the one that occurred in the past at  $t_0$ . Which is worse, to be indifferent to a person suffering in a distant time and place, or to a person suffering on the floor in front of you? The more proximate an evil is, the greater the value of responding to it becomes.<sup>17</sup> Hence, the claim must be greatest when the event is occurring. Afterwards, this claim begins to decrease. However, the value of this claim in the distant future does not necessarily approach zero. If it did, then far enough out in time, the difference between the value of hating this immense evil, and hating a smaller evil at the same time, would become negligible. Instead, the value of hating the evil approaches a lower asymptote whose height is determined by the height of the initial value at  $t_0$ .

The question then arises, is further harm being done by using the data? It seems that once a data set has been created, it exists on its own, separate from the subjects used to create it. The accuracy of its results depends on the accuracy of the procedure, not the ethical status. Furthermore, to use this data as the basis or a component of otherwise ethically sound research is not to re-use the subjects involved as means. Yet this does not mean it is permissible to use unethical data just because the damage has already been done. Unethical data are certainly not on a level playing field with ethical data. This is because unethical data still have a claim against their use. As noted earlier, the value of hating evil, the claim against unethical data, maintains weight even after the evil has occurred. Though this value decreases with time, making the use of unethical data less bad, it is still bad. Ethical data does not have this claim against it. When data are available through ethical means—whether by tapping a different database or repeating an experiment—we should use it.<sup>18</sup>

Yet, can the data really be separated from the victims in such a way? A thought experiment may shed light on this question. Dr. Graham is a psychiatrist treating a patient, John, for depression. Naturally, during the course of the therapy, John's relationships with various people are discussed. One day, John's spouse calls Dr. Graham with a concern that John is cheating on her. Having actually discussed this matter the previous day, Dr. Graham knows this to be true. Though John's spouse certainly has a claim to knowing this information, there is a problem with Dr. Graham providing it: it is not his own. Though he no longer needs John to know this piece of information since the purpose for him acquiring the information was for treatment, he cannot use it for other matters unrelated to that treatment.<sup>19</sup>

This idea may be extended to information acquired through research. When informed consent is given to participate in a research experiment, the participant provides consent on two different accounts: first, the collection of the data, and, second, the purpose of its collection. That is, in giving information connected to one's person, an individual has a claim as to how that information is used. In the case of unethical data, this indicates that there is an *active*<sup>20</sup> claim present after the initial violation from the experiment itself. For purposes of simplicity, this claim—to decide how data are used—will be referred to as the "Use Claim." To write off the victims as "emotional cripples,"<sup>21</sup> ignoring their protests against data use, is not only problematic intuitively, it is a violation of an active Use Claim.

How does this Use Claim fit in with the initial one against the experiment? Does it simply prevent the original claim from decreasing in value, or does it exist as its own separate claim? Consider a victim who feels that the data should be used. Ferdinand Labaloue, a victim of the Nazi hypothermia experimentation, supports the use of the data even if he is not to benefit from the results: "...I feel that if the data gained from experiments on me have been used to help others, I would never have prevented that."<sup>22</sup> He is giving his consent to the data being used when there is a need. What effect should this have on the Use Claim? It can no longer be against using the data because he is not against data use. Instead, it becomes a positive claim in favor of using the data when there is a need.<sup>23</sup> If the Use Claim was considered as part of the original claim, causing it to remain active instead of becoming inactive, then if the victims agreed to allow data use, there is no longer anything to separate the value of using unethical data from using ethical data.

What happens if the claims are separated? The two are summed. Yet, the Use Claim, which applies directly to the use of the data, can only be applied once the data is in existence, that is, for some time  $t > t_0$ . This would then imply that the sum of the two claims—the Total Claim—is greater at  $t > t_0$  than it is at  $t = t_0$ ; the victims have a greater claim against the data (its use and existence) after it has been collected than while it is being collected. This is hardly plausible. Certainly, the greatest grievance occurs at  $t_0$ —the claim against being involved in an unethical experiment. This is the most direct use of the person as a means. One solution is if the value of the Experiment Claim, or the original claim, is defined to be infinite. If this is the case, then the Use Claim is negligible in comparison until the Experiment Claim has decreased to finite value. This seems attractive intuitively and, as will be shown, is correct.

Given that the total claim against the data (both its existence and use) continues indefinitely, what makes it acceptable to use the data? There exists a competing claim from those who would benefit from the use of the information. As noted, if information is available to help those in need, they have a claim to it. Whether this claim outweighs other claims against the use of the data is a separate question. The strength of their claim to use the data is inherently linked to the size<sup>24</sup> of their need. That is, the greater their need, the greater their claim. The claim would certainly be bigger when a life is at stake than when one is not. The nature of this claim for use, however, is continuous<sup>25</sup> over the time when the person needs the information. This makes intuitive sense. If there is a need, it exists until it is satisfied or disappears. Unlike the Use and Experiment Claims, this claim, the "Need Claim," ceases to exist upon death. This is because the information can no longer help a person who is dead; the need has ceased to exist. In such a way, there is a continuous value to the desire to bring about this aid, a value to the love of the good.

The claim to use information only applies to unethical data when other avenues are unavailable. If untainted data are available, yet tainted data are used, this is ignoring the negative claim that lingers from the way in which it was acquired. Using unethical data when other means are available is thereby further promoting the bad, and constitutes a bad in itself since, of two options, the worse was chosen.

Once it has been established that no other avenue is feasibly available, the two competing values must be compared. The total weight of the claims for using the data is balanced against the total weight of the claims against using the data for each moment in time.<sup>26</sup> That is, the data may only be used when the value of using the data exceeds the value of not using the data. In fact, not only is the data use allowed, it is then *required*.

But consider this objection: Could the claim of the people in need ever outweigh the claim of the research subjects against being used as mere means? If the claim of a person against being used in unethical research is finite, then a number of claims to the researched information could sum to be greater than the Experiment Claim. This, however, is not an accurate interpretation. The claim of people to information could never outweigh the claim against being used in the research at  $t_0$  because the information does not yet exist; a Need Claim cannot exist if the needed information does not exist.

Something else, however, exists in its place: a claim to the pursuit of information. Consider a person suffering from an unknown illness. To help him, he must first be diagnosed. A doctor with the capacity to do this certainly has an obligation to help him by trying to discover what it is he is suffering from. Or, for example, if a crime occurs, the police have a duty to get to the bottom of it—to find the thief, the murderer. In such a way, those in need have a claim to the pursuit of information. It is this claim, the "Research Claim," that must outweigh the Experiment Claim.

As a result, the same problem that existed before arises: What if the research required only one human subject, but ten, 100, 1,000, one billion people had a claim to it?<sup>27</sup> Would not the sum of the claim for information be far greater than the claim of the one person against being used as a means in such a way? This is a disturbing thought. The answer must be no. The claim against being used as a mere means is a fundamental one that must be adhered to.

Yet, what if the research only required withholding a small amount of information from only one human subject? This is unethical, but if the risk to the subject was negligible, and it would save the lives of millions of people, the decision is no longer as clear. Is the size of the claim against a violation proportional to the nature of the violation? That is, if a violation is less unethical, is the claim against it weaker? The inverse may be easier to answer: If a violation is more unethical, is the claim against it stronger? Intuitively, the answer is yes, and, as will be discussed, it affects the nature of the Use Claim. In most cases, however, the initial ethical violation caused by the experiment is not negligible: regardless of how large the claim to information is, it cannot trump the individual's right to his own person, his claim against such experimentation. In most cases, it is a barrier that cannot be overcome. Therefore, for purposes of simplicity, the value of this claim against the unethical experimentation will be considered as being infinite.<sup>28</sup>

This is consistent with the conclusion reached earlier. It solves the problem created by a summation of the Experiment Claim and the Use Claim, the "Total Claim," being greater than the active Experiment Claim. Yet, if the fundamental principle

to be followed is not to use people as means, why is the Use Claim assumed to be less than the Experiment Claim? This, indeed, appears problematic. Since the Use Claim stems from the idea that when a person must give consent on two accounts—the data's collection as well as its use—it seems that a violation of the Use Claim is a violation of their autonomy and is therefore to use them as mere means.

Why, then, was it assumed that the two claims had different weight? A thought experiment may shed some light. Imagine a situation in which there are only two choices<sup>29</sup>: to use unethical data or to unethically research new data at a given time  $t_1$ . (The unethical data already in existence was unethically acquired at time  $t_0$ .) The victims of the first experiment are opposed to the data's use. The would-be victims of the second will not be opposed to the data use once the data have been collected, although they are certainly opposed to the initial experimentation. Which is the lesser of two evils? If both the Use Claim and the Experiment Claim have the same value, the two choices are equally bad. This is hardly plausible—how can subjecting a new group of people to the initial violation not be worse than using unethical data already in existence? The claim of those against experimentation must be greater than the claim of those against the use of already-acquired unethical data.

The reason for this is that the experimentation is to use a person more fully as a means. The use of data does this to a lesser degree. While it violates the principle of respect for persons,<sup>30</sup> it is still a use of information. Even though the people from whom the information was acquired should have a voice in deciding its use, to ignore their claim is not so much to use them directly as it is a violation of respect. This differs from unethical experimentation, which cannot in any way be separated from the person whom it is violating. This being the case, the Experiment Claim—when active—is of infinite value, while the Use Claim is always finite.

*What does this imply for how the weights change over time? How soon after  $t_0$  does the Experiment Claim fall back to finite proportions? What is the shape of the Use Claim, and how should its initial value be determined?*

First, consider the Experiment Claim. To determine the rate at which the weight of this claim decreases, assume the Use Claim is neutral—that is, the victims of the experiment are indifferent to data use. Continuing the analogy to the value of virtue and vice over time, if a given virtue or vice had value at  $t_0$ , the decrease in its value is negligible at  $t_0+$ , an extremely small amount of time after  $t_0$ . For example, hating the suffering caused by the Holocaust has the greatest value at  $t_0$ , while the suffering is occurring. However, the differences between hating the suffering a day, two days, three days—in the case of the Holocaust, even years and decades—after it has ended are negligible.

Does this slow decline in value hold for the Experiment Claim? Though appealing to think so, note this difference between the Experiment Claim and the value of the vice discussed: the value of the Experiment Claim is the value of the *claim* against the evil, a base-level good; the value of hating the Holocaust is just that—the value of *hating* the evil, a virtue, but not a base-level good. Though the latter has immense value, it may never approach the value of the evil itself, as explained under the recursive account of virtue and vice.<sup>31</sup> The value of hating the evil is finite; it will always be finite. The weight of the Experiment Claim, however, is infinite when that claim is active. Hence, an extremely small decrease in its value for short time intervals after  $t_0$  will result in a value that is still infinite.

Why is this problematic? What needs to be determined in the case of the Experiment Claim is at what point the claim returns to a finite value. Until this point, there is no situation where it could *ever* be justifiable to use the data—regardless of the lack of a Use Claim and the immense size of the Need Claim to the information. Once it becomes finite, a large enough Need Claim could justify the use of the data. This is not to say that it would be permissible to use the data in all situations where a Need Claim existed but, rather, that the possibility would exist for the use of the data to be justifiable in some situations. Hence, in determining how the weight of the Experiment Claim changes, the first question is: How much time must pass after the data have been collected until there could be a situation where its use is justifiable?

Setting instrumental concerns of deterrence aside for the moment, it seems that such a situation could arise almost immediately. If an unethical experiment, performed on a disadvantaged population in Africa, actually discovered the cure to AIDS, how long must the world wait to be able to use the cure? Currently, 36.1 million people are infected with HIV/AIDS. There are 5.3 million new infections per year, or 15,000 per day, and 1,700 of these daily infections are in children under the age of fifteen. The disease has already killed 21.8 million people.<sup>32</sup> Given the extent and severity of the disease, the claim is immense. Once an unethical experiment has been performed and a cure is in existence, the size of the claim is such that to withhold the cure would be wrong. Further, since for the purposes of the current discussion the Use Claim has been considered neutral, or even in favor of data use, the claim against the initial existence of the data should not outweigh the Need Claim. Similar cases could be drawn experimenting with the severity of the need and the severity of the experiment's ethical violation. It appears that the Experiment Claim must almost immediately return to finite, albeit still immense, proportions.

How can this be achieved? The only solution that maintains continuity is a curve that is initially extremely steep before leveling out to a lower asymptote. The problem with this, however, is that once the curve has reached finite proportions, it very quickly approaches its asymptote. If this is to be the case, then there are great differences in the weight of the claim for small time intervals very early on, but little difference in the weight between times shortly thereafter and times far in the future. This does not seem plausible. The Experiment Claim should be significantly greater close to the breach than far in the distant future. As a result, the Experiment Claim has a discontinuity at  $t_0$ , when it moves from an active to an inactive claim. The decrease will be similar to the one described above, allowing for negligible difference in the weight of the claim over short time intervals early on, while bottoming out to an asymptote. The initial weight of this claim after the discontinuity at  $t_0+$  is given by the degree of the ethical breach. In other words, the more unethical an experiment was, the greater a claim should exist against the use of its data.<sup>33</sup> In such a way, it parallels the analogy to virtue and vice over time as presented above.

When considering the Use Claim, another relational issue occurs: How should it compare to the claim against the data's existence for time  $t > t_0$ ? Recall the problem with including the Use Claim within the Experiment Claim: if a victim had no problem with data use, or even wanted the data to be used, this would erase the claim against the use of unethical data, placing it on even footing with the use of ethical data. Once they have been separated, however, should this still be a concern?

It turns out that actually the reverse is true. Since the Total Claim against the data has been separated into two claims, the Experiment and the Use Claims, this would no longer be a concern. Even if the three claims—the Experiment, the Use, and the Need Claims—summed in favor of using the data at time  $t^*$ , the value of using this data is still less than that of using ethical data.<sup>34</sup> The danger of giving unethical data use and ethical data use the same value having been avoided, the case should be reconsidered. If a victim of unethical experimentation, like Ferdinand Labaloue,<sup>35</sup> wanted the data to be used when the need was great enough, why should it not be, provided that ethical data alternatives<sup>36</sup> are unavailable? At the end of the day, the victims must be respected. To ignore their desire to have the data used because the value of hating the data's existence is greater would be to commit the same folly as using the data against their wishes: it disregards the value of the victims' opinions. Therefore, when it is active over  $t > t_0$ , the Use Claim must be greater than the Experiment Claim.

While determining the exact magnitude of the Use Claim is beyond the scope of this paper, it has some interesting properties. First, it is the same for each individual, regardless of how they were experimented upon. This is because the Use Claim is a claim to *consent* or *control* information use, not a claim against the existence of the data itself. Any variation in the Total Claim against the data use is caused by the Experiment Claim.<sup>37</sup> Second, the Use Claim is active over the lifetime of the victim. As a result, its weight is also constant (though its direction, for or against data use, may change). Indeed, the distance from the time the information was given, if subjects are still alive, should not affect their right to control the information. Third, this claim becomes inactive upon whichever comes last, their death or their expected death—at the end of their projected life expectancy. The reason for the transition being located at the later of these two events is to protect against any difference in weights against using the data if the victim dies as a result of the experiment. That is, the Use Claim is active not just over their actual lifespan but over what it would have been. One cannot decrease the value of the evil of experimentation by doing greater evil, causing the subject to die. This is essentially parallel to the inactivity of the Experiment Claim—the claim becomes inactive when there is no longer any possibility of it being asserted, with the safeguard being the only substantial difference. However, this does not imply that the Use Claim drops immediately to zero. Instead, there is a gradual decrease over time. When a person dies, it does not give a *carte blanche* to disregard their wishes. The desire of surviving family members to uphold a deceased loved one's requests demonstrates this.<sup>38</sup> Indeed, there is something troubling about waiting for the moment someone dies to do what one wants.

A final point<sup>39</sup> with regard to the Use Claim must be considered: Where does the decrease in value bottom out? If it were to decrease in value indefinitely, this would cause positive Use Claims eventually to become negative and vice versa. This is not plausible. The Use Claim may never change sign once it has become inactive because the victim is no longer present to change its direction. However, the Use Claim does approach zero. The more time that passes, the weaker the claim becomes—the living must have a greater claim than the dead to life-sustaining information. This is not to say, however, that the claim ever *becomes* zero but approaches it. The difference between the two is negligible but still present.

The framework has now been laid out. Three claims—the Experiment Claim, the Use Claim, and the Need Claim—must be balanced in deciding when, if ever, unethical data may be used once it has been collected. Of the three, the Use

Claim is the most powerful, possessing the ability to essentially double the claim against data use, or to tip the scales in favor of it. As a result of the way in which the Experiment Claim and the Use Claim decrease over time, the data becomes more available to needs of decreasing severity. This increase in availability becomes much quicker once the victims of the experiment (would) have died. To determine data use at any given moment, the vectors of the various claims are summed. Though the claim against the data never disappears entirely, time causes the scales to tip in favor of data use. Eventually, a point will be reached when the data must be used in most cases for which ethical data is unavailable. However, once this framework has been established, what can be done with it?

### The Real World

The use of unethical data is nearly always controversial in the short term. Dr. J. Marion Sims, often referred to as the “father of gynecology,” was criticized by a number of his peers for his experimentation on slaves and, later, poor Irish communities in New York.<sup>40</sup> However, little more than 100 years later, few give notice to the fact that modern gynecology is based largely on this unethically acquired data.<sup>41</sup> In fact, much of modern medicine was developed through the use of this and other types of unethical data.<sup>42</sup> The framework presented above offers a plausible explanation for this phenomenon. To move from the theoretical to the useful, however: To whom would it matter behaviorally if this theory is right?

One of the groups that the framework may affect behaviorally is journal editors. Journal editors must make publication decisions based upon a piece of research's scientific validity and ethical status. According to the Committee on Publication Ethics's “Guidelines on Good Publication Practice”:

(7) Formal and documented ethical approval from an appropriately constituted research ethics committee is required for all studies involving people, medical records, and anonymised human tissues. (8) Use of human tissues in research should conform to the highest ethical standards....<sup>43</sup>

Failure to live up to these standards may amount to misconduct.<sup>44</sup> Under these guidelines, at least, the publication of unethical data is not approved.

If the framework is correct, there may be room for revision. Journal editors would be able to publish unethical data after a certain amount of time had passed, provided there was a need for which ethical data was unavailable.<sup>45</sup> How long should this time be? This number is difficult to pinpoint. It should be at the discretion of the individual journal to decide whether they wanted to create a general policy or decide on a case-by-case basis. Public Knowledge laws may provide some guidance. Pharmaceutical patents last only 11.7 years,<sup>46</sup> while regular patents expire after twenty.<sup>47</sup> In some states, birth and death records enter the public domain after fifty years have passed following the individual's death.<sup>48</sup> Copyright for writing and music expires seventy years after the death of the artist.<sup>49</sup> In the case of the pharmaceutical patents, the Need Claim is high. Without an Experiment Claim to balance against, the Use Claim would quickly be trumped. In the case of music copyrights, the Need Claim is low, hence, the Use Claim trumps for a greater period of time. While this cannot be a direct comparison, it does shed some light on approximate time intervals. For the use of unethical data, the Experiment Claim and the Need Claim vary on a case-by-case basis. Given this, it might be better to make the decisions in a similar case-by-case fashion, with the general wait period being roughly thirty

to forty years after the death of the last victim.<sup>50</sup> Similar applications may also be useful to policy makers in determining the funding of scientific projects. For example, if a project relies upon unethical data, it must wait the required time before receiving federal funding.

The use of the framework to allow data use after a given period of time, however, raises an interesting question: What should be done about deterrence? One leading argument against using unethically acquired data is that not using it creates a disincentive to pursue new unethical experiments when the ethical route becomes too costly (whether monetarily or otherwise).<sup>51</sup> However, if the claims weigh in favor of the data use, not to use the data is wrong. The Need Claim is substantial enough that the data must be used; the victims themselves may even want the data to be used. Not to use it on the premise that an example must be made of the unethical scientist, on the grounds of preventing future crimes and preserving research integrity, seems wrong. In a way, it is once again giving control to those who perform unethical research, even if it is not what they would choose. Deterrence, an instrumental concern, should be achieved through other means.

This is where the policy-makers—legislators, lobbyists, other bureaucrats—must come in. While they can use the framework to help steer funding, this use of their power is limited in the same way as that of journal editors. However, they do have the power to deter scientists from performing unethical research by means unrelated to the data's use: punishment. For the truly one-minded, science-oriented scientist, this may not be enough of a deterrent; as long as he is making a discovery that is of use, he is content. Yet, for many, punishment in terms of fines or jail sentences may be an effective deterrent. Shame may also play a role: scientists who have performed unethical experiments could be judged ineligible to present work at professional meetings.<sup>52</sup> Any benefits accrued from discoveries, monetary or otherwise, could be confiscated. While funding should not be taken from the scientist ethically relying on the unethical data, it could and should be taken from the scientist who performed the unethical experiment in the first place.

This framework also has another problem when applied to the real world: determining the status of the Use Claim. This is the case with any framework that employs a similar notion. Victimization through crime causes trauma. The literature regarding trauma victims indicates a need for control as an essential part of the recovery process.<sup>53</sup> Indeed, as Quinn notes: "[...] supporters of the data's use fail to understand that we continue to harm the victims by not giving them control over the use of the data."<sup>54</sup> She takes this idea a step further, noting: "We should not say what it means for the victims to be in control, for to do so is paternalistic."<sup>55</sup> The excuse that it may result in dissenting opinions is not valid; the victims must still be given control.<sup>56</sup> However, Quinn does not explain or suggest how this might be done.<sup>57</sup>

The theoretical framework presented here also takes the victim's claim into consideration: through the ability of the Use Claim to outweigh the Experiment Claim, the victim has the ability to cast a powerful vote for or against the data's use. This, too, fails, however, because it is never suggested how the victim's opinion might be obtained.

While many other issues may be bracketed for future discussion,<sup>58</sup> this one may not. The reality is that *there may not be a way to give victims complete control*. It has nothing to do with writing them off as "emotional cripples" or considering their view to be biased in such a way that they could not make the decision.<sup>59</sup> The theoretical framework takes a step in the

right direction by offering a straightforward way of analyzing their opinions. The victims' claim to control the use of the data is the same in all cases; they simply need to decide whether this value is for, against, or indifferent to the data's use in a particular situation. Yet, determining even this much proves challenging.

*Prima facie*, the obvious choice would be to contact the victims, but this is problematic. Some may not want to be contacted. "Many victims will have particular triggers that remind them of their victimization, such as sights, smells, noises, birthdays, holidays, or the anniversary of the crime."<sup>60</sup> Especially in cases of those who suffer from "long-term crisis reactions," these kinds of triggers can cause them to have a relapse of the initial crisis reaction.<sup>61</sup> Asking for consent to use unethical data raises the issue yet again. For some, this could be medically problematic. Others may simply not want to deal with it, having moved on with their lives. In other cases, the victims may be unaware of their participation and leading "normal" lives. Informing them is to make them aware of how they were victimized, possibly inflicting trauma. Directly approaching the victims is not an option.

One solution would be to open the forum to discussion. Victims would be encouraged to come forth and discuss but not forced. Sufficient care would need to be taken to ensure that they would not be re-victimized by the process. While the details of how to do this are beyond the scope of this work,<sup>62</sup> the key is to *listen* to the victim. If they say they do not want the data used, that is their answer. They are not to be interrogated or made to feel guilty for their opposition to data use. One of the difficulties with this solution is the need to publicize so that the victims are aware of the discussion taking place, without being obtrusive. Media attention on the people involved in the study itself must be curtailed.<sup>63</sup> To a certain extent, unfortunately, this is unavoidable.

What should be done in cases where the victims do not express their opinion, or there is no way to reach the victims—to even know who they are? The Use Claim is determined by whether the victim wants the data to be used or not; that is, whether or not the victim *consents* to the data use. This being the case, not voicing an opinion is not to grant consent. Hence, unless instructed otherwise, the Use Claim should always count against the use of the data. In high-stake cases, sticking to this may prove difficult. If the Need Claim is so great that the difference between using the data and not using the data turns on one individual's Use Claim, making a decision by assuming the unknown Use Claim to be negative is difficult. In these situations, decisions should be made on a more case-by-case basis, perhaps in consultation with an Ethical Review board.

## Conclusion

The framework laid out here attempts to reconcile the variations in opinion toward the use of unethical data with respect to time. By relying on the idea of a "claim," a right on the part of the individual asserting it, or, alternatively, a moral obligation on the part of those in control of resources or information, the weight of the claim is set into motion as a decreasing function over time. After establishing the existence of competing claims—here, the Experiment, the Use, and the Need Claims—the way in which to resolve them is discussed. The result is that as time passes the claim existing against the use of the unethical data decreases, while the claim in favor of its use remains positive. Thus, there will arrive a point, after a given time interval, during which data use becomes not only justifiable but mandatory. This point, as has been shown, typically occurs sometime after the last victim has died. The framework also has real-world applications in addition to the



theoretical ones. It may be of particular use to journal editors in making publication decisions with regard to the ethical status of an article. More interestingly, it sheds light on the need for a separation between instrumental concerns and claims when determining data use: deterrence should be achieved through a means that does not affect the ethical decision on the data use made with regard to the claims. For it to achieve its full potential, the determination of the Use Claim status, in addition to who may decide the way in which the balance occurs, must be worked out. These questions, however, are beyond the scope of this work. In sum, the framework appears to be a plausible explanation with strong possibilities for application. Will it work? Only time will tell.

## Endnotes

1. Kant, 95.
2. O'Leary, 427; Cotton, 54-55, 57-63.
3. O'Leary, 427; Sartin, 500, 504.
4. Cotton, 55.
5. For purposes of simplicity, from this point forth, "unethical data" will be used to refer to data acquired through unethical experimentation on humans. The reason why the data are unethical, or how the ethical status of data might be determined, are separate questions not discussed in this paper.
6. The object of their claim may be an actual "object"—a thing—such as information or medicine. In other cases, it may be a claim for or against an action, in which case the possibility of the action or the potential for the action to occur must exist.
7. This is not to discount its value. However, there exists a large gap between the amount of harm done by the data collection and the amount of harm done by its use, which extends from the fact that the initial violation is of infinite proportions, as will be discussed.
8. Another way of explaining this is to establish that there are certain base-level goods and certain base-level evils. Loving the goods and hating the evils is intrinsically good. The reverse response, hating the goods and loving the evils, is intrinsically bad. This account is recursive, meaning that an attitude toward these responses may also be thought of in this way (e.g., loving the love of a good is also a good). A further explanation and defense of this theory can be found in Thomas Hurka's *Virtue, Vice, & Value*.
9. This is not a matter of maximizing welfare, but a matter of the value—or weight—that should be given to different claims.
10. In determining policy, this point should be considered as existing not after their death but after the end of their expected "lifetime" or life expectancy. This would help prevent any unwanted ease that would arise in decision-making from their premature death as a result of the experiment.
11. Source unknown.
12. The decrease results from the child living, not from the cost of treatment itself. Beyond this, the exact details of how this trade-off would work shall be suspended for purposes of the thought experiment. For the moment, consider the orphan's well being sufficiently close to the "barely worth living level" (Kagan) so as to insufficiently balance a substantial decrease in others' well being.
13. The caveat here is that the information is known (i.e., is already in existence). As will be discussed, there is no claim to unknown information. However, there is a claim to the pursuit of knowledge.
14. Kant, 95.
15. The Experiment Claim applies *only* to the claim against being treated as a means by the experiment at  $t_0$ . It does not yet consider the effects of further data use.
16. How they came to be equally bad is not important; it could be as a result of them being identical in nature and scope, or for some other reason. The important consideration is that the "badness" of the  $t_0$  experiment at time  $t_0$  and the "badness" of the  $t_1$  experiment at time  $t_1$  are the same.
17. This is consistent with the first modal condition of the recursive account of virtue and vice, which states: "concern for one of these objects has less value when the object's existing is a more remote possibility, or would require greater changes in the world" (Hurka, 118).
18. What of repeating extremely dangerous experiments? Sometimes the results of unethical experiments indicate a substance to be dangerous. In these situations, it would be unethical to repeat the experiment, given the knowledge that it is dangerous. This is because those being experimented on have a right *against* being subjected to unnecessary dangers. It is an example of a claim in favor of data use that outweighs the claim against it.
19. Professor Gorovitz raised an objection to this point: What if John told Dr. Graham he was going to kill his wife—and Dr. Graham believed him? In this situation, Dr. Graham must warn the wife: her claim to life outweighs John's claim to confidentiality. However, the point being demonstrated by the thought experiment above remains: suppliers of information have a claim to controlling its use.
20. As has been noted, two types of claims exist: active and inactive. For example, the Experiment Claim at the time of the experiment,  $t_0$ , is an active claim. Once the unethical experiment has been performed, however, this claim has already been violated and cannot be violated again in the same way. Thus, the claim moves from being "active" to "inactive." The Use Claim is active over the course of a person's life. Even if the data were to be used, this does not preclude the data from being used again. Hence, unlike the Experiment Claim, it remains active even after it has been violated.
21. Quinn, 317.
22. Quinn, 324, fn. 3.
23. Why does it not simply become neutral? Consider a case where data are collected to fill a need. Once the data have been collected, it is useful in filling the need. However, for some unknown reason, the researchers decide not to use the data to alleviate the need. This is problematic. However, if the claim is neutral (i.e., nonexistent for purposes of the question), there is nothing wrong with the fact that an undue burden was placed on the research subjects (there will still be an unsatisfied claim to the data from those in need). Therefore, the Use Claim is positive in favor of data's use for the purpose intended. The fact that there is a positive claim in favor of using the data, however, does not necessarily mean that there will always be a need. The intended purpose

- for the data use must be present for the Use Claim to be positive. Otherwise, it remains neutral. This has strong consequences for the use of ethically acquired data in the use of further research for which it was not originally intended. As a result, policy governing informed consent may need to require the consent to be given for “research,” thereby relinquishing the Use Claim altogether. If someone does not want to do that, then they do not participate in the study.
24. This is both in terms of the size of the individual need as well as the number of individuals who have such a need.
  25. Given the ability of time to alter circumstances, this would not necessarily be true in actual application. For example, some might argue that since there is a claim for every moment that the need exists, with each maintaining weight as time passes, every moment actually has more than one Need Claim. As a result, the summation of these could imply that those who had waited longer to have their needs met have a larger claim and should be given greater priority. Another example might be that the necessity of curing an illness or debilitating condition is greater when a person is younger, since there is more at stake and more to be gained from the procedure. In such a way, the initial values of the claims would differ. The exact nature of these claims and how they sum, however, is a question beyond the scope of this paper. For purposes of simplicity, this claim will be considered continuous over time until it disappears or is met.
  26. The comparison for any given moment does not take into account past or future claims. Any change in claim that would result from the benefit to an individual from the amount of future value they would receive or the length they have been waiting is already included in their claim at a given point in time. The way in which this factors into the Need Claim is beyond the scope of this paper, however, as noted in fn. 25.
  27. It is interesting that this is the place where utilitarianism had failed.
  28. Whether or not the Research Claim might trump the Experiment Claim and the way in which it would do this are questions that require their own discussion. Fortunately, the simplification does not change the framework. As will be discussed, there is a discontinuity at  $t_0$  when the Experiment Claim becomes inactive. Even if the initial, active Experiment Claim is not infinite, this break will still allow the Total Claim to be greatest at  $t_0$ .
  29. For the sake of this thought experiment, the reason why these two choices are the only options is irrelevant. Furthermore, one of the two must be selected; not deciding is not allowed.
  30. The principle of respect for persons is one of the three values listed in the Belmont Report on human experimentation research ethics (“Guide” Section 4).
  31. Hurka, 129, 133.
  32. These statistics are as of 2000, taken from the Office of National AIDS Policy “Summary Fact Sheet on HIV/AIDS.”
  33. The exact formula for determining this height is beyond the scope of this paper.
  34. During a conversation with Professor Gorovitz, the question was raised: What if a victim wants the data to be used—regardless of whether ethical data is available—because they feel that at least their suffering would have done some good? It seems that, in this case, they would be denying the value of the Inactive Experiment Claim. Given the broad nature of this question and its implications, it is left for another time.
  35. Quinn, 324, fn. 3.
  36. Whether these “ethical data alternatives” are using an ethical data set or redoing an experiment following ethical standards is irrelevant.
  37. An interesting result of this is that the range of possible weights against data use is equal to twice the Use Claim.
  38. This point was made to me during a discussion with Professor Gorovitz.
  39. This is the last point this paper will take into account, though there are certainly more to be considered. Another interesting question that could be raised is whether the Use Claim can change back and forth between being for or against data use. It seems that once permission has been given in favor of using the data for a particular case, it cannot be rescinded. However, this does not appear to suggest that the claim could not recede back to neutral (i.e., move from being in favor of data use to being indifferent).
  40. O’Leary, 427-429; Sartin, 500.
  41. *Ibid.*
  42. Cotton, 48, 54-55, 57-63.
  43. “Guidelines,” 69.
  44. *Ibid.*
  45. When publishing unethical data, it may be advisable to make a special note condemning unethical research procedures. However, doing so might create an incentive by demonstrating that unethical data will eventually be published. The proper course of action is left to the journal to decide.
  46. “Ten.”
  47. “Beginner,” 1.
  48. For example, in Rhode Island, birth certificates are kept confidential for 100 years before being moved into the public archives. Death certificates are moved into public archives after fifty years (“Office”).
  49. “Beginner,” 1.
  50. Thirty years seems like a reasonable estimate, given that the Need Claim is great, as in the pharmaceutical case, but taking into account an added Experiment Claim. What if the evil researcher outlives his victims, even though his victims do not die prematurely? For example, consider the situation in which a young researcher unethically experimented on elderly people. It was established earlier that the distance from the time the information was given should not affect the subject’s right to control the information. The same would apply after the victim has died. Though it might seem preferable to raise the inactive Use Claim for elderly victims since, otherwise, the unethical data would be used closer temporally to when it was acquired, once a victim has died, the harm done to them by using the data is still less. The wishes of both the elderly victim and the one who was experimented upon in his youth should be

respected after their deaths. Indeed, using the number of years after the victim's death is consistent with the example of copyright laws, where a work moves into the public domain a set number of years after the artist's death instead of a set number of years after the work was copyrighted. Measures might be taken, however, to deny the evil researcher any form of credit for the data.

51. Quinn, 317.
52. This was suggested by Professor Samuel Gorovitz.
53. "Alliance," 2.
54. Quinn, 322.
55. Quinn, 323.
56. This is ironic. For example, in some tests, trial data might be randomized in such a way that a given piece of information may not be traced to the source. Even if all the victims could be contacted, how would the determination of the data's use be decided? A majority would still deny the minority their control. It seems as though this is an unavoidable dilemma, unless each individual's data set may be separated from the group's.
57. Quinn, 324.
58. One of the other important issues that this paper does not address is who should decide the strength of the Need and the Experiment Claims, thereby determining the balance either in favor or against the data. Since the application discussed here is for journal editors making publication decisions, they are ultimately in control when deciding whether to publish the data. This is a reality. Whether it is right is a matter for another discussion.
59. Quinn, 317.
60. "Alliance," 2.
61. Ibid.
62. Additionally, laws outlining the treatment of rape victims during legal proceedings may be a useful place to begin. Though these laws are by no means sufficient, they have made progress in thinking about how to protect victims while giving them a voice (Watson).
63. Media attention focusing on victims when they do speak out can be brutal. This was the case during a rape trial in Mexico City: "The shocking nature of the case focused intense news media attention in the problem of rape in Mexico. But that same attention added to the victims' trauma. The three girls have shunned their therapy [which resulted from the case] and are virtually in hiding, maintaining almost no contact even with those who helped them" (Watson).

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## Singleton v. Norris: Precursor to Abu Ghraib? The Importance of Role Integrity in Medicine

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Judges are always engaging in balancing. In great contrast is the medical profession in which physicians work towards a common goal, namely the aid of the patient.

—Justice Harry Blackmun<sup>1</sup>

I am in this earthly world; where to do harm

Is often laudable, to do good sometime

Accounted dangerous folly.

—*Macbeth*, IV, ii

### Introduction

Physicians often face conflicts between their professional duty of loyalty to patients and their conflicting responsibilities to third parties. This latter responsibility may be to family members, or other parties interested in a patient's welfare. Or, it may take an economic form, increasingly reflected by the influence of health plans and other third-party payors in clinical decision-making.<sup>2</sup> Or, it may be a responsibility to a court's request for a forensic evaluation, or to a state institution, like a prison, which requires specific duties of physicians that conflict with those they would otherwise honor. Or, the responsibility may be to the military, whose ultimate goal is to protect the security of a population over that of individuals. In each case, these additional or peripheral responsibilities may divide the physician's initial duty to patient care.

Military duties are often particularly difficult to square with other personal and professional, or even legal, duties. The history of judicial deference to the military in this country, embedded in the Constitution<sup>3</sup> and known as the separate community doctrine,<sup>4</sup> reflects our willingness to cabin military duties as both separate from other duties and (for the most part) absolute.<sup>5</sup> Perhaps it should not be surprising, then, that when a service member believes a given order to be in conflict with his or her own moral value or ethical code, an easy justification is available: the imposed military duty is a *separate* responsibility apart from those that normally attach to an individual in his or her "personal" life.<sup>6</sup> One is not to be held personally responsible for actions performed while operating in a specific (and sanctioned) role such as soldier, attorney, physician, etc. One may only be held professionally responsible (i.e., judged on the basis of shared professional ethical guidelines). It remains an open question how individuals ought to honor their personal values when professional duties require conflicting action, and much of the literature on role morality has focused on this question.<sup>7</sup> The implications of sacrificing one's personal moral values for professional obligations can be disturbing, even if ultimately justifiable from a utilitarian perspective.

More disturbing, however, should be the apparent ease with which robust professional norms and duties in one profession (namely, medicine) seem to have been suppressed in favor of those in another (namely, the military). The strong evidence that doctors ignored, justified, or even helped in the humiliation, degradation, and physical abuse of Iraqi detainees at Abu Ghraib has shocked many in both the medical and nonmedical communities.<sup>8</sup> Mounting evidence suggests that physicians falsified and delayed death certificates, shared detainees' medical information with military interrogators, ignored abuse, and covered up homicides<sup>9</sup>—all activities in clear contravention of international law and medical ethics.<sup>10</sup>

While the abuse by nonmedical reservists has attracted substantial Congressional and media attention,<sup>11</sup> which has centered on personal culpability and the individual transgressions of a few, the discussion of abuse by physicians and nurses has been far less widespread and often shifts the focus to institutional problems stemming from the influential power of the military and its virtual nonreviewability.<sup>12</sup> After all, if the Supreme Court of the United States defers to the judgment of the armed forces, why shouldn't a uniformed physician do the same?

The question itself reveals the answer in its implied understanding of the physician and her role. The physician in the question is a professional, enlisted, recruited, hired, or seconded like any other, to advance the goals of the military. She would seem to have no discrete medical obligations that might rise to the level that they challenge those of her military duties. Her professional ethics are no more robust or supported or recognized by the military or government than are her personal ethics. Given the current status of medical professional norms and responsibilities in the military, which make them virtually indistinguishable from personal norms and responsibilities, a physician's complicity and involvement in "legal," but medically unethical, activity in Iraq and Afghanistan should not surprise us any more than the participation of decent and good nonmedical personnel who follow orders that come under judicial review in retrospect.<sup>13</sup>

This view of the physician and her professional role (as deferential to military norms, be they legal or not) is neither new nor unique. I propose, on the contrary, that the disempowered professional role of the physician is a result of the gradual degradation of the medical role by courts and by

physicians themselves over the past thirty years. The physician involvement at Abu Ghraib typifies a broader situation in which American physicians increasingly allow other duties to trump their ethical obligations to patients and to the profession. This paper focuses on one recent example of the degradation of a physician's core responsibilities—the forced medication of death row inmates for the purpose of executing them—as one example of factors leading up to the sins (of omission and otherwise) committed by physicians and nurses who otherwise represent the best of the medical profession through their service and sacrifice.

Undergirding this analysis are two basic claims. First, that the state has an interest in preserving (or at least not threatening)<sup>14</sup> public trust in certain professions that benefit society.<sup>15</sup> And second, that medical professionals, by virtue of the nature of their work and its effects, should be given greater deference in pursuit of their ethical obligations than other professionals. The work of the physician is not only unique in that it involves particular vulnerabilities on the part of patients but also because it carries the potential to elicit powerful and conflicting psychological and emotional impulses on the part of physicians and patients. The integrity of the medical professional role is of greater importance than appears at first blush, and, although it would be foolish to suggest that medical professional values should always trump competing values, stronger support of medicine's autonomy is called for, as well as a more formal structure of accountability for those who would violate the profession's core values. A history of medical involvement in immoral activity, state-sanctioned or otherwise, demonstrates that when physicians become morally detached from the interests of their patients, abuse flourishes.<sup>16</sup> At the very least, judges and policy-makers ought to attend more carefully to this phenomenon in their evaluations of medical ethical norms.

Recent medical jurisprudence in this country has served to degrade the integrity of the physician's role. Physicians' obligations to nontherapeutic ends ought to be reconsidered in light of increasing role conflict faced by physicians and decreasing support from courts and legislators. Policies protecting physician autonomy in the ethical pursuit of the medical profession should be supported, and the primary duties of physicians employed by the state (in prisons, in courts, and in the military) should be clarified and protected by law.

Reasoning from a specific case to general policy, this paper discusses the involvement of physicians in the forced medication of a death row inmate against the backdrop of the abuse at Abu Ghraib, as well as the psychological dynamics of medical care, which have been all but disregarded in the discussion of physician responsibility to the aims of criminal justice and the military.

### **Singleton v. Norris: Physician-Assisted Execution**

On a warm summer night in Arkansas in 1979, a young man named Charles Singleton walked into York's grocery store in the small town of Hamburg, Arkansas, and asked for a pack of cigarettes.<sup>17</sup> When Mary Lou York turned around to hand over the cigarettes, Singleton showed his gun and demanded all the money in the register.<sup>18</sup> York refused and fought with Singleton.<sup>19</sup> Singleton fired the gun and missed, then stabbed Mary Lou York in the neck with a knife.<sup>20</sup> Charles Singleton was prosecuted for robbery and felony murder. Evidence showed blood on his clothes, as well as ear witness accounts of the crime, and Singleton confessed.<sup>21</sup> He was convicted and sentenced to death in 1979 by the Circuit Court of Ashley County, Arkansas, for capital murder.<sup>22</sup> He then remained on death row for longer than any other prisoner in the state's

history.<sup>23</sup> He appealed through both the state and federal systems on procedural grounds,<sup>24</sup> claiming ineffective assistance of counsel and invalid aggravating factors<sup>25</sup> until 1998, after twenty years of appeals, when a new issue arose—one that lies at the center of medical ethics, health policy, and law.

During Charles Singleton's lengthy incarceration, he became psychotic and was diagnosed with paranoid schizophrenia.<sup>26</sup> In 1997, he was medicated involuntarily<sup>27</sup> because he was found to be a danger to himself and others,<sup>28</sup> and his treating psychiatrists found that it would be in his best medical interest to receive treatment by force.<sup>29</sup> This evaluation changed, however, once Singleton was sentenced to death. The Constitution requires that prisoners be mentally competent to be executed.<sup>30</sup> Mentally retarded individuals cannot be executed,<sup>31</sup> nor can individuals who are psychotic.<sup>32</sup> The standard is, generally, that the individual being executed must understand the crime committed and the punishment prescribed. Singleton's physicians were faced with a troubling dilemma. Unmedicated, Charles Singleton was floridly psychotic. He suffered from hallucinations and delusions, and he mutilated himself. But he was alive. Once medicated, he would be killed. The question before the Eighth Circuit Court of Appeals in *Singleton v. Norris*<sup>33</sup> was whether a psychotic prisoner could be medicated without consent, even if his psychosis is the only thing keeping him from being executed by the State.

### **Execution of Incompetent Individuals: "A Miserable Spectacle"**

The notion that it is inappropriate to execute incompetent individuals dates back to late fifteenth-century common law. Sir Edward Coke argued, for example, that "because execution was intended to be an 'example' to the living, the execution of 'a mad man' was such a 'miserable spectacle...of extreme inhumanity and cruelty' that it 'can be no example to others'."<sup>34</sup> The Supreme Court recently made the following observation in *Ford v. Wainwright*:

[T]oday, no less than before, we may seriously question the retributive value of executing a person who has no comprehension of why he has been singled out and stripped of his fundamental right to life. ...Similarly, the natural abhorrence civilized societies feel at killing one who has no capacity to come to grips with his own conscience or deity is still vivid today. And the intuition that such an execution simply offends humanity is evidently shared across this Nation (*Ford v. Wainwright*, 477 U.S. at 409).

The Court noted that the prohibition against killing the insane does not merely "protect the condemned from fear and pain without comfort of understanding" but also "protect[s] the dignity of society itself from the barbarity of exacting mindless vengeance."<sup>35</sup>

The *Ford* Court, therefore, deferred to an historical and "natural abhorrence" to such "barbarity"<sup>36</sup> and found that the state interest for retribution did not overcome the rights of the condemned nor the dignity of society. The punishment, according to the Court, becomes "mindless" when the person does not know the reason for which the punishment is being meted out. Additionally, the Supreme Court has required competency so that convicted individuals would have the opportunity to appeal.<sup>37</sup> The procedural safeguards anticipated cannot be actively pursued if the individual is not competent. Some believe that competency is required for individuals to make peace with their God before death, or at least to come to terms with their death. Lastly, some have argued that it is inhumane to kill someone with severe disturbances of the

cognitive capacities of consciousness, comprehension, or reasoning, regardless of whether or not these capacities rise to the level sufficient to participate in their own defense or to seek reconciliation in religion.<sup>38</sup>

Clearly, this case presents a number of issues concerning the death penalty (e.g., the purpose of medication, the rights of a petitioner, etc.). The important question, however, for understanding physician behavior is: “What are, or should be, doctors’ duties to their patients, and should the law respect such duties?” My aim is to address the issues raised by Singleton’s claim and to discuss specifically the ethical duty of a physician employed and instructed by the government to render care so as to effectively prepare his patient for execution. I will not discuss the ethics of execution as a criminal penalty in the United States.<sup>39</sup> I will, however, include a brief legal history of the issue because my intention is to uncover and introduce some of the professional ethical conflicts for physicians that contribute to the dilemma presented by the *Singleton* case.

#### **Legal History: The “Medically Appropriate” Requirement**

The United States bars executions of mentally-ill prisoners.<sup>40</sup> And, although the Supreme Court has decided several cases in which a criminal defendant or a convicted criminal may be medicated against his or her will, it denied certiorari on the *Singleton* case.<sup>41</sup>

The Court has ruled that a prisoner has a “significant liberty interest” in avoiding the unwanted administration of an antipsychotic drug.<sup>42</sup> But there are cases in which the Supreme Court has allowed the state to forcibly medicate an inmate or criminal defendant without consent. In *Washington v. Harper*, the Court found that if an inmate is a threat to himself or others while incarcerated, and if medication is also in his “medical interest,” then the state may forcibly medicate without consent.<sup>43</sup> The Court has also noted that a state may be justified in forcibly medicating an insane criminal defendant if it can establish that “it [cannot] obtain an adjudication of [a defendant’s] guilt or innocence by using less intrusive means.”<sup>44</sup>

Nondangerous criminal defendants may also be forcibly medicated if doing so will render them competent to stand trial, and if doing so is “sufficiently important to overcome the individual’s protected interest in refusing it.”<sup>45</sup> In *Sell v. United States*, the Court found that the government had not shown a need for treatment without consent and overruled the Eighth Circuit on the issue.<sup>46</sup>

No court other than the Eighth Circuit in the *Singleton* case has addressed the issue of whether the state can medicate an inmate for the primary purpose of carrying out his sentence once he has been found guilty. In *Singleton*, a divided Eighth Circuit held that the Eighth Amendment, forbidding “cruel and unusual punishments,” is not violated by forcibly medicating an insane condemned person so that he becomes sufficiently sane to execute.<sup>47</sup> The court held that the state could force a mentally ill criminal defendant to take antipsychotic medication in order to render him sufficiently competent to be executed. To reach this decision, it applied the same test that it used in *Sell* (which went uncontested by the Supreme Court on appeal): the state must “(1) ‘present an essential state interest that outweighs the individual’s interest in remaining free from medication’, (2) ‘prove that there is no less intrusive way of fulfilling its essential interest’, and (3) ‘prove by clear and convincing evidence that the medication is medically appropriate’.”<sup>48</sup>

The Eighth Circuit Court found that the government has a compelling interest in carrying out a lawfully imposed criminal sentence. It ruled that the state’s interest in carrying out

Singleton’s sentence outweighed Singleton’s interest in remaining free from medication in this case. (Even Singleton preferred to be medicated rather than unmedicated, so long as he wasn’t going to be executed as a result.) The Court also found that no less-intrusive method existed by which the state could attain its end. Finally, the Court found that Singleton’s medication was medically appropriate and that there was no need to factor the issue of execution into the consideration of Singleton’s medical interest. Because it was in Singleton’s short-term interest to be medicated, it satisfied the third prong of the Eighth Circuit’s *Sell* test.

Several problems have been noted in the Eighth Circuit’s ruling.<sup>49</sup> Most troubling, however, to physicians, is the problem noted in *State v. Perry* (1992): “[F]orcing a prisoner to take antipsychotic drugs to facilitate his execution does not constitute medical treatment but is antithetical to the basic principles of the healing arts.”<sup>50</sup> The physician who prescribes the drugs arguably violates medical ethical tenets of beneficence and nonmaleficence.<sup>51</sup>

The predominant legal question, which received the most attention throughout Singleton’s case, was, “Does the forced administration of antipsychotic drugs to render Singleton competent to be executed unconstitutionally deprive him of his ‘liberty’ to reject medical treatment?”<sup>52</sup> But an equally important question (and more reflective of the medical legal norms surrounding recent scandals in Iraq, Afghanistan, and Guantanamo Bay) is, “Does the same forced care deprive the treating physician or physicians of a right to practice medicine within the ethical framework and guidelines of their profession?” And if not, why not? When, if ever, should the law defer to a profession’s ethical standards and requirements? In other words, Singleton may not have had a compelling legal or ethical right to avoid execution, but his physician may have a right (and perhaps an obligation) to refuse to treat Singleton, given the fatal consequences of that treatment and the potential consequences for the profession.<sup>53</sup> One wonders how the *Singleton* case might have been argued or decided if it had remained before the Court during or after the reports of physician involvement at Abu Ghraib had surfaced.

#### **Precedent: The Offense Principle**

As in any case with more than twenty years of history and appeals, Singleton’s is far more complicated than I have described thus far, but the central issue of when the state may and should forcibly medicate a person has been the most troubling (among the issues presented by *Singleton*) for the courts to adjudicate.<sup>54</sup> There is, however, some guiding case law. Several similar issues have come before the courts. In *Washington v. Harper*, which involved the forced medication of a prisoner in a correctional facility, the Supreme Court recognized that an individual has a “significant” constitutionally protected “liberty interest” in “avoiding the unwanted administration of antipsychotic drugs.”<sup>55</sup> However, the Court (apparently guided by principles of harm and paternity) concluded that the state law authorizing involuntary treatment amounted to a constitutionally permissible “accommodation between an inmate’s liberty interest in avoiding the forced administration of antipsychotic drugs and the state’s interests in providing appropriate medical treatment to reduce the danger that an inmate suffering from a serious mental disorder represents to himself or others.”<sup>56</sup>

Singleton’s case was different, of course, in that the State’s interest extended beyond protecting Singleton and others from harm, and toward the pursuit of justice in carrying out a sentence for a crime. One might easily anticipate an argument on behalf of the State based on the Offense Principle, which claims an offense against Singleton’s victims and their fellow

citizens as a result of Singleton's having successfully avoided his punishment. This kind of argument would be supported by the finding in *Riggins v. Nevada*.<sup>57</sup>

In *Riggins*, a case involving a defendant who was unfit to stand trial without treatment by antipsychotic medication (which he refused), the Court decided that an individual has a constitutionally protected liberty "interest in avoiding involuntary administration of antipsychotic drugs"—an interest that only an "essential" or "overriding" state interest might overcome.<sup>58</sup> The Court suggested that, in principle, forced medication in order to render a defendant competent to stand trial for murder was constitutionally permissible. The Court, citing *Harper*, noted that the State "would have satisfied due process if the prosecution demonstrated...that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others."<sup>59</sup> The Court noted that the State "[s]imilarly...might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence" of the murder charge "by using less intrusive means."<sup>60</sup>

The question in Singleton's case, then, may have been whether the execution of an individual is as "essential" or "overriding" a state interest as the adjudication of that individual's guilt or innocence.

The Supreme Court's rulings thus far point toward a constitutional permission granted to the government to involuntarily administer antipsychotic drugs to a mentally ill person *only if* (among other things) the treatment is medically appropriate, which the Court defines as "in the patient's best medical interest in light of his medical condition."<sup>61</sup>

### Primary Ethical Challenges

But how can any treatment be considered in a patient's best medical interest if the consequence of that treatment will be certain death for the patient? And what exactly is meant by "the patient's best medical interest?" Should one view the determination of that interest as guided only by the narrow medical evaluation of health before and after treatment? Clearly, the concerns of most physicians will be that the patient may benefit from treatment in the short term (antipsychotic medication, in this instance), but the secondary result will be death...decidedly *not* in the patient's best medical interest. And, since most physicians will view their duties of beneficence and nonmaleficence as extending beyond the period of time immediately after the prescribed treatment, the patient's "best medical interest" would likely be interpreted by the medical profession as having wider implications. Indeed, physicians are trained to view patients in light of their full medical history and underlying diagnoses, as well as the current environment and situation in which they are evaluated. Physicians must consider treatments in terms of all their effects, intended and incidental, immediate and eventual.<sup>62</sup> The Eighth Circuit disregarded this value by dividing Singleton's medical interests into short and long term, and then considered only the former.

As the four dissenting circuit judges indicate, the majority's opinion "leaves those doctors who are treating psychotic, condemned prisoners in an untenable position: treating the prisoner may provide short-term relief but ultimately result in his execution, whereas leaving him untreated will condemn him to a world such as Singleton's, filled with disturbing delusions and hallucinations. ...[This] ethical dilemma...is not simply a policy matter; courts have long recognized the integrity of the medical profession as an appropriate consideration in its decision-making process."<sup>63</sup> Both the American Medical Association and the American Psychiatric Association have

stated that participation in execution by physicians is unethical.<sup>64</sup> They have not, however, defined what is meant by "participation." What is implied, however, is that no physician should pursue a course of treatment that will result in or lead to a patient's death,<sup>65</sup> be that treatment the proximal, secondary, or remote cause.<sup>66</sup>

There may be some exceptions to the guideline, but they should be asserted as such. It is boldly disingenuous to claim that one's involvement in a patient's care ceases at the moment that the physician's labor is complete. Other values may override the physician's duty to care for the patient (e.g., national security, public health and safety), but in Singleton's case the legal presumption was that physicians were caring only for the patients' immediate medical condition, and that their treatment was unrelated to its deferred consequences.

This is implausible. Singleton's involuntary medication, while legal under *Washington* during a stay of execution, became unethical once an execution date was set because the treatment rendered was no longer in the patient's best medical interest. This was a novel issue for the courts, as the consequences of treating Singleton with antipsychotic medication affected his medical interests in a way that it did not affect Harper's or Riggins's. While serving a long prison sentence or standing trial *may* not have been in Harper's or Riggins's best medical interest, neither necessarily constituted a specific and certain medical harm. These claims failed in Singleton's defense because they were made on behalf of the inmate-defendant and not the physicians. Limited to a balancing test between justice (carrying out a lawful sentence) and liberty (not forcibly medicating an individual), the defendant's argument begged the relevant question: Why shouldn't Singleton be treated? Because if he's treated, he'll be executed. Why shouldn't he be executed? Because he can't be executed without being treated. It is doubtful that the Supreme Court, in its discussion of "best medical interests," intended such an outcome—that criminals should be protected by the state from the very actions that the state imposes upon those individuals. Of *course* execution is not in the patient's medical best interest, but the state does not, in this case, have that kind of medical interest in mind.<sup>67</sup>

More compelling, and more appropriate to the balancing of competing social values, were the interests of the physician and the medical profession (and the social values there embedded). The second legal question, then, "Does the forced care of Singleton deprive the treating physician or physicians of a right to practice medicine within their profession's ethical framework and guidelines?" would have been more productive from the perspective of all stakeholders, except the prosecution.

Implicit in the legal question are two ethical questions: "Should physicians ever treat a patient when such treatment is not only without the patient's consent, but also not in the patient's best medical interest?" and "Do the state's justice interests ultimately trump those of the physicians?"

### Common Morality versus Professional Ethic: "To Do a Great Right, Do a Little Wrong"<sup>68</sup>

The question Singleton's case presents for physicians may be seen as a conflict between a common morality and a professional ethic. Viewed in that light, the moral dilemma presented by the Singleton case resembles that of *Tarasoff v. Regents of University of California*.<sup>69</sup> In that case, the California Supreme Court held that in certain limited circumstances when a physician determines—or should have determined—that her patient presents a serious danger of violence to another, she incurs a duty to use "reasonable care to protect

the intended victim.<sup>70</sup> If she fails to do this, she may be liable for tort damages.<sup>71</sup>

The goals of common morality in *Tarasoff* (protecting potential victims from harm) were viewed by a majority of the presiding court to outweigh the reasonable and valuable professional ethic of confidentiality and undivided commitment to the patient (even though that ethic was argued by the minority to have been an element of a more valuable goal of common morality—to provide psychiatric aid to those who would otherwise commit harm to ever more potential victims).<sup>72</sup> Should we be guided, then, by the majority in *Tarasoff* when they concluded that the “protective privilege ends where the public peril begins?”<sup>73</sup> Should Singleton’s right to liberty end only where public peril begins? More importantly, should the descriptive ethics of a professional code be honored only until such time as it creates or supports some kind of public threat (anywhere from menace to peril)?

Even the ethical guidelines of psychiatry (a profession historically supportive of strong professional autonomy) yield, ultimately, to a common morality represented by law. As Dan Beauchamp notes, the “Ethical Guidelines for the Practice of Forensic Psychiatry” of the American Academy of Psychiatry and Law (AAPL) clearly state that “substituted consent” may be obtained “in accordance with the laws of the jurisdiction,”<sup>74</sup> suggesting that the profession’s ethical guidelines readily yield to the law of the land, whatever it may be. It would seem, then, at least according to AAPL, that if the courts decide that forcible medication of a psychotic person is legal (whether it be in the medical interest of that patient or not), then the physician is ethically free (and perhaps obligated) to act in accordance with that decision. Beauchamp further notes, however, that “[t]he law is not the repository of our moral standards and values, even when the law is directly concerned with moral problems. ... [F]rom the fact that something is legally acceptable, it does not follow that it is morally acceptable.”<sup>75</sup>

Physicians have historically taken their moral guidance from the maxim *primum non nocere*, “Above all, do no harm.” As W. D. Ross suggests, a *prima facie* obligation must be fulfilled unless it conflicts on a particular occasion with an equal or stronger obligation.<sup>76</sup> The physician has no obligation to punish. Her obligation is to provide care, as should be her first, if not only, obligation.<sup>77</sup> When a physician enters a treatment relationship with a patient, her role is clear. She *must* treat the patient.<sup>78</sup> Any obligation the physician may have to contribute to a wider social justice does not *a priori* outweigh the obligation to provide care to the patient. If we were to accept such a competing value as duty to greater societal justice, we might consider it unethical for physicians to treat and care for murderers, rapists, and enemies of the state.

Some suggest, however, that the physician can step in and out of her role as she likes.<sup>79</sup> I do not agree. Physicians cannot step in and out of the role. They may refuse to enter the relationship, and such is the case of physicians who take advantage of so-called conscience clauses, which excuse physicians from the legal responsibility to treat under circumstances that violate their religious or moral beliefs.<sup>80</sup> If, however, a physician does treat an individual with medical care, a doctor-patient relationship necessarily exists.<sup>81</sup> If the rules and role definitions surrounding the doctor-patient relationship are meant to protect both individuals from potential consequences of the treatment relationship, then what other than treatment would be sufficient criterion for the relationship to exist?<sup>82</sup>

### The Consequentialist Approach

Consequences of forced medication include, on one hand, the preservation of effective justice (including the vindication

of victims), and, on the other hand, a challenge to the integrity of physicians’ autonomy and professional ethic. Not medicating Charles Singleton would result in exactly the reverse set of circumstances. Which, then, is the best utilitarian outcome?

The deterrent function of criminal justice relies on the perception that sentences are carried out. Perceived weaknesses in the system may weaken its effectiveness. The relevant adverse consequences of this particular action are, however, extremely limited. It is not the criminal justice system *in toto* that is being obstructed or impeded. Rather, it is the prescribed justice in a particular case in which a certain punishment (the most severe our system allows) is undeliverable for the time being. And Charles Singleton never attempted to fully escape punishment.<sup>83</sup> He was incarcerated without parole. He was suffering insofar as while he continued to live, he did so in a psychotic state. Furthermore, with regard to the potential weakening of deterrent values, the number of cases involving a death row inmate who is insane and has refused to be treated medically for his mental illness are considerably small. The integrity of the justice system was not, therefore, practically threatened in this case.

The integrity of the medical code, however, has been more substantially affected. First, Singleton’s treating physicians were instructed to act in a professional capacity that was not in their patient’s medical best interest. They arguably violated the most sacred provision of their professional code. More important, however, is the potential effect on the medical community. A precedent has been set for the state’s right to order a physician to treat a patient not only against the patient’s expressed wishes but also against the physician’s best medical judgment, her professional code of ethics, and her *prima facie* responsibility to do no harm. The consequences of such a precedent are broad. They can be read into the debate over physician-assisted suicide,<sup>84</sup> the duties of military physicians, forensic evaluation, and palliative care. The narrow interpretation of a patient’s medical best interest favored by the Eighth Circuit renders the value of professional medical duties meaningless. If a physician’s duty extends no further than the immediate effect of treatment rendered, without regard to any consequences, then the physician “involvement” in interrogation and abuse at Abu Ghraib, Guantanamo, and in Afghanistan was not illegal nor, by the court’s reasoning, unethical. To restrict professional duties and obligations to the intent of the practitioner is to eliminate the concept of professional role morality. The effect can only be the reduction of professional responsibility to the scope of individual personal responsibility. Insofar as no individual ought to intentionally cause harm to another, the role morality of physicians ought to establish a higher standard of care, which ought to be supported in law. Once physicians are permitted to deliver care that does not preserve life and health (by order of the state, by request from patients, or by their own will), the nature of the profession and of the work of a physician changes. Courts have often favored this line of reasoning but only when it serves other public policies, like those disfavoring physician-assisted suicide,<sup>85</sup> or aimed at pro-competition business models in health industries.<sup>86</sup>

Even if, in *Singleton*, it were conceded, *arguendo*, that forced treatment is (given these particular circumstances) ethical, the treatment still should not have been permitted. The fact that the individual act is morally acceptable is not itself sufficient to justify the act.<sup>87</sup> Though justice may be best served by restoring Singleton to sanity—even if for the sole purpose of executing him—the decision so adversely affects the integrity of medical practice that the otherwise moral act should be avoided. Just as active euthanasia may be morally



justified when patients nonetheless experience extreme, uncontrollable, and unremitting pain, it may be ethically appropriate to nonetheless restrict physician-assisted suicide because of the difficulties involved in controlling abuses of the practice. Of greater concern, however, will be the further complication of the already incredibly cumbersome psychological task of the physician, which I will address below.

### ***Primum Non Nocere***

"I will not give a drug that is deadly to anyone...nor will I suggest the way to such a counsel."<sup>88</sup> This prohibition against the use of deadly drugs by physicians has been interpreted by many as a prohibition against physician-assisted suicide, euthanasia, and involvement in executions.<sup>89</sup> The National Catholic Bioethics Center has rewritten the passage as follows: "I will neither prescribe nor administer a lethal dose of medicine...nor counsel any such thing nor perform act or omission with direct intent deliberately to end a human life."<sup>90</sup> The interpretation of the original prohibition (though arguably valuable to contemporary medical ethics) is dubious. Ancient Greeks practiced capital punishment. And although there is no record of whether physicians participated in executions, the matter does not seem to have been relevant to the prohibition against giving "deadly drugs." Rather, the rule most likely addressed fears that physicians would collaborate with murder by poisoning.<sup>91</sup> Appeals, therefore, to ancient values to support a contemporary prohibition against physician involvement in executions are ultimately unconvincing. Furthermore, the Supreme Court has clearly indicated that it shows little deference to the Hippocratic Oath in guiding its Constitutional interpretation.<sup>92</sup>

More convincing, though, are appeals to another ancient value, which, though not misinterpreted, has been historically misattributed. The paramount principle in Western medical ethics is, and has been, "Do No Harm."<sup>93</sup> But where did this principle come from, and what does it mean? The idea is often incorrectly attributed to the Hippocratic Oath, but neither the Oath nor any Greek medical treatise contains any such phrase. The closest idea appears in *Epidemic I*: "Practice two things in your dealings with disease: either help or do not harm the patient."<sup>94</sup> It is unclear how or when "First, do no harm" came to be attributed to Hippocratic medicine, or how it became *the* paramount principle.<sup>95</sup> Its history, however, is revealing of the medical norms our current jurisprudence threatens to degrade. Steven Miles traces the idea to 416 BCE (about the time that the Hippocratic Oath was written), at which time Nicias, an Athenian general and politician, spoke against what he accurately judged would be a disastrous military expedition to Sicily. He called upon the chair of the Athenian Council to "be the physician of your misguided city...the virtue of men in office is briefly this, to do their country as much good as they can, or in any case no harm that they can avoid."<sup>96</sup>

The analogy is striking. To compare a physician to a military leader illuminates the inherently aggressive nature of medical practice and the need to temper aggressive (even murderous) impulses with virtuous principles. It is remarkable to think that the most well-known tenet of medical ethics originated from an intended restraint against explicitly hostile activity and not simply well-intentioned risk (as it has come to be used). As Steven Miles notes, "First do no harm...is of overrated utility. All therapies entail risk. A physician could not perform any surgery or administer any drug (even one dose of penicillin that could cause a lethal allergic reaction) if he or she was obliged to avoid the chance of harm. The pursuit of therapy—any therapy—represents a decision that the probability and magnitude of benefits outweigh the chance and severity of harms. This clinical calculation accepts risks rather than

avoiding them."<sup>97</sup> Yet, it is worth recognizing the original meaning of the principle, especially when one frames the guidelines within a psychoanalysis of medicine.

### **Managing Conflict and Aggression: A Psychodynamic Account**

Why should a prohibition against aggression by a physician be so entrenched in the history of modern medicine? Regardless of its history, nonmaleficence has persisted in one form or another as a guiding principle of clinical medicine more than any other<sup>98</sup> and often undergirds denunciations of physician involvement in human rights abuses<sup>99</sup> and capital punishment.<sup>100</sup> But why should this one value be so important as to outweigh all others that may inform a physician's decision-making? The answer reveals a potent conflict in the physician's work that the courts have generally not understood, or perhaps not valued.

This conflict is what Robert Burt calls the "ubiquitous feature of medical practice:"<sup>101</sup> that helping patients frequently involves inflicting bodily harm on them (cutting them open, penetrating them with painful needles or catheters or diagnostic scopes, invading them with near-poisonous chemicals or radiation).

To carry out these various iatrogenic invasions, physicians must overcome deep-seated inhibitions inculcated in everyone from early childhood. One of the implicit agenda items in initial medical training is to encourage and assist fledgling physicians to transcend their inhibitions (as in their dealings with cadavers, their so-called "first patients," in Gross Anatomy Laboratories). Many techniques are offered for this purpose, most notably, the fervent belief that patients are helped to restored health and prolonged life by all medical practice, no matter how horrific particular medical interventions might appear to patients or to physicians.<sup>102</sup>

In almost every profession, there is a cardinal prohibition. While many professional transgressions may be tempting, and some more devastating than others, there is often one transgression that professionals tend to regard as distinct.<sup>103</sup> In most cases, that prohibition is against some transgression that, while devastating to the profession, is simultaneously seductive and not easily avoided by the professional. For the legal field, perhaps the prohibition against lying is paramount because of the ease and appeal of doing so in an adversarial setting. While stealing a client's assets may have equal or even worse practical consequences, the temptation to steal is no greater for a lawyer because of his role. It may, however, be of greater temptation for an accountant because of her role. For the clergy (and for therapists), perhaps abuse of power in the relationship between clergyman and congregant (or therapist and client) is the ultimate transgression because of its adverse effects but also because of the strong pull toward such a transgression that must be consciously avoided. It is the nature of the role in these cases that provides the special opportunity for particular malfeasance. For physicians, there is a special opportunity for (and a strong—if largely unconscious—pull toward) aggression.<sup>104</sup>

Much has been written about physicians and psychological conflict, particularly around feelings of aggression.<sup>105</sup> Frederick Hafferty's close observation of medical students and physicians is of one the most notable contributions to this discussion.<sup>106</sup> In one series of interviews, Hafferty asked medical students toward the conclusion of their first-year lab experience whether they would donate their own bodies to medical schools for educational purposes. What is most interesting, for the

purposes of this discussion, about the answers he recorded is the kind of language used by students:

One cannot help but be struck by the symbols of violence and destruction. Answers rarely contained such scientifically neutral terms as dissection, probe, and pick. In their place emerged more physical, graphic terms: slash, rip, pull apart, hack....<sup>107</sup>

This language of aggression was present only at the end of a lengthy interview, and only when students were asked to put themselves in the place of the cadavers with which they had been working. Only then could these students acknowledge to themselves the inherently violent nature of medical practice.<sup>108</sup> The transgression of deep taboos about respect for bodily integrity has always accompanied the duty of the physician, and yet it is rarely, if ever, discussed or acknowledged.<sup>109</sup> In fact, the practice of medicine (from surgery to psychiatry) is invasive, aggressive, and likely accounts for the often detached or asocial behavior that traditionally characterizes practitioners.<sup>110</sup> Perhaps this is one explanation for some physicians' tendency to depersonalize their encounters with patients. The stereotype of the arrogant surgeon who has no interaction with his patient before or after surgery and views the body on the table not as a person, but as an object, is likely rooted in this psychological conflict. And it is an implicit and historical recognition of this unconscious conflict that underlies the profession's undeterred commitment to principles of beneficence and non-maleficence.

In 1964, Anna Freud addressed medical students at Western Reserve Medical School on the subject of what may incline children to a later career in medicine as adults. Drawing from her vast experience with and observations of children, she took a few sentences from a speech of several pages to discuss the role of aggressive wishes and impulses in medical practice:

[T]he child's wish to help and to cure is...very close to the wish to hurt and to maim. The younger the child, the stronger the wish to hurt. The older and more socially adapted he becomes, the more this aggressive wish can be submerged under a strong urge to help.<sup>111</sup>

Some unconscious "work" is required for the physician to suppress the overwhelming feelings of guilt that would otherwise be associated with aggressive wishes sublimated through medical practice. In other words, for a surgeon to cut into the flesh of a fellow human being and invade the most personal space imaginable, she must depersonalize the object and rest assured that her actions are curative and will not harm. A physician's ability to do his work, therefore, is crucially based on the knowledge that that work (however antagonistic it may feel or appear) is for the patient's benefit and to her health.

### **The Social Psychology Perspective: "It Is Always Good Men Who Do the Most Harm in the World"**<sup>112</sup>

For years, evidence from social psychology has demonstrated that minimal, but incremental, degradation of social and professional norms can lead to extreme and otherwise unexpected abuse.<sup>113</sup> The famous experiments conducted by Stanley Milgram revealed the elements sufficient to turn "normal" people into executioners.<sup>114</sup> Three of the most important elements were (1) minimal initial compromises, (2) vague rules and boundaries, and (3) the re-labeling of roles. In the Milgram experiment, individuals were asked to harm their fellow subjects (actually confederates in the experiment)

minimally. Their instructions and obligations were vague.<sup>115</sup> And the harming aggressor was re-cast as the helping "teacher."

Phillip Zimbardo's famous Stanford Prison Experiment is also an important source of empirical guidance.<sup>116</sup> The 1971 study demonstrated the power of roles and individual transformation in obedience to prescribed role obligations. One guard wrote in his diary before the experiment, "as I am a pacifist and nonaggressive individual, I cannot see a time when I might maltreat other living things."<sup>117</sup> By day five of the experiment, this same student wrote the following in his diary: "This new prisoner, 416, refuses to eat. That is a violation of Rule Two: 'Prisoners must eat at mealtimes,' and we are not going to have any of that kind of shit. ...Obviously we have a troublemaker on our hands. If that's the way he wants it, that's the way he gets it. We throw him into the Hole ordering him to hold greasy sausages in each hand. After an hour, he still refuses. ...I decide to force feed him, but he won't eat. I let the food slide down his face. I don't believe it is me doing it. I just hate him more for not eating."<sup>118</sup>

Although the Stanford Prison Experiment is most often cited as an example of how role definitions can be used to incite individuals to harmful behavior that they would otherwise eschew, it may serve as an example of the equally powerful potential of role definition to prevent harm. Whereas a pacifist cast into the role of a guard may be incited to do harm, a physician that self-identifies as such and acts as a physician may be protected from competing impulses or incentives to do harm. Put another way, the just cannot, by the practice of justice, make people unjust.<sup>119</sup> Milgram's and Zimbardo's studies, despite their ethical flaws (striking in retrospect), provided explanatory power to the observation that good men do bad things and brought the interaction of situational variables into the foreground of criminal behavior. The studies also show, however, how strong role identification can either support or counteract situational factors.<sup>120</sup>

### **Third-Party Influences**

As Richard Wasserstrom observes, "[t]he existence of a system of role-defined behavior can...create expectations relevant to the behavior of others not directly affected by the existence of the role. These other persons also will come to expect that the role-defined behavior will continue, and this may give them license to act on these expectations rather than from a more universal moral perspective."<sup>121</sup> Wasserstrom's analysis was directed at attorneys, but is equally applicable to the recent events at Abu Ghraib, where it may be argued that physician involvement in detainee interrogation led to torture that might otherwise not have taken place. As Bloche and Marks note, interrogators knew that physicians were observing interrogation of detainees.<sup>122</sup> Applying Wasserstrom's intuition to this situation, one can easily imagine interrogators' reliance on the medical role as a "check" on their behavior. Noninterference by physicians could easily be read as permission—not just by the individual physicians but by the medical profession and its ethics.

### **Objections**

The call for greater deference to the integrity of medical norms and guidelines is largely based on the physician's right to honor her role obligation of nonmaleficence. However, the physician's *prima facie* obligation to "do no harm" may be interpreted as an instruction not to always avoid harming any patient but to strive in one's work to always balance harm against benefit. Clearly, the physician who breaks his patient's ribs to administer CPR is weighing harm against benefit in a way that is unquestionably ethical and appropriate. As Jay Katz wrote in a discussion of the inadequacy of professional codes of medical ethics, many of the ethical dilemmas

encountered by physicians have “been all too uncritically assumed [to] be resolved by fidelity to such undefined principles as *primum non nocere*....”<sup>123</sup> The objection, then, would be that the act of medicating Charles Singleton was not, in fact, in contradiction to the physician’s duty. It could be argued that the physician is not “doing harm” by treating the patient because the benefits (to society) of that action far outweigh the costs (to the individual). One may further argue that by refusing to medicate Singleton, the physician has indeed “done harm” to Singleton’s victims, to society, and to the criminal justice system.

The problem with such an argument, however, is that while the idea of nonmaleficence may include a balancing of harm and benefit to any one particular patient, it is quite a different matter to suggest that harms against that same patient should be weighed against benefits to someone or something other than that patient. In rare cases, we may ethically withhold care from—or even inflict harm on—a patient to the benefit of others. We may consider it ethical to sacrifice one for the good of the many, or we may have no choice but to do so—as in any number of classic ethical dilemmas in which an individual endangers the public health, or harms another party, or makes use of scarce resources for which he cannot pay. But we should not allow *physicians* to make such decisions. Nor should we expect (much less require) them to do so.

Another objection is based on an argument for role differentiation, which asserts that some subjects of a physician’s clinical work should not be considered patients (i.e., soldiers, prisoners, defendants in court proceedings, detainees, etc.). The potential for harm to these individuals is, therefore, not the physician’s responsibility.<sup>124</sup> This is a dangerous line of reasoning and brings to mind Edmund Burke’s well-known caution that good people doing nothing is all that evil requires to succeed. Physicians who determined detainees’ “fitness” for torture under authoritarian regimes in the 1970s and 1980s maintained that their work served state campaigns against subversion and thus should not be judged by the ethics of patient-physician relations.<sup>125</sup> I propose that when a physician brings medical skills and training to a situation, he ought to be bound by medical ethics.

### The Importance of Role in Varying Contexts

Few, if any, would argue with the view that physicians should not be involved in torture or human rights abuses and should be compelled to report such activities when they occur. But the idea that physicians should not use their skills and training to support legitimate social purposes such as public safety, justice, or the appropriate rationing of limited resources is not as compelling. The profession’s social responsibility has led to physicians’ participation in myriad settings, and not always for the benefit of their (non-)patients. Physicians work in the military (where doctors treat wounded patient-soldiers for return to combat), in forensics (where doctors’ medical evaluations often lead to adverse consequences for their patient-evaluees), and in research (where doctors’ experimental “treatments” can have adverse consequences with little or no benefit to the individual patient-subject). In some cases, the competing values weighed by the physician are between the individual health and welfare of the patient and the relative health of the community. Vaccination, for instance, which may pose a minimal risk to the individual, is justified by the long-term collective benefit of high immunization rates preventing epidemics.<sup>126</sup> But, in other cases, a physician’s undivided commitment to patient well being (at the level of either the individual or the population) is challenged by decidedly nonmedically therapeutic duties, as

in the *Singleton* case. The physician’s role was to treat the patient so that he would be executable.

The problem presents not when an individual chooses the value of one set of obligations over another but when the individual ignores the sacrifice of one to the other. When behavior (be it personal or professional) that is potentially criticizable on moral grounds is blocked from such criticism by an appeal to the existence of the actor’s role, which, it is claimed, makes the moral difference, the integrity of other roles is not compromised, it is obliterated. And in eliminating the competing role(s), the actor eliminates those values that might otherwise be morally relevant, if not decisive, reasons for acting or not acting.

### Implementation: “What Men ‘Do’ Do”

Hard cases make bad law. And hard-line rules make bad ethics. I am aware, in advocating for increased legal deference to physicians’ professional responsibility and ethical norms, of the unfortunate tendency among theorists to give short shrift to implementation concerns—specifically, how, and how well, will a policy protecting physicians’ right to pursue life and health to the exclusion of other social values be implemented?<sup>127</sup> In Singleton’s unfortunate case, I can imagine little difficulty in implementing a policy that safeguards physicians’ duty to pursue health and life, even at the expense of other social or ethical values. However, I am troubled by other possible applications of such a bright line rule (e.g., “Physicians’ simultaneous responsibility to do no harm and to pursue health and wellness outweighs any other responsibility”). In the case of end-of-life care, for instance, I would favor a system of shared decision-making in which a patient’s wish to refuse treatment, even if it will certainly hasten death, would be honored.<sup>128</sup> I recognize that such a policy may unavoidably involve physicians in allowing patients to effectively commit suicide. My view here, though, is informed by my concerns about implementation. I would ideally prefer to encourage physicians to argue for life and pursue treatment even in the most dire of patients’ circumstances. But a default rule that allows (or even requires) the substituted judgment of a physician for a patient poses intolerable risks—not because of the insult to patient autonomy but because of the potential for abuse by physicians. Just as physicians may be drawn by unconscious aggressive impulses to hasten death, they may react as well in defense of those impulses by pursuing life when it should not be artificially maintained.

The case of Donald Cowart may be illustrative in comparison to the Singleton case. In the summer of 1973, Donald “Dax” Cowart was critically injured in an explosion in which his father lost his life. Cowart was left blind and with third-degree burns over more than sixty-five percent of his body. Despite his repeated protests, Cowart was forced to undergo excruciating medical treatments and surgeries for more than a year. He left treatment with severe disfigurement, the loss of his fingers, permanent hearing loss, and blindness. He went on to marry and to become a successful attorney and remains steadfast in his position that treatment should have been stopped when he, a competent adult, ordered that he be allowed to leave the hospital and return home to die from his injuries. (He was repeatedly declared to be competent by a psychiatrist during this period.<sup>129</sup>)

In Cowart’s case, I believe that patient autonomy outweighs a physician’s responsibility to avoid participation in patients’ death. I want to be clear, though, that this view is a concession to my theoretical wish that physicians *never* forego their pursuit of health and wellness (when possible), even in the face of patient protest. I concede my theoretical position because I am more concerned about the potential for abuse

(cases in which patients *cannot* be saved or cured) and, more importantly, institutional incapacity to care appropriately for patients forced to undergo treatment. *Cowart* presents, for me, a clear case in which the costs of requiring policy to defer to physicians' credo (costs that include patients' suffering and loss of liberty, and physicians' involvement in hastening certain death) outweigh the potential benefits (possible recovery and restoration to health for the patient, and protecting the integrity of the medical code). *Singleton* seems an equally clear case in which the known benefits (keeping physicians far from the possibility of doing harm) outweigh the costs (postponing execution of a prisoner, maintaining a prisoner in a state of psychosis, *inter alia*).

Between these two cases (*Cowart* and *Singleton*) lies another for which implementation concerns are less clear: physician-assisted suicide. The cost of forcing those in pain and near the end of their lives to suffer needlessly or to commit suicide by other, more desperate, means must be weighed against the countervailing potential cost of physician abuse under a policy allowing physician participation in suicide. This conflict strikes at the center of an internal role conflict for physicians. Some who support physician-assisted suicide see the potential for a new ethic of caring—one that encompasses assisted death as part of the professional role. But those well-meaning physicians who would euthanize their patients with compassion are also often stressed, fatigued, and bewildered by the new responsibility.<sup>130</sup> This reaction would seem to support the above psychodynamic analysis, as well as the policy implications. In other words, the anxiety felt even by those who support physician-assisted suicide may reveal important dynamics of the physician-patient relationships that are protective of both individuals' health and welfare and ought to be preserved.

Another implementation concern, however, cuts the other way. An argument favoring individual moral reasoning when confronted with conflicting roles neglects the likelihood that external factors will almost always determine the outcome. Yeats writes about the dangers of making a thing "subject to reason."<sup>131</sup> Gerald Postema takes Yeats's observation to be a condemnation of moral philosophers' inclination to "play" with professional ethics without full knowledge of the concrete details.<sup>132</sup> The physicians at Abu Ghraib were under attack daily by enemies with whom the detainees were formerly allied. Their safety was ensured by the same men and women who committed abuses and sought their aid. In these circumstances, the reasonable consideration of conflicting moral values is an unreasonable expectation. Two conclusions can follow: either no role requirement will be observed in such situations, or only the strongest of them will.

### Conclusion: The Protection of Role

The problem of role conflict is a familiar one in moral theory. I do not intend to resolve it here. I hope, however, to have highlighted the tensions inherent in the inevitable conflict among medicine's various values (to individual patients, patient populations, society in general, etc.). I also hope to have made a case for more careful consideration of the consequences that follow from the degradation of the physician's role, in particular, or the sacrifice of it to competing duties. My own view is that clinical fidelity to the individual patient should be a standard of medical responsibility that is extremely difficult to violate. For some years, the public conception, self-conception, and morale of the medical profession has been on the decline.<sup>133</sup> The productive transition from physician paternalism to patient autonomy has had the unfortunate consequence of dispiriting practitioners and rendering them less able to keep faith with patients.<sup>134</sup> Whether this transition

has prompted courts and policy makers to abandon their faith in physicians, or vice versa, is unclear.

*Singleton v. Norris* reflects the current disregard for physicians' role integrity, and the abuses at Abu Ghraib reflect the potential consequences of further neglect. It remains, therefore, the responsibility of medical ethicists and professional organizations to convince and remind courts that there is more at stake in the protection of the physician's prescribed role than mere professional exclusion, political autonomy, or social equity. What is at stake is, quite literally, a matter of life and death.

### Endnotes

1. Interview with Harold Koh, *America and the Courts*, CSPAN, Federal Judicial Center, July 6, 1994.
2. See Marc Rodwin, "Conflicts in Managed Care," *N Engl J Med*, 332 (1995): 640. See also Marsha Gold, et al. "A National Survey of the Arrangements Managed Care Plans Make with Physicians," *N Engl J Med*, 332 (1995): 1678 (describing physicians' financial and other incentives to withhold services from patients).
3. U.S. Const. art. I, § 8, cl. 14.
4. The separate community doctrine is also known as the military necessity or nonreviewability doctrine. See generally Comment, "God, the Army, and Judicial Review: The In-service Conscientious Objector," *Calif L Rev*, 56 (1968): 379, 379-85, 413-47.
5. "[I]n no other area has the [Supreme] Court accorded Congress greater deference." *Roskter v. Goldberg*, 453 U.S. 57, 64-65 (1981). See also *Wallace v. Chappell*, 661 F.2d 729 (9th Cir. 1981) (rev'd on other grounds, 462 U.S. 296 (1983)); ("[T]he Supreme Court has voiced a general objection to judges 'running the army'," 661 F.2d 729, at 732 (quoting *Orloff v. Willoughby*, 345 U.S. 83, 93-94 (1953))); Joseph E. Broadus, "Don't Ask, Don't Tell, Yes: Don't Second-Guess the Military," *A B A J*, Oct. 1993, 54 (military policy has always been upheld in the courts because the special needs of the military require that the courts defer to expert military opinion).
6. This justification reflects what Gerald Postema refers to as a "schizophrenic" view of role morality by which one "simply dissociates the private personality from the...professional personality, regarding them as separate, independent selves." "Self-Image, Integrity, and Professional Responsibility." In *The Good Lawyer*, edited by David Luban, 286-314 (1983); at 292.
7. See e.g., R. S. Downie, *Roles and Values: An Introduction to Social Ethics*, 121-145 (1971); Richard Wasserstrom, *Roles and Morality*. In Luban, *supra* note 6; Arthur Isak Applbaum, *Ethics for Adversaries: The Morality of Roles in Public and Professional Life* (2001).
8. See M. Gregg Bloche and Jonathan Marks, "When Doctors Go to War," *N Engl J Med*, 352 (2005): 3.
9. *Ibid.* (Reporting that U.S. medical personnel (1) failed to report evidence of detainee abuse and murder in Iraq and Afghanistan, citing Steven Miles, "Abu Ghraib: Its Legacy for Military Medicine," *Lancet*, 364 (2004): 725; (2) shared health information, including patient records, with army units that planned interrogation, citing N. Lewis, "Red Cross Finds Detainee Abuse at Guantanamo," *NY Times*, November 30, 2004; (3) participated in interrogation that was tantamount to torture, citing *Ibid.*; and (4) medics and "others" neglected the clinical needs of some detainees, Bloche and Marks, at 3). The Pentagon responded to

the accusations of the International Committee of the Red Cross (ICRC) by denying allegations that detainee medical files were used to harm detainees, *Ibid.* See also, Robert Jay Lifton. "Doctors and Torture," *N Engl J Med*, 351 (2004): 415; Benjamin Meier. "International Criminal Prosecution of Physicians: A Critique of Professors Annas and Grodin's Proposed International Medical Tribunal," *Am JL and Med*, 30 (2004): 419.

10. "Doctors shall not countenance, condone, or participate in torture or other forms of degrading procedures...in all situations, including armed conflict and civil strife." World Medical Association Declaration of Tokyo. Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment. Adopted by the 29th World Medical Assembly Tokyo, Japan, October 1975. Though some of the activity also violated military laws, much of it did not. Physicians' collaboration with military intelligence teams and participation in interrogation, for instance, is not illegal. Testimony by Colonel Thomas M. Pappas, chief of military intelligence at Abu Ghraib, revealed physicians' systematic role in developing and executing interrogation strategies for individual detainees *for whose care the same physicians were responsible*. Testimony of Thomas Pappas, Commander, 205th MI Brigade, February 9, 2004 (obtained by the American Civil Liberties Union in a lawsuit and posted to the Web on October 21, 2004, at <http://www.aclu.org/International/International.cfm?ID=16864&c=36>).
11. See, e.g., Associated Press. "Soldier Gets Closer to Abuse Retrial," *NY Times*, May 25, 2005 (the most recent covered event at the time of this writing, regarding the last of several trials to prosecute army reservists involved in the abuse of Iraqi detainees at Abu Ghraib; see *infra* note 12).
12. Meier, *supra* note 9.
13. Whether the actions of those reservists prosecuted in connection with abuses at Abu Ghraib were the result of explicit or implied orders from military leadership apparently remains an open question. With the possible exception of Spc. Charles Graner (demoted to private, serving ten years), however, most of those indicted for their involvement at Abu Ghraib had little or no indication of previous wrongdoing in their records: Sgt. Javal Davis (sentenced to six months, reduced to private and dishonorably discharged), Spc. Roman Krol (sentenced to ten months and bad conduct discharge), Staff Sgt. Ivan L. "Chip" Frederick II (sentenced to eight years, reduced to private and dishonorably discharged), Spc. Armin J. Cruz, Jr. (sentenced to eight months, reduced to private, and bad conduct discharge), Pvt. Jeremy Sivits: (sentenced to one year, bad conduct discharge), Spc. Megan Ambuhl (reduced to private and separated from Army), Spc. Sabrina D. Harman (sentenced to six months, bad conduct discharge), Pvt. Lynndie England (awaiting retrial at the time of this writing for two counts of conspiracy to maltreat detainees, four counts of maltreatment, and one count of committing an indecent act).
14. The trust of military soldiers in physicians is also important. The role of the soldier requires that soldiers put their lives and safety at risk in all sorts of especially demanding ways. To be potentially subjected to harm by one's own physicians may frustrate a soldier's willingness to be potentially subjected to harm in warfare. If physicians are known to cause harm to enemies for the sake of national security, they may be perceived or known to cause harm to their countrymen when called on by the interests of national security.
15. Though not an obvious claim, I take for granted the proposition that public trust in the medical profession is worth preserving. Indeed, in some cases, government regulation takes general and specific notice of the importance of the doctor-patient relationship and its impermeability. The Medicare antikickback statute (Pub. L. No. 92-603, 86 Stat. 1419 (1972) (codified as amended 42 U.S.C. § 1320a-7b(b) (1994)) and related regulations, for example, were enacted (and are currently enforced) to preserve the traditional role of the physician "to provide treatments...in the best interests of the patient" (Office of Inspector General, 59 Fed. Reg. at 65,376). They may serve the additional function of curtailing inappropriate or over-utilization, but that is a secondary purpose (see, e.g., Thomas N. Bulleit, Jr. & Joan H. Krause, "Kickbacks, Courtesies or Cost-Effectiveness?: Application of the Medicare Antikickback Law to the Marketing and Promotional Practices of Drug and Medical Device Manufacturers," *Food & Drug LJ*, (1999): 279. As Richard Wasserstrom notes, "It must...be shown that the particular relationship and the particular kind and degree of [public] trust it promotes or engenders is, from the standpoint of morality, worth preserving." Richard Wasserstrom, *supra* note 7, at 35. Two questions arise out of Wasserstrom's analysis. First, should a certain role exist? And second, given that a certain role exists, should the occupant of that role do what the role, so constituted, requires? This essay focuses more on the second question than the first, which has been argued convincingly in the affirmative. See generally, *inter alia*, Ezekial J. Emanuel & Nancy N. Dubler, "Preserving the Physician-Patient Relationship in the Era of Managed Care," *JAMA*, 273 (1995): 323; Ralph Cranshaw et al. "Patient-Physician Covenant," *JAMA*, 273 (1995): 1553.
16. See, e.g., M. Lippman, "The Nazi Doctors Trial and the International Prohibition on Medical Involvement in Torture," *Loyola of Los Angeles Int'l & Comp LJ*, 15 (1993): 395; T. Brennan & R. Kirschner. "Medical Ethics and Human Rights Violations: The Iraqi Occupation of Kuwait and Its Aftermath," *Ann Intern Med*, 117 (1992): 78; J. Singh. "American Physicians and Dual Loyalty Obligations in the 'War on Terror'," *BMC Med Ethics*, 4 (2003): E4 (describing detainee abuse in apartheid South Africa); V. Jacopino, et al. "Physician Complicity in Misrepresentation and Omission in Postdetention Medical Examinations in Turkey," *JAMA*, 276 (1996): 396.
17. Rob Stafford, "Crazy Like a Fox?" *Dateline NBC*, NBC News Transcripts, April 5, 1999.
18. *Ibid.*
19. *Ibid.*
20. *Ibid.*
21. *Singleton v. Norris*, 319 F.3d 1018, 1020 (8th Cir., 2003).

22. *Singleton v. State*, 274 Ark. 126, 128, 623 S.W.2d 180 (Ark. 1981).
23. Michael R. Wickline. "Man on Death Row 20 Years Loses Appeal," *Arkansas Democrat-Gazette* (Little Rock, AR), January 25, 2002.
24. *Singleton v. State*, 623 S.W.2d 180 (Ark. 1981) (cert. denied *Singleton v. Arkansas*, 456 U.S. 938 (1982)), *Singleton v. Arkansas*, 459 U.S. 882 (1982)), *Singleton v. Lockhart*, 871 F.2d 1395 (8th Cir. Ark. 1989) (habeas corpus proceeding), *Singleton v. Lockhart*, 962 F.2d 1315 (8th Cir. Ark. 1992) (habeas corpus proceeding), *Singleton v. Endell*, 870 S.W.2d 742 (Ark. 1994).
25. *Singleton v. Norris*, 319 F.3d at 1020.
26. *Ibid.*, 1030.
27. *Singleton v. Norris*, 319 F.3d 1018, 1021 (8th Cir., 2003). Singleton had been medicated voluntarily during much of his stay in prison prior to 1997. Psychotropic medication was initially prescribed to alleviate anxiety and depression. Singleton did not present with psychotic symptoms until 1987. *Ibid.* at 1030.
28. *Ibid.*, 1018.
29. *Ibid.*, 1030.
30. *Ford v. Wainwright*, 477 U.S. 399, 410 (1986).
31. *Atkins v. Virginia*, 536 U.S. 304 (2002). The governing standard for determining whether a prisoner is competent to be executed is that the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it. *Ford*, 477 U.S. at 422 (Powell, J., concurring). The prohibition against executing inmates who are mentally retarded, therefore, rests on the presumption that mentally retarded individuals are incompetent to be executed because they are unaware of the punishment and its justification.
32. *Singleton*, 319 F.3d at 1023. Psychotic inmates are precluded by the Eighth Amendment from execution only if they are unaware of the punishment and its justification, *supra* note 31.
33. *Singleton*, 319 F.3d 1018.
34. *State v. Perry*, 610 So.2d 746, 749 (La. 1992) (quoting 3 E. Coke, Institute 6 (1794)).
35. *Ford*, 477 U.S. at 410. See Note, *The Eighth Amendment and the Execution of the Presently Incompetent*, *Stan L Rev*, 32 (1980): 765, 777, n. 58 (cited by the *Ford* Court, and suggesting no societal retributive interest in executing persons who have no comprehension of why they have been singled out and stripped of their rights to life).
36. See *Ford*, 477 U.S. at 406-10 (outlining rationales for excluding insane individuals from execution); Collins, M. "Involuntarily Medicating Condemned Incompetents for the Purpose of Rendering Them Sane and Thereby Subject to Execution," *Wash ULQ*, 70 (1992): 1229, 1236-41 (delineating rationales for ban on execution as practical, religious and humane); M. Radelet & G. Barnard. "Ethics and the Psychiatric Determination of Competency to Be Executed," *Bull Am Acad Psychiatry & L*, 14 (1986): 37, 39-42 (discussing rationales for not executing insane); R. Schopp. "Wake Up and Die Right: The Rationale, Standard, and Jurisprudential Significance of the Competency to Face Execution Requirement," *La L Rev*, 51 (1991): 995, 998-1010; D. Katz. Note, "Perry v. Louisiana: Medical Ethics on Death Row - Is Judicial Intervention Warranted?" *Geo J Legal Ethics*, 4 (1991): 707, 709-10; see also "Mindless Vengeance": Medicating Charles Laverne Singleton So He Is Sane Enough to Be Executed Defies Constitutionality as Well as Logic and Ethics," *St. Petersburg Times*, Feb. 25, 2003. Available online at <<http://www.sptimes.com/2003/02/25/newsp/Opinion/Mindlessvengeance.shtml>> ("The U.S. Supreme Court has said execution of the insane serves no cause of justice, and the public shares that opinion").
37. This falls out of the Court's longstanding pronouncement that "[t]he fundamental requisite of due process of law is the opportunity to be heard," *Grannis v. Ordean*, 234 U.S. 385, 394 (1914).
38. See Schopp, *supra* note 36, at 1046. But see Kursten B. Hensl, Note: "Restored to Health to be Put to Death: Reconciling the Legal and Ethical Dilemmas of Medicating to Execute in *Singleton v. Norris*," *Vill L Rev*, 49 (2004): 291 (arguing that state action to restore competency for the purpose of execution amounts to nothing more than standing someone up to kick him down again).
39. Nor did Singleton's defense not include a priori Constitutional objections to the death penalty.
40. *Ford*, 477 U.S. at 410 (1986).
41. *Singleton v. Norris*, 540 U.S. 832 (2003).
42. *Washington v. Harper*, 494 U.S. 210, 221-22 (1990).
43. *Washington*, 494 U.S. at 227.
44. *Riggins v. Nevada*, 504 U.S. 127, 135 (1992).
45. *Sell v. United States*, 539 U.S. 166 (2003).
46. *Sell*, 539 U.S. 166.
47. *Singleton v. Norris*, 319 F.3d at 1027.
48. *Ibid.*, 1024 (quoting *United States v. Sell*, 282 F.3d 560, 567 (8th Cir.)).
49. See, e.g., Melinda S. Campbell, Comment: "Sell, Singleton, and Forcible Medication—Running Roughshod Over Liberty," *U Tol L Rev*, 35 (2004): 691; Hensl, *supra* note 38; Brent W. Stricker. "Seeking an Answer: Questioning the Validity of Forcible Medication to Ensure Mental Competency of Those Condemned to Die," *McGeorge L Rev*, 32 (2004): 317; Rebecca A. Miller-Rice. "The 'Insane' Contradiction of *Singleton v. Norris*: Forced Medication in a Death Row Inmate's Medical Interest Which Happens to Facilitate His Execution," *U Ark Little Rock L Rev*, 22 (2000): 659.
50. *State v. Perry*, 610 So.2d at 751.
51. Four central principles (autonomy, beneficence, nonmaleficence, and justice) have dominated the public health literature, though the two I have highlighted have a more robust historical footing in medical ethics. See *passim*, Tom L. Beauchamp & James F. Childress. *Principles Of Biomedical Ethics*, 4th ed. (1994). Moreover, under these circumstances, the physician is re-cast in the role of punisher. The prisoner does not consent to the drugs' administration, and if the primary reason for their administration is to carry out the condemned prisoner's sentence (rather than, for example, the prisoner's own medical benefit and the safety of fellow prisoners and prison staff), then the administration of the drug arguably becomes *part of the sentence*. It is no doubt a harm (at the very least a dignitary harm) to the patient. And if it is

- (a) a harm, and (b) part of the prisoner's sentence, it constitutes punishment—punishment to which no court lawfully sentenced the prisoner.
52. U. S. Const., Amdt. 5 (Federal Government may not “deprive[e]” any person of “liberty...without due process of law”).
53. The physicians treating Singleton may indeed have had an exercisable right not to treat him against his wishes, just as physicians are generally protected from professional activity that violates personal moral or religious values (*see infra* note 77 on conscience clauses). I am proposing, instead, that physicians should have an *obligation* not to forcibly treat patients under these circumstances that, while not absolute, ought to be afforded greater deference by law and policy.
54. As I have already noted, Singleton did not present physicians' professional obligation as a defense on his behalf.
55. Washington, 494 U. S. at 221 (1990).
56. *Ibid.*, 236.
57. *Riggins*, 504 US 127.
58. *Riggins*, 504 U.S. at 134-135.
59. *Ibid.*, 135.
60. *Ibid.*
61. *Ibid.*
62. Julia C. Spring. “Singleton's Story: Choosing between Psychosis and Execution,” *Hastings Center Report*, 35 (2005): 30.
63. *Singleton*, 319 F3d, at 1037.
64. American Medical Association, Code of Medical Ethics; American Psychiatric Association, Ethical Code.
65. One may further question what is meant by “treatment,” and, specifically, what constitutes a doctor-patient relationship. What are the duties of a physician to an individual he sees for a forensic evaluation? It would be odd to presume that in the context of forensic evaluation confidentiality would be protected, but informed consent might still be required. In Singleton's case, there was no doubt among the parties that a doctor-patient relationship existed, though the law avoids defining the specific ways in which the scope of a physician's duty is narrowed in the prison setting.
66. The courts have employed a “double effect” argument by focusing on whether treating physicians ever intended to medicate Singleton for the purpose of executing him. In one of the district court's denials of a petition for habeas corpus, the court reasoned that no evidence could be found “that the actions and decisions of the medical personnel involved [in forcibly medicating Singleton] were in any degree motivated by the desire, purpose or intent to make Mr. Singleton competent so that he could be executed,” *Singleton*, 319 F.3d at 1021 (quoting the district court, then reversed by the appellate court, which granted a stay of execution). This reasoning is as specious as the kind employed as a defense by physicians involved in torture. A physician called upon to evaluate a military prisoner for the purpose of interrogation can easily claim that his intent was unrelated to the interrogation or torture. Similarly, treating prisoners who have been tortured, without reporting the suspected abuse, may be justified because such a responsibility would fall outside the direct scope of the physician's duties as proposed. These claims must fail if physicians are to be held accountable to any reasonable professional ethical standard.
67. Because Singleton was tried for his crimes, convicted, and sentenced, to claim a right not to be forcibly medicated because it will result in the very punishment to which he has been legally and ethically sentenced (again, putting aside one's potential concerns about the death penalty) seems illogical, unreasonable, and unethical. If we accept, for the purposes of this argument, the justice of the legal proceedings and their ultimate sentence, we are compelled to evaluate Singleton's desire not to be treated on the same core grounds as anyone else's desire not to be treated. We should furthermore not be swayed by the result of our decision because we may believe that result to be unfortunate. In other words, Singleton's execution should not be viewed as unfortunate or undesirable, and our sense of justice requires us to avoid making any liberty claim against forcible medical treatment simply to avoid what we must accept as a fair and deserved punishment. Therefore, the realm of potential ethical challenges posed by the first question, regarding the threat to Singleton's liberty by forced medication, seems rather limited. In a sense, the competent Singleton has made himself inaccessible and has left in his place an insufficient proxy (in the psychotic Singleton). It may be unreasonable to suggest, therefore, that Singleton is being unfairly harmed by medication that will restore his sanity. In this view, it is Singleton who sacrifices his own autonomy and liberty interests when he sacrifices sanity for psychosis. Of course, psychosis is not voluntarily acquired, but the decision to *remain* psychotic is voluntary when it is made by a patient with full (if temporary) competence.
68. Bassanio's bootless plea to Portia in the trial scene, *Merchant of Venice*, Act IV, sc.1, l. 212.
69. 551 P.2d 334 (1976).
70. *Ibid.*, 340. The facts of *Tarasoff* were as follows: Poddar, a University of California graduate student, told his therapist that he intended to kill Tatiana Tarasoff, a young woman whom he had previously dated. *Ibid.*, 341. The therapist consulted with his supervisor and then contacted the campus police who questioned Poddar and released him once he promised to stay away from Ms. Tarasoff. *Ibid.* Two months later, Poddar went to Ms. Tarasoff's home and killed her. *Ibid.*, 339. Subsequently, her parents filed suit on a variety of tort theories, including the failure of Poddar's therapists to warn Ms. Tarasoff's parents that Poddar was a “grave danger” to their daughter. *Ibid.*, 340-41.
71. *Ibid.*, 342. In its second decision in the case, the California Supreme Court found that a “duty to protect,” rather than a “duty to warn” exists:  
when a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the

therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances. *Ibid.*, 340.

72. See Beauchamp, T. In Beauchamp, T. and Walters, L. *Contemporary Issues in Bioethics*, 6<sup>th</sup> Edition (CA: Wadsworth Publishers, 1999), 3.
73. Tarasoff, 551 P.2d 332.
74. Beauchamp, T. and Walters, L., *supra* note 72, 30.
75. *Ibid.*
76. W. D. Ross. *The Right and the Good* (1930), 30-32.
77. Of course, physicians are also citizens whose professional obligation is one of many. A physician may feel compelled by certain moral and/or religious obligations, in which case she may be able to legally avail herself of conscience clause protection. See 42 U.S.C. §300a-7 (2002) (known as the “Church Amendment”); Indiana Code §16-34-1-4 (2002); KY Rev. Stat. Ann. §311.800 (2001); VA Code Ann. §18.2-75 (2002). See also West, J. Andrew, “Defining the Limits of Conscientious Objection in Health Care,” *APA Newsletter on Philosophy and Law*, Fall 2005. But in balancing her obligations to patients and her conflicting moral and/or religious obligations, a physician ought to be required to refer patients in need to other physicians. While a physician may feel precluded from rendering certain types of care, and may even feel compelled to counsel a patient against what she believes to be immoral actions, she ought to assist her patient in finding appropriate care, so long as it is within the boundaries of standard practice among her colleagues. A physician who objects to abortion on moral or religious grounds ought nonetheless to assist her patient in finding a capable physician elsewhere. To do otherwise would be to take advantage of a patient’s dependency. Some physicians may feel compelled by other duties to counsel patients against what they believe to be immoral actions (e.g., abortion, risky sexual behavior, unnecessary or cosmetic medical procedures, refusing to donate blood, bone marrow, or organs to a family member in need), but their influence should extend no further than that counsel. The enormous influence physicians have over their patients (by virtue of the entrenched and implicit norms of the doctor-patient relationship) warrants caution. A physician’s influence may be used appropriately in communicating medical advice—as that is the task for which the physician is trained and qualified and (more importantly) for which the patient seeks a physician out. Offering moral guidance is a primary duty of a clergyperson, not a physician. Again, this is in part because of a clergyperson’s experience and training in both ethical decision-making and counseling congregants on moral issues, but, more importantly, the clergyperson’s influence in that area (ethics, religion morality) is implicitly recognized when his or her counsel is sought by a congregant or parishioner.
78. It may be argued what constituted treatment. Viewed in the context of professional responsibility, I find a treatment relationship when a medical professional brings his or her medical skills and talents to bear. A physician is not compelled to do so—doctors are free to contract at will. Nor are they compelled to act, always, as physicians. (A witness to a crime, for instance, who happens to be a physician, is under no obligation other than those that would attach to nonphysicians.) But if they bring medical skills, which they are licensed by the state to use, to a task, they should be responsible to at least the core values of the profession. Health organizations as well as professional medical organizations generally interpret treatment and physician responsibility for care broadly. In the case of domestic violence, for instance, the physician’s duty is often read to include preserving health not just in the narrow context of the patient’s clinical presentation but in his or her activity beyond the observation room (see, e.g., Council on Ethical and Judicial Affairs, American Medical Association, “Physicians and Domestic Violence, Ethical Considerations,” *JAMA*, 267 (1992): 3190.)
79. See Paul Appelbaum. “The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm,” *Int’l J L & Psychiatry*, 13 (1990): 249, 252 (using the example of a forensic psychiatrist called upon by the prosecution in a criminal proceeding to present evidence concerning an individual’s defense of not guilty by reason of insanity.) Appelbaum argues that the doctor is not involved in a healing capacity while offering testimony and, therefore, has no *professional* duty to preserve the health of a sometime patient.
80. See *supra* note 77.
81. Physicians are often called upon by courts to treat individuals, in which case a doctor-patient relationship does exist, and all values that normally attach to the relationship (e.g., confidentiality) should be respected. See, e.g., *Pettus v. Cole*, 49 Cal. App.4th 402, (1996) (finding a physician’s duty of confidentiality to be inviolable beyond description of “functional limitations” in response to an employee’s request for disability leave).
82. The research context, as well as that of forensic evaluations, provides difficult and useful cases. In both, though a doctor-patient relationship is understood *not* to exist, it is helpful to consider which responsibilities remain (e.g., informed consent, do no harm) and which do not (e.g., confidentiality). The military context provides a third and more difficult example. In this case, as with many prompted by the military, extraordinary deference has historically been granted. Once an individual’s body is not her own (which must be the case either when an individual voluntarily joins the military, or when she is drafted), individual autonomy has been so seriously compromised that patient autonomy can no longer be plausibly respected. Following the same reasoning, a physician’s autonomy may be no more robust than a patient’s, if they are both soldiers of the state. It may, then, only be professional autonomy, granted by states through the licensing of medical practice, that preserves important social and ethical obligations in the military context.
83. Singleton’s Eighth Circuit appeal was not a challenge to the validity of his conviction or sentence but only the manner in which it was to be carried out.



84. Arguments against physician-assisted suicide that rely on a professional medical judgment that physician-assisted suicide is not in the patient's medical best interest can now be rebutted.
85. See, e.g., *United States v. Bailey*, 444 U.S. 394, 403-406; *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 278-280; *Ibid.*, 287-88 (O'Connor, J., concurring) *Vacco v. Quill*, 521 U.S. 793, 793 (U.S., 1997); George Annas. "The Bell Tolls for a Constitutional Right to Physician-Assisted Suicide," *N Engl J Med*, 337 (1997): 1098. Palliative care, in these cases and their precedent, stands in for euthanasia, all seemingly in deference to the physician's code. Not so in Singleton's case.
86. See, e.g., Medicare antikickback statute, *supra* note 15. Courts have often recognized legal duties outside of the doctor-patient relationship that attach by virtue of a particular relationship, such as one defined by the status of an individual (*Craig v. State*, 220 Md. 590 (1959)), or by the particular status relationship (Annot., 10 A.L.R. 1137 (1921). (parent to child); *Territory v. Manton*, 19 P.387 (husband to wife); *Regina v. Smith*, 8 Carr. & P. 153 (Eng. 1837) (master to apprentice); *United States v. Knowles*, 26 Fed.Cas. 800 (No. 15,540) (ship's master to crew and passengers); cf. *State v. Reitze*, 86 N.J.L. 407, 92 A. 576 (innkeeper to inebriated customers)), or by contractual relationship (*Regina v. Smith*; *Rex v. Ellen Jones*, *supra*; 19 Cox Crim.Cas. 678; *People v. Montecino*, 152 P.2d 5., or where one has "voluntarily assumed the care of another and so secluded the helpless person as to prevent others from rendering aid" (*Reg. v. Nicholls*, 13 Cox Crim.Cas. 75; *Rex v. Ellen Jones*, *supra*; 1 Wharton, Criminal Law, § 455 (12th Ed.). Cf. *Rex v. Gibbins and Proctor*, 13 Crim.App.R. 134 (Eng. 1918); *State v. Noakes*, 40 A. 249). See also *Jones v. U.S.*, 308 F.2d 307, 310 (1962).
87. In other words, rule utilitarianism is to be favored in this case over act utilitarianism.
88. L. Edelstein, *The Hippocratic Oath* 3 (1943).
89. See L. Hasday. "The Hippocratic Oath as Literary Text: A Dialogue between Law and Medicine," *Yale J Health Pol'y L & Ethics*, 2: 299; See also *Krischer v. McIver*, 697 So. 2d 97 (FL, 1997) (on Florida state's interests outweighing patients' desires for physician-assisted suicide).
90. Value of Life Committee. "The 1995 Restatement of the Oath of Hippocrates, circa 400 BC." National Catholic Bioethics Center, Boston, MA 02135. Available online at <<http://www.ncbcenter.org>>.
91. Littré Vo. IV: 624 cited in Steven Miles. *The Hippocratic Oath and Medical Ethics*. 73 (2004); A. MacIntyre. *Whose Justice? Whose Rationality?* (1988): 42-68; Aristophanes. *Plutus*, translated by B Rogers. Vol. III (1988): 407-8. In Miles, 73.
92. See, e.g., *Compassion in Dying v. Washington*, 79 F.3d 790, 829 (9th Cir., 1996).
93. See Beauchamp & Childress, *supra* note 51.
94. *Epidemics I:XI* cited in *Ibid.* at 143. "The commonly cited Jones translation follows Littré and goes: 'As to diseases, make a habit of two things—to help, or at least do no harm' (Hippocrates [1923a]). Jonsen notes that the Greek text does not contain the words 'at least'. Jonsen, AR. 'Do No Harm,' *Ann Int Med*, 1978; 88:827-32." *Ibid.*, 147, n.23.
95. *Ibid.*, 144.
96. Thucydides. *The Landmark Thucydides: A Comprehensive Guide to the Peloponnesian War*, edited by RB Strassler. (1996) at 6.14 cited in *ibid.*, 144.
97. *Ibid.*, 144.
98. For an exhaustive account of the four-principles (autonomy, beneficence, nonmaleficence, and justice) approach to medical ethics, see Raanan Gillon, *Principles of Health Care Ethics*, pt. 1 (1994).
99. See, eg., British Medical Association. *Medicine Betrayed: The Participation of Doctors in Human Rights Abuses* (1982).
100. American Medical Association Council on Ethical and Judicial Affairs. "Physician Participation in Capital Punishment," *JAMA*, 270 (1992): 365.
101. Robert Burt, *Death Is That Man Taking Names*, (2002): 87-105.
102. Robert Burt. "The Medical Futility Debate: Patient Choice, Physician Obligation, and End-Of-Life Care," *J of Pall Med*, 5 (2002): 249, 252-53.
103. See, e.g., Michael Davis & Andrew Stark, eds., *Conflict of Interest in the Professions* (2001).
104. See Frederick Hafferty, *Into the Valley: Death and the Socialization of Medical Students* (1991); Robert Burt, *Taking Care of Strangers: The Rule of Law in Doctor-Patient Relations* (1979).
105. See *ibid.* See also Burt, *supra* note 101; Jay Katz, *The Silent World of Doctor and Patient* (1986, 2002).
106. Hafferty, *supra* note 104.
107. *Ibid.*
108. Burt, *supra* note 101, 92.
109. Hafferty, *supra* note, 104.
110. *Ibid.*
111. Freud, A. "The Doctor-Patient Relationship." In Jay Katz, *Experimentation with Human Beings* (1972), 643.
112. Henry Brooks Adam.
113. See, e.g., Stanley Milgram, *Obedience to Authority* (1983); Philip G. Zimbardo, et al., *The Psychology of Attitude Change and Social Influence* (1991); Robert Cialdini, *Influence: The Psychology of Persuasion* (2000).
114. Stanley Milgram. "Behavioral Study of Obedience," *J Abnorm & Soc Psych*, 67 (1963): 371. Stanley Milgram conducted a study at Yale University and in Branford, New Haven, focusing on the conflict between obedience to authority and personal conscience. He examined justifications for acts of genocide offered by those accused at the World War II, Nuremberg War Criminal trials. In the experiment, Milgram paid subjects to participate in what they thought was an experiment about memory. "Teachers" (who were actually the unknowing subjects of the experiment) were asked to administer an electric shock of increasing intensity to a "learner" for each mistake he made during the experiment. When subjects asked whether increased shocks should be given, they were encouraged to continue. Sixty percent of the "teachers" obeyed orders to punish the learner to the very end of the 450-volt scale. (The last three voltage levels were marked "X," "XX," and "XXX" and were administered after the "learner" had screamed out in protest, complained of a heart condition, and eventually gone silent. In advance of the study, forty psychiatrists were asked how many subjects might

- administer all 450 volts. The estimate was one percent. No subject stopped before reaching 300 volts.) Ibid.
115. In the Milgram study, the rules of “the experiment” were clear but not of the real subjects’ obligations to either the false experiment or the real study.
116. Craig Haney & Philip Zimbardo. “The Socialization into Criminality: On Becoming a Prisoner and a Guard.” In *Law, Justice, and the Individual in Society: Psychological and Legal Issues*, edited by Tapp & Levine, (1977), 198. In the summer of 1971, Philip Zimbardo of Stanford University led an incredible experiment using the psychology building on campus as a makeshift prison. He and two graduate assistants assembled a group of college-aged volunteers, sorted them for emotional stability, and randomly assigned them to positions of either guard or prisoner. Within a few days, the guards assumed the roles of guards and the prisoners started to display the attributes of “first-timers” at real prisons. Within six days, the experiment had to be terminated because the situation became “too real” and too intense, with several prisoners having to be dismissed because of psychological trauma.
117. Ibid., 207.
118. Ibid., 209.
119. Plato, *Republic* I, 335c.
120. One need only look to the psychological evaluations of the Nazis to remember the ease with which monstrous actions can be disassociated from personal morality, if protected by a defined role. See, e.g., Hannah Arendt, *Thinking and Moral Considerations: A Lecture, Soc. Res.*, 417 (1971) (describing, for example, the ease and disunity of personality with which Adolph Eichmann carried out his political and military obligations as he saw them); Leon Goldensohn & Robert Gellately, eds., *The Nuremberg Interviews* (2004). But see Postema, *supra* note 6 (discussing the Socratic observation of man’s inherent need for unity of self and the consequent pain that comes from psychological disunity caused by moral conflict).
121. Richard Wasserstrom, *supra* note 7, 32.
122. Bloche and Marks, *supra* note 8.
123. Katz, *supra* note 111, 7.
124. Various arguments along these lines have appeared in varying contexts, some notorious in the recent history of medicine. See, e.g., Robert Proctor, *Racial Hygiene* (1988). See also Christian Pross & Aly Götz, *The Value of the Human Being: Medicine in Germany 1918-1945* (1991).
125. M. Gregg Bloche. “Psychiatry, Capital Punishment, and the Purposes of Medicine,” *Int J Law & Psych*, 16 (1993): 301.
126. Paul E. Fine. “Herd Immunity,” *Epidem Rev*, 15 (1993): 265; see also K. R. Stratton, et al. “Adverse Events Associated with Childhood Vaccines Other than Pertussis and Rubella,” *JAMA*, 271 (1994): 1602; see also *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905) (upholding the Constitutionality of a legislature choosing between medical arguments on behalf of individuals and medical arguments on behalf of the public population).
127. Theodore R. Marmor, *Understanding Health Care Reform* (1994), pp. 215-224.
128. The case of Dax Cowart, now famous in the bioethics literature, is an example of an unfortunate situation in which I believe a patient’s right to refuse life sustaining treatment ought to be protected (though not exclusively, and without much conversation and counseling) even if treating physicians are required to forego their pursuit of health and life. See Lonnie D. Kliever, ed., *Dax’s Case: Essays in Medical Ethics and Human Meaning* (1989).
129. Ibid.
130. Roger S. Magnusson. “‘Underground Euthanasia’ and the Harm Minimization Debate,” *JL Med & Ethics*, 32 (2004): 486. Magnusson actually argues for a policy of legalization or greater regulation of physician-assisted suicide because of the harm that underground euthanasia creates. As a matter of policy for euthanasia, I agree with his conclusions, but I note his observations about physicians’ reactions to assisted-suicide for the purposes of this discussion insofar as they reveal the particular conflicts outlined above.
131. “Once one makes a thing subject to reason, as distinguished from impulse, one plays with it, even if it is a very serious thing. I am more ashamed because of things I have played with in life than of any other thing.” W. B. Yeats, in an unsent letter dated 1910, In Richard Ellmann, *Years: The Man and the Masks* (1948), p. 175, cited in Postema, *supra* note 6, 286.
132. Ibid.
133. M. Gregg Bloche. “Cutting Waste and Keeping Faith,” *Ann Intern Med*, 128 (1998): 688.
134. M. Gregg Bloche. “Clinical Loyalties and the Social Purposes of Medicine,” *JAMA*, 281 (1999): 268.

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## Defining the Limits of Conscientious Objection in Health Care

J. Andrew West

### Introduction: The Controversy Over Conscience Clauses

The practice of conscientious objection in the United States enjoys a respectable pedigree in both the legislatures and the courts.<sup>1</sup> While the right to conscientious objection was initially recognized in the context of military service, the reproductive rights debates of the 1970s opened the door for the rights of conscience to become a permanent fixture of the health care landscape. For thirty years, the need to recognize health care providers’ right to conscientious objection has materialized in so-called “conscience clauses.”<sup>2</sup> Conscience clauses are provisions in laws, regulations, and other governing instruments that permit medical providers and facilities to refuse to provide services to which they are morally or religiously opposed. These clauses protect providers by making them immune from civil and criminal liability for damages that result from their conscientious objection.

The present controversy over conscience clauses does not center on the question of whether we should have them at all. The medical profession has long recognized that conscience clauses of some sort are desirable. Rather, medical professionals and legislators have focused on the following question: What are the proper limits of conscientious objection in health care?

Answers to this question have ranged from clauses practically unlimited in scope to others that enumerate specific procedures to which care providers may object. In July 2004, Mississippi passed an example of the former, which allows any class of health care worker to refuse “to counsel, advise, provide, perform, assist in, refer for, admit for purposes of providing, or participate in providing, *any health care service or any form of such service*.”<sup>3</sup> In contrast, a 2003 Wisconsin bill, ultimately vetoed by Governor Jim Doyle, tried to limit the right to conscientious objection to six procedures.<sup>4</sup>

I will argue that we should prefer narrow conscience clauses because they (1) respect patients’ right to informed consent and (2) reduce risks to vulnerable populations. I will then propose and defend an example of what a narrow conscience clause might look like. The clause I propose allows:

- (1) any person
- (2) directly involved in providing
- (3) nonemergency medical treatment or service
- (4) to refuse to provide the treatment or service in question, so long as the person
- (5) objects on moral or religious grounds and
- (6) cooperates in the transfer or referral of the patient to a willing provider.

Before I turn to these arguments, a brief overview of the genesis and evolution of conscience clauses in medicine is in order.

## **I. Conscience Clauses in American and International Health Care**

### *A. The Genesis of Conscience Clauses*

Just six months after the Supreme Court’s 1973 *Roe v. Wade* decision, which legalized abortion nationwide, Congress passed the Church Amendment. Introduced by Senator Frank Church (R-ID), this amendment was the first conscience clause to become federal law. It stated that no “individual” or “entity” receiving certain federal funds would be required to perform a sterilization procedure or abortion, or make its facilities available for those procedures, if doing so “would be contrary to religious beliefs or moral convictions.”<sup>5</sup>

Opposition to the Church Amendment was minimal. To the extent that the amendment protected individual rights, it seemed reasonable to most pro-choice advocates. After all, as writer Emily Bass notes, “The abortion debate had been waged on the battlegrounds of conscience and the rights of women to make their own decisions.”<sup>6</sup> Taking into account the personal choice of the providers being asked to perform abortions seemed fair, especially in an era when medical care was largely provided through private practices.<sup>7</sup> On a practical level, pro-choice groups, encouraged by *Roe*, focused instead on establishing a network of women’s clinics across the nation.<sup>8</sup>

### *B. The Evolution of Conscience Clauses*

Judging from the pace at which other conscience laws were passed at the state level after the Church Amendment, they struck a responsive chord. By the end of 1974 more than half the states had adopted conscience clauses, and by 1978 nearly all states had done so.<sup>9</sup>

Although the conscience clauses enacted in the wake of *Roe* were almost exclusively concerned with abortion, they differed on matters of individual versus institutional conscience and duties to provide referrals or information to those seeking abortions. According to research by Rachel Benson Gold of

The Allan Guttmacher Institute, forty-six states instituted abortion-related clauses that applied to individuals, and forty-two adopted clauses that also applied to medical facilities.<sup>10</sup> Nine clauses allowed individuals to refuse to some extent to provide abortion-related advice or referral, while six allowed facilities to refuse to provide either advice or referral. Finally, thirteen states passed legislation allowing individuals or facilities to withhold contraceptive services and information, while eleven states allowed individuals or facilities to refuse to perform sterilizations and provide information.<sup>11</sup>

What is surprising about this legislation is that very few of these state laws required the individual or facility claiming a conscientious exemption to *inform* anyone of this fact. Of the forty-six clauses allowing individuals to decline to perform abortions, only eighteen required any sort of written notice, and in most cases this was only notification of their employer or hospital. Only three clauses required the physician to notify the patient, and only seven of the forty-two state laws allowing facilities to refuse to perform abortions required any form of public notice.<sup>12</sup>

Though the initial round of laws passed after *Roe v. Wade* sowed the seeds of the current conflict over conscience clauses, the issue lay dormant for over a decade. Not until the 1990s did the rapid expansion of “managed care” breathe new life into the debate. At that time, medical corporations began to replace the traditional private practices that once dominated the marketplace. As policy analyst Rachel Benson Gold observes, this transfer of power “blurred the once-sharp line between the providers and the payers of care, leading to an array of questions about which entities should appropriately be entitled to claim a conscientious objection to providing ‘sensitive’ medical services.”<sup>13</sup> Furthermore, competition among health care providers “led to a wave of consolidations and mergers between religious and secular institutions,” thus raising concerns about “the dominance of one organization’s religious dictates over those of a previously secular organization.”<sup>14</sup>

The changes in the health care system brought about by the managed care revolution have led states to pass broader conscience provisions. These new laws differ from their predecessors in two important respects. First, the new laws go beyond abortion and sterilization, with many of them applying to *any* health service to which an individual or institution might object. Second, they take into account the changes in the health care landscape by enlarging the category of entities permitted to claim a conscientious objection. The protected entities now include not only health care providers (both individuals and facilities) but also insurers and corporate payers, such as health plans. Advocates of broad conscience clauses argue that expanding the class of protected entities is necessary to respect the corporate “conscience” of institutions, while opponents regard such an expansion as a dangerous move that allows insurers to opt out of paying for any health care service at will under the guise of conscience.<sup>15</sup>

The most recent development in federal legislation occurred in December 2004 when President Bush signed into law the 2005 Labor, Health and Human Services Education Appropriations Bill. The bill contained the Hyde/Weldon Conscience Protection Amendment, which prohibits the disbursement of federal health and human services funds to federal agencies and programs and state and local governments that discriminate against health care entities that refuse to provide, pay for, or refer for abortions. The Hyde/Weldon Amendment is another example of conscience legislation that is concerned primarily with abortion. It also shows how legislators have expanded the range of protected

entities. For instance, a health care entity is defined broadly to include any “health care professional” and “any other kind of health care facility, organization, or plan.”<sup>16</sup>

### C. Conscience Clauses Abroad

Outside the United States, a number of other nations have laws protecting the rights of conscience in health care. The Protection of Conscience Project, a Canadian-based organization that tracks international conscience legislation, points to conscience clauses in Australia, Ireland, New Zealand, Slovenia, and the United Kingdom.<sup>17</sup> Like the early U.S. state laws, international conscience laws focus almost exclusively on abortion, though some differ on the duty to refer or inform. In Australia, for example, five of the eight states offer protection to conscientious objectors, though four of those states appear only to have abortion-specific laws dating to the 1920s and 1930s. In 1995, the state of Victoria extended conscientious objection to “research involving the use of gametes, zygotes or embryos.”<sup>18</sup> New Zealand’s legislation applies only to abortion and contraception but does include the right to refuse to “offer or give any advice relating to contraception.” In Ireland, practitioners can object to family planning services and prescriptions for contraceptives and are not obligated to give any information.<sup>19</sup>

Despite the relatively small number of foreign laws addressing conscientious objection in health care, it would be wrong to assume either a lack of controversy on the matter or a lack of interest on the part of lawmakers. Canadian lawmakers, for instance, have tried unsuccessfully since 1994 to pass conscience legislation on both the federal and provincial levels.<sup>20</sup>

## II. Arguments in Favor of Conscience Clauses

As earlier noted, controversy over conscience clauses has rarely focused on the question of whether they should exist at all. For several reasons, this should not be surprising. U.S. courts had recognized the right to conscientious objection in the armed forces well before the reproductive rights movement gained steam; therefore, the practice was not foreign to Americans when medical practitioners began to appropriate it in the context of abortion and sterilization.

Conscience clauses also accord with our moral intuitions about not forcing others to be complicit in what they believe to be immoral behavior. Moreover, this intuition is a part of what Ken Baum and Julie Cantor, authors of a recent *New England Journal of Medicine* article, have called the “quintessentially American custom of respect for conscience,” and what former Supreme Court Chief Justice Charles Evans Hughes called a “happy tradition.”<sup>21</sup> Baum and Cantor also claim that “the right to refuse to participate in acts that conflict with personal, ethical, moral, or religious convictions is accepted as an essential element of democratic society.”<sup>22</sup> Other commentators cite the toleration of moral diversity as a “first principle” in “post-industrial, democratic societies,” which lack “any common moral ground” for “adjudication of our differences.”<sup>23</sup> Lynn Wardle, a law professor who has written on the protection of conscience in health care, calls protection for rights of conscience a “significant contemporary American value” for which there is “overwhelming evidence” in the Bill of Rights and U.S. case law.<sup>24</sup>

Finally, we live in a society that does not require professionals to abandon their morals as a condition of employment. Otherwise, as Wardle observes, “health care licenses would be little more than badges of moral slavery.”<sup>25</sup> Health care professionals, such as physicians and pharmacists, complete graduate programs in their area of expertise, obtain licenses to practice their trade, and join professional

organizations with their own codes of ethics; they “are not automatons completing tasks.”<sup>26</sup>

There are, of course, many other reasons why we see little, if any, opposition to the existence of conscience clauses as such. One line of argument, beyond the scope of this paper, is that the practice of medicine is a “moral enterprise,” and, therefore, physicians should be allowed to integrate their own moral and religious convictions with their provision of public goods.<sup>27</sup> My purpose here, however, has not been to present a comprehensive defense of conscience clauses but, rather, to survey some of the reasons why the idea of incorporating conscience laws into health care has, in principle, been regarded as unobjectionable.

## III. Possible Responses to the Controversy

There are three possible responses to the question of conscientious objection in health care: no right to object, an unlimited right to object, or a limited right to object.<sup>28</sup>

The first two responses are unjustifiable.

### A. No Right to Object

*Complete rejection* of a right to conscientious objection would be problematic on several grounds. First, from an ethical perspective, creating an environment in which institutions forbid their employees to exercise personal moral judgment of any kind on pain of civil and criminal liability or license revocation is surely a recipe for moral bankruptcy. Many enter medicine because they see it as a profession with a moral purpose, such as relieving suffering, helping those in need, or saving lives. Since a concern for morals has led many people into medicine in the first place, making medicine a domain in which individual moral judgments are impermissible will drive many of these people away from medicine and will discourage others from entering the profession. Second, given the longstanding legal precedents for the rights of conscience in health care settings, it is unlikely that any law categorically forbidding conscientious objection would withstand a legal challenge.<sup>29</sup> Third, if legislative protection for conscientious objectors did not exist, or was eliminated by a drastic change in law, sectarian health care providers would face a major crisis. Many Catholic providers, for example, would likely shut down, or at least suspend, enough operations to avoid conflicts of conscience—a threatening specter given that Catholic hospitals constitute the largest group of nonprofit health care providers in the United States, accounting for fifteen percent of the nation’s hospitals.<sup>30</sup>

### B. An Unlimited Right to Object

An *unlimited right* to object is equally problematic. This right is precluded by federal law. The *Emergency Medical Treatment and Labor Act* (EMTALA) states:

If any individual...comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either— (a) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (b) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.<sup>31</sup>

Subsection (c) on transfers lacks any mention of conscientious objection as a justification for transfer. Since a truly unlimited right to object would necessarily extend to emergency treatment, EMTALA is a formidable statutory obstacle for the proponent of unlimited conscience clauses. Another problem, as we will see later, is the possibility that prejudiced health care workers might hide behind an unlimited conscience

clause as they discriminate against patients who are homosexual or belong to a racial minority.

These extreme positions might deserve more attention if anyone was advocating them in the current literature on conscience clauses. That is not the case. We are thus left with the third alternative: a *limited right* to object. The difficulty of articulating a principled clause that falls somewhere in this vast middle ground is the driving force behind the current debate.

#### C. A Limited Right to Object

Participants in the debate tend to classify limited conscience clauses as either “broad” or “narrow.” Broad conscience clauses grant a wide range of health care workers the right to refuse almost any kind of procedure or service. An example of a broad clause is the Mississippi law allowing health care workers to object to “any health care service.” Pro-choice groups are often the first to decry such clauses as too broad.<sup>32</sup> Narrow clauses try to limit either the class of objectors or applicable procedures and services. The Church Amendment, which granted the right to refuse only in the context of abortion and sterilization, is an example of what many would consider a narrow clause. Pro-life groups are often the most outspoken critics of narrow conscience clauses.<sup>33</sup>

#### IV. The Dangers of Broad Conscience Clauses

Here, I argue that lawmakers should adopt narrow conscience clauses because broad clauses (1) violate patients’ right to informed consent and (2) increase risks to vulnerable populations that seek medical care. I define “broad clause” to mean a conscience clause that allows any employee of a health care provider to refuse to participate in any nonemergency medical procedure or service without fear of liability. Mississippi’s clause is broad in this sense.

##### A. Informed Consent

The principle of informed consent is central to the humane practice of medicine. It states that (1) health care providers should allow patients to participate in making choices about their health care, and (2) patients must be fully informed in order to do so. We can ground this principle in a patient’s legal and ethical right to direct what happens to her body. A number of generally accepted requirements must be met for a patient to be considered fully informed. These requirements include a discussion of the nature of the procedure or treatment, alternatives to the proposed intervention, and the risks and benefits associated with the options. The informing party should also assess how well the patient understands, and, finally, the patient should consent to whatever action is taken.

The most common way in which legislators have broadened recent conscience clauses is to allow doctors and nurses—those who most regularly constitute the “informing party”—to refuse even to discuss certain medical alternatives with patients for whom those alternatives are medically relevant and legal. Refusal to transfer or refer patients to other willing providers often accompanies the refusal to inform. Wisconsin Governor Jim Doyle vetoed Wisconsin’s proposed conscience clause last year precisely because it protected these kinds of refusals. In vetoing the bill, Doyle stated, “Not only could a health care provider refuse treatment, there are no requirements that the health care professionals advise patients of their treatment options, provide a referral to the patient, transfer certain patients, or render care if the patients’ health or life is threatened.”<sup>34</sup>

The lack of any requirement to inform, refer, or transfer patients is especially unacceptable. The notion that the government can legitimately curtail one’s rights when they harm or infringe upon the rights of another is a fundamental

concept in American law. Conscience clauses that allow health care providers to refuse to inform, refer, or transfer patients violate that concept and allow the ideological commitments of doctors and nurses to dramatically affect a patient’s information on issues of *life and death*. Consider a scenario in which a woman experiencing severe abdominal pain is determined to be in the early stages of an ectopic pregnancy—a life-threatening implantation of the egg outside of the uterus—and, yet, is not counseled about the possibility of surgically removing the fertilized egg because her doctor believes that such a procedure amounts to murder. The tragedy is exacerbated when the doctor refuses, under protection of the law, to refer her to any other doctor who will fully inform her about her options. The scenario is especially perilous when it occurs in a rural area where patients do not have the luxury of visiting other hospitals or doctors’ offices.<sup>35</sup>

Allowing doctors to refuse to provide or refer for reproductive counseling services keeps patients from fully appreciating their medical options—and thus violates the norms of informed consent. The American Medical Association has said the following about informed consent:

The patient’s right to self-decision can be effectively exercised *only if the patient possesses enough information to enable an intelligent choice*. ...The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.<sup>36</sup>

Likewise, in 1982, the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research issued the following statement:

Since the judgment about which choice will best serve well-being properly belongs to the patient, *a physician is obliged to mention all alternative treatments, including those he does not provide or favor*, so long as they are supported by respectable medical opinion.<sup>37</sup>

The broad conscience clauses that legislators are passing today allow medical professionals to flout the standards of good care expressed in these statements.

Even safeguards designed to protect patients, such as those instituted by Medicaid, are often inadequate. Medicaid patients, including those in religiously sponsored managed care plans, have a right to receive federally mandated medical services and to have them paid for by Medicaid. Furthermore, a Medicaid managed plan must provide written notice to its enrollees of its refusal to provide information and referral. However, neither of these facts guarantees that patients will be able to make adequate judgments about their own care. In the course of receiving medical counsel and care, how does the patient know at what moment her provider is withholding information so as not to offend the provider’s conscience?

Combining the right to refuse to inform with the right to refuse referral and transfer flies in the face of the patient’s right to have enough information to make an intelligent choice. In a pluralistic society, there is no justification for believing that one group’s religious or moral scruples, no matter how sincere, are moral trumps to others’ basic right to make informed decisions about their own physical health.

##### B. Risks to Vulnerable Populations

In discussing any health care policy, we should ask what its practical effects will be for vulnerable or disadvantaged groups. Why should these groups receive special consideration in evaluating the effects of a policy? Vulnerable populations have historically had unequal access to health and economic

resources, as well as social and political power. According to the Center for Vulnerable Populations Research, “Vulnerable populations are often discriminated against, marginalized and disenfranchised from mainstream society, contributing to their lower social status and lack of power in personal, social, and political relationships.”<sup>38</sup> Vulnerable populations may be low-income families, women, children, racial and ethnic minorities, homosexuals, the elderly, or the homeless. Vulnerable populations are often unable to successfully integrate into the mainstream health care delivery system. This results in higher mortality rates, lower life expectancy, reduced access to care, and lower quality of life.

Broad conscience clauses are objectionable because they increase the risks that vulnerable populations face. More specifically, they increase the risk that vulnerable populations will have reduced access to the full range of legal medical services or will face discrimination disguised as conscientious objection. The vulnerable populations who will likely face higher risks because of broad conscience clauses are rape victims, homosexuals, and rural patients, especially pregnant women who have low incomes or who live in underserved areas.

In early 2004, a Texas pharmacist, citing personal moral objections, rejected a rape survivor’s prescription for emergency contraception. The pharmacist and two other co-workers were later fired by Eckerd Corp. for violating the company’s policy that pharmacists cannot opt out of filling prescriptions for religious or moral reasons.<sup>39</sup> A recent news report from New Hampshire told of a pharmacist who refused to fill a prescription for emergency contraception, or to direct the patron, Suzanne Richards, to another pharmacist who would do so. He scolded the twenty-one-year-old single mother, who then “pulled over in the parking lot and started crying.” By the time Richards found another pharmacy to fill her prescription, the seventy-two hour period during which women must take emergency contraception had passed.<sup>40</sup>

On its website, Pharmacists for Life International (PFLI) states, “It is not an inconvenience to refuse to refer such a client since the pharmacist is doing the woman and her unborn child a favor in terms of their physical and spiritual health.”<sup>41</sup> Rape victims thwarted by such logic are vulnerable not only by virtue of the physical and emotional trauma they have suffered as a result of the rape but also because taking emergency contraception is a time-sensitive matter: victims must obtain and fill a prescription within a narrow window of efficacy.

Broad clauses in health care settings also extend the risk of discrimination against homosexuals to yet another aspect of life. If pharmacists can already refuse to fill or refer prescriptions for emergency contraceptives and conventional birth control based on their beliefs about abortion or contraception, there is nothing to stop them from objecting to filling other kinds of prescriptions. The authors of a recent article on conscientious objection among pharmacists give the following example:

A customer who fills prescriptions for zidovudine, didanosine, and indinavir is logically assumed to be infected with the human immunodeficiency virus (HIV). If pharmacists can reject prescriptions that conflict with their morals, someone who believes HIV-positive people must have engaged in immoral behavior could refuse to fill those prescriptions.<sup>42</sup>

Since pharmacists do not have access to a customer’s medical history, judgments about what prescription they can fill in good conscience may be medically inappropriate and susceptible

to bias and prejudice. Some of the most recently proposed conscience clauses, such as Michigan’s, prohibit providers from refusing to participate in a service based on specific patient characteristics like race, ethnicity, or religion. Opponents of the Michigan legislation, however, have pointed out that the list does not include sexual orientation and that “the legislation would give providers license to refuse care to homosexuals.”<sup>43</sup>

People—and pregnant women in particular—who live in rural areas comprise a third group that broad conscience clauses put at risk. As of 1998, the federal government had deemed ninety-one Catholic-run hospitals to be “sole providers” of health care in federally designated underserved areas.<sup>44</sup> Catholics for a Free Choice (CFFC) reports that the number of Catholic sole providers rose sixty-five percent in just three years in the 1990s (from forty-six in 1994 to seventy-six in 1997). Some of these Catholic sole providers serve counties in which Catholics make up less than one percent of the population.<sup>45</sup>

Catholic hospitals in the United States must follow the church’s *Ethical and Religious Directives for Catholic Health Care Services*, established by the National Conference of Catholic Bishops. An instance of ectopic, or extrauterine, pregnancy provides an example of how the interaction of broad conscience clauses with the *Directives* can put patients in underserved areas at risk. Directive 48 states: “In the case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.”<sup>46</sup> The *Directives* define abortion as “the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus.”<sup>47</sup> Doctors, however, may disagree on the question of viability. That disagreement combined with the right to refuse to counsel, refer, or transfer puts the woman in a situation of grave danger if the Catholic hospital is a sole provider in that area. The risk heightens in the case of low-income patients who lack the means to travel great distances to other providers.

While the impact of broad conscience protection on vulnerable populations is a question for further empirical study, it is inevitable that certain groups—be they rape victims, homosexuals, or rural patients—will bear the cost of freedom of conscience in medicine. This, in conjunction with the threat that broad clauses pose to the norms of informed consent, underscores the need for more narrowly tailored conscience clauses.

## V. A Proposal for a Narrow Conscience Clause

An adequate conscience clause should address questions of who, when, and how. That is, it should answer questions about whose conscience is protected, in what situations, and how institutions and facilities should accommodate these objections. My aim is to propose and defend a conscience clause that answers these questions while balancing the rights of both health care workers and patients. I recommend a clause that allows:

- (1) Any person (2) directly involved in providing (3) nonemergency medical treatment or service (4) to refuse to provide the treatment or service in question, so long as the person (5) objects on moral or religious grounds and (6) cooperates in the transfer or referral of the patient to a willing provider.

While the term “conscience clause” usually refers to a comprehensive piece of legislation replete with definitions and subsections, I use the term here to refer only to the above statement. Incorporating my proposed statement into an actual piece of legislation would require work that goes beyond present purposes, such as specifying the damages to which persons are entitled when their rights of conscience are violated. Instead, I wish only to show that the limitations in

the above clause are defensible. I will consider the six elements of the clause in turn.

#### A. "Any person"

One of the first tasks of a conscience clause is to identify the persons it protects. Conscience clause drafters sometimes distinguish between individuals and institutions and public or private persons. The most common term used to identify the protected individual or institution is "person."<sup>48</sup> The Delaware statute is an example of how "person" is used broadly:

*No person* shall be required to perform or participate in medical procedures which result in the termination of pregnancy; and the refusal of *any person* to perform or participate in these medical procedures shall not be a basis for civil liability to *any person*, nor a basis for any disciplinary or other recriminatory action against him.<sup>49</sup>

Other statutes, like Iowa's, protect only the "individual."<sup>50</sup> As others have noted, "individual" is more restrictive than "person" because corporations and other legal institutions are "persons," for at least some purposes, but are never "individuals."<sup>51</sup>

In 1993, Lynn Wardle found that about one-fifth of conscience provisions excluded institutions from coverage. In these cases, the use of "person" or "individual" suggested that only individual human beings were protected.<sup>52</sup> The common term for institutions is "hospital," but many clauses extend protection to other "health care facilities" or "medical facilities."<sup>53</sup>

The term "person" in my proposed clause applies to both individual human beings and institutions. Extending protection to individual human beings is uncontroversial, for we naturally think of an individual as the possessor of a conscience. I will, therefore, focus on defending my inclusion of institutions.

The distinction between individuals and institutions in the context of conscience laws is invalid. Institutions or corporations (including hospitals, medical associations, and other health care organizations) are legal entities "organized by individuals to achieve purposes that can best be achieved by collective action, including protecting or promoting values that individuals best can express and implement by collective activity."<sup>54</sup> For the government to endow such an organization with legal personality, the organization must have a specific purpose that the government sanctions. The law recognizes such entities as legal "persons" and even gives them significant legal benefits—such as tax exemptions—when they promote goals that the state favors. Many of these government-sanctioned goals can be seen as moral. In the case of a university, the goal may be to educate the unlearned; the goal of a health care corporation or hospital may be to relieve suffering, cure the sick, or save lives. If lawmakers exclude institutions or corporations from protection, they deny the conscience of the individuals whose moral purposes the entities were created to advance.<sup>55</sup>

To deny legal protection for the conscience of health care institutions is also at odds with other legal doctrines that protect the rights of institutions. Wardle notes that protecting individual conscience but not institutional conscience is analogous to protecting the First Amendment right to individual free speech but not the collective speech of corporations or cooperative groups. The Supreme Court, however, has repeatedly protected collective, corporate speech.<sup>56</sup>

#### B. "Directly involved in providing"

Many conscience clauses protect only persons engaged in directly providing medical treatment or services (e.g., the

persons in the operating room or the place of delivery).<sup>57</sup> Wardle contends that "[t]his confined conception of the class of persons whose rights of conscience merit protection is unjustifiable" because "one may feel morally culpable even if one is not the immediate or direct provider of an immoral act."<sup>58</sup>

I do not dispute that some persons may feel morally culpable for acts in which they are only indirectly involved. These persons' feelings, however, must be weighed against the patients' rights. When conscience clauses extend protection to all persons without regard to their degree of involvement, the threat to informed consent, the risk to vulnerable populations, and the chance of discrimination all increase greatly.

Take, for example, the case of an ambulance worker in suburban Chicago who recently sued a company that had purportedly fired her for refusing to transport a patient suffering severe abdominal pain to a clinic for an abortion.<sup>59</sup> As a result of the delay caused by the driver's objection, the patient had to be taken to an emergency room instead of the abortion clinic.<sup>60</sup> Here, the objection of someone only indirectly involved in the treatment put a patient's life at risk. Later that same month, again in Illinois, a county settled a lawsuit brought by an employee allegedly denied a promotion because she refused to translate into Spanish information for clients on abortion options.<sup>61</sup> This example shows us what lies at the bottom of the slippery slope when lawmakers extend protection to persons only indirectly involved in the health care delivery process. Refusal to translate abortion-related information into Spanish is a double threat, for not only does the translator's action interfere with the patients' right to be informed of their pertinent medical options, but it involves patients who are vulnerable because of the language barrier.

Courts in two states have distinguished between direct and indirect involvement. In *Spellacy v. Tri-County Hospital*, Pennsylvania courts held that a part-time admissions clerk who was fired by a hospital because of her refusal to participate in admitting abortion patients was not protected by the state's conscience clause because her position was one of "ancillary" or "clerical" assistance.<sup>62</sup> Likewise, in *Erzinger v. Regents of University of California*, the California Appellate court ruled that the federal conscience clause protected only persons directly involved in performing abortions or sterilizations. The court stated that "indirect or remote connections with abortions or sterilizations are not within the terms of the statute."<sup>63</sup>

Given that the threat to informed consent and vulnerable populations is more than hypothetical, a conscience clause must draw a line on the issue of degree of involvement. The space between direct and indirect involvement is the only nonarbitrary place to draw that line. The distinction between direct and indirect involvement is principled. It simultaneously protects the right to informed consent, vulnerable populations, and the conscience rights of those providers who most likely bear the risk of moral culpability due to their direct involvement in controversial procedures.

#### C. "Nonemergency medical treatment or service"

The most common statutory exception in conscience clauses is for medical emergencies.<sup>64</sup> Yet many clauses still fail to provide exceptions explicitly for emergencies. Some think this failure reflects the general belief that few persons will have moral or religious objections to providing treatment in real medical emergencies.<sup>65</sup>

For completeness, however, exceptions for emergencies should be included in conscience clauses. Even supporters of broad conscience clauses recognize that exceptions should be built into conscience legislation "for life-threatening

emergencies in which the controversial procedure provides the best hope of saving a patient's life."<sup>66</sup>

EMTALA, as discussed earlier, also requires facilities to do whatever is necessary to stabilize emergency room patients. The special duty of care required in medical emergencies and the federal statutory requirement to provide services make emergency exceptions essential features of conscience clauses. As part of this exception, comprehensive conscience clauses should state that emergency room employees are not immune from liability for damages that result from their refusal to provide care. Furthermore, states should provide exceptions to employment discrimination prohibitions in the hiring of emergency room employees (thus allowing them to turn down applicants who refuse to provide all emergency procedures).<sup>67</sup>

Even supporters of broad conscience clauses agree that facilities established for the primary purpose of providing specific services may exclude from employment persons who refuse to provide those same services if the persons' conscience rights cannot be reasonably accommodated. Two different proposals for comprehensive conscience clause legislation, one by law professor Lynn Wardle and the other by the Protection of Conscience Project, protect employers who wish to hire people for specific tasks.<sup>68</sup> For example, an abortion clinic could justifiably refuse to hire someone opposed to abortion if the position the clinic seeks to fill necessarily involves performing abortions. This same logic should carry over to emergency rooms. Emergency rooms are established for the primary purpose of treating patients with medical emergencies. Therefore, an emergency room should be able to ensure that all of its employees are willing to provide the full range of services—including controversial ones—in a *bona fide* medical emergency.

D. *"To refuse to provide the treatment or service in question"*

My focus here is on the term "refuse" and the logistics of refusal. When and how should one raise an objection? First, the act of refusal should be expressed orally to the objector's supervisor and to others, as determined by the supervisor, whose work with either the patient or the objector might be impacted.<sup>69</sup> Second, the statute should require the objector to state the objection in writing.<sup>70</sup> Stating the objection in writing serves two functions. As a matter of documentation, the written objection may protect the employer from liability when it allows an employee to refuse to provide a service. The written objection also preserves the evidence of conscientious objection in cases where the employee might have had reasons to refuse other than moral or religious objection (such as when the employee personally dislikes the patient or does not want to stay late to provide the service).

In addition to stating the objection, individuals should be required to object in a timely manner, preferably as soon as they are asked or assigned to participate in the treatment or service. Since most people know what they object to before being asked, new employees should make known their objections when hired. This requirement makes accommodating the objection easier for the facility. These requirements for stating the objection also pertain to institutions. The law should require institutions to post notice and inform patients of their refusal policy and to give immediate notice to the patient when an objection is going to affect the patient's care noticeably.<sup>71</sup>

E. *"Objects on moral or religious grounds"*

Most conscientious objectors base their objection on religious beliefs, but there is no reason why the law should favor religiously based objections over those based on sincerely held, nonreligious moral or ethical convictions. There is legal precedent for nonreligious objections in cases dealing with

conscientious objection in the military. Although the military policy defines a conscientious objector as one who objects to war "by reason of religious training and belief," the policy later defines this as

Belief in an external power or being or deeply held moral or ethical belief, to which all else is subordinate or upon which all else is ultimately dependent, and which has the power or force to affect moral well-being.<sup>72</sup>

Moreover, the Supreme Court has, on various occasions, declared that, in the eyes of the law, "religious training and belief" need not have anything to do with attending church, believing in God, or following the teachings of a particular religion.<sup>73</sup>

In one case, conscientious objector Elliot Welsh repeatedly told the draft board that his belief was not "religious." Yet in *Welsh v. United States* (1970), the Supreme Court said that Welsh qualified for conscientious objector status because even though he did not think his belief was religious, the law did. The court held that a moral objector qualified for exemption as long as his belief was central to his life.

Protecting only those whose beliefs are "religious" in the usual sense of the word would also likely violate the establishment clause of the First Amendment. If challenged, a conscience clause of this sort would fail the various "tests" the Supreme Court has applied in recent years to legislation involving religion. These include the *Lemon* test, part of which asks whether the challenged legislation has the primary effect of advancing or inhibiting religion, and the "endorsement" test, which asks if the state action unconstitutionally endorses religion by "conveying or attempting to convey a message that religion or a particular religious belief is favored or preferred."<sup>74</sup> A conscience clause that granted religious reasons special status over other sincerely-held ethical or moral convictions would be ripe for challenge in the courts since it creates a perception in the mind of a reasonable observer that the government is endorsing religion over nonreligion.<sup>75</sup>

One may object that it is too difficult to determine the validity of an objection based solely on moral or ethical beliefs, whereas religious objections can be verified by checking them against the public teachings of a particular church. While I do not underestimate the difficulty of determining which persons and what kinds of objections will have valid claims for protection, that determination is not one I need to make to prove my larger point.<sup>76</sup> My point is simply that there is no reason for favoring religious to nonreligious objections. The courts have already undertaken some of the work of creating enforceable definitions of "moral" and "religious," and these determinations are open to further refinement through the law.

F. *"Cooperates in the transfer or referral of the patient to a willing provider"*

In section IV, I argued that allowing health care professionals to refuse to transfer or refer a patient to a willing provider violated the patient's right to informed consent and increased risk to vulnerable populations. The same argument applies here. Lawmakers must realize that the rights of conscience cannot be exercised in isolation in the context of health care. Conscientious objection affects patients, whose interests and rights the law also protects. The nature of a health care worker's job necessitates compromise between the rights of providers and patients. The requirement to cooperate in transfer and referral is crucial to protecting the well being of patients and ensuring the continuity of care.



Two professional associations have already moved in this direction. In 1998, California's pharmacist association added to its conscience policy a "Duty to Care" policy that recognized the responsibility to refer.<sup>77</sup>

The American Pharmaceutical Association has also adopted a policy that supports "the establishment of systems to ensure patient access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal."<sup>78</sup>

Health care workers can cooperate in transfers and referrals in several ways. Hospitals and pharmacies can display in plain sight the contact information of other facilities that offer the services to which they object. A pharmacist, for example, can cooperate by displaying this information in a noticeable location, or by providing customers with the information when the pharmacist exercises a conscientious objection. Pharmacies could also provide patients with a toll-free phone number—such as 1-888-not2late—that gives callers the names and numbers of pharmacies in their area willing to fill prescriptions for emergency contraception.

The goal of the transfer and referral requirement can be achieved through simple means. Narrow conscience clauses need not require objecting doctors to take patients by the hand to the nearest abortion clinic but only to take some easy steps toward helping patients gain access to information. One may object that this information is easily available to any member of the public who will invest the time to do research. This objection, however, wrongly assumes that all patients have equal access to the resources needed to conduct the research, such as Internet access, a phone, or a vehicle. Requiring medical workers and facilities to provide the information or refer the patient to a willing provider is a safety measure for patients without access to information-gathering resources, most of whom likely belong to vulnerable populations.

Reasonable compromises on the issue of providing information are also possible. The Sexual Assault Survivors Emergency Treatment Act, enacted by the Illinois state legislature in 2001, represents such a compromise.<sup>79</sup> This law, which requires emergency rooms to inform rape survivors about emergency contraception but does not require them to furnish it on-site, has been praised by one observer as a "creative approach ... to deal with the conflicting needs of rape victims and religious hospitals."<sup>80</sup> The Act gives each hospital the freedom to develop its own protocol for providing information. The Illinois Catholic Hospital Association (IHCA) did not oppose the bill and was able to collaborate with its member institutions to devise a uniform protocol that satisfied the requirements of both the statute and Catholic doctrine.<sup>81</sup>

### Conclusion

Because of the American commitment to individual rights and the fact that "religious and moral freedom is considered sacrosanct,"<sup>82</sup> the support for conscience clauses will not only continue in the United States but will lead the debate into increasingly contentious territory as technology advances. As the battle ensues, lawmakers should remember that the health care professions by definition involve more than just the providers of care, and, thus, they should consider the rights of all parties.

The clause I have proposed is broad enough to protect the conscience rights of those providers for whom the risk of moral culpability is highest (i.e., direct providers of morally controversial, nonemergency services). It is also narrow enough to guard against violations of the right to informed consent, the rights of vulnerable populations, and the likelihood of blatant discrimination in the delivery of health care.

### Endnotes

1. See, e.g., *The Selective Service Act, Statutes at Large* 54, 5(g), 889 (1940), and, more recently, *The Military Selective Service Act, U.S. Code*, App. 451 et seq., sec. 456, 26 (2003); *United States v. Seeger*, 380 U.S. 163 (1965); *Welsh v. United States*, 398 U.S. 333 (1970).
2. Some critics call them "refusal clauses." See Emily Alpert. "Refuting the Health Care 'Refusal Clause'," *Chicago Maroon*, October 27, 2004; Adam Sonfield. "New Refusal Clauses Shatter Balance between Provider 'Conscience', Patient Needs," *The Guttmacher Report on Public Policy*, 7 (2004).
3. *Mississippi Health Care Rights of Conscience Act*, Senate Bill 2619, sec. 2 (2004) (emphasis mine).
4. The six procedures were: abortion, sterilization, embryo research, fetal tissue transplants, withholding of nutrition/hydration, and euthanasia. See *2003 Wisconsin Assembly Bill 67* (February 18, 2003). Wisconsin Governor Jim Doyle vetoed the bill on April 21, 2004. See <[http://www.wisgov.state.wi.us/docs/042104\\_Veto\\_AB67.pdf](http://www.wisgov.state.wi.us/docs/042104_Veto_AB67.pdf)>.
5. *Church Amendment to the Public Health Service Extension Act of 1973*, 42 U.S. Code § 300a-7.
6. See Emily Bass. "Unconscionable Care: Is the Religious Right Compromising Your Healthcare?" *Ms. Magazine*, (June/July 2001).
7. *Ibid.*
8. See Angela Bonavoglia. "Co-opting Conscience: The Dangerous Evolution of Conscience Clauses in American Health Policy," *ProChoice Matters*, (January 1999), 1.
9. See Rachel Benson Gold. "Conscience Makes a Comeback in the Age of Managed Care," *The Guttmacher Report on Public Policy*, 1 (February 1998), 1.
10. See Rachel Benson Gold. "Special Analysis...Provider 'Conscience' Questions Re-emerge in Wake of Managed Care's Explosion," *State Reproductive Health Monitor*, The Alan Guttmacher Institute, (June 1997), 3.
11. *Ibid.*, 5. Also see Bonavoglia, *supra* note 3.
12. *Ibid.*
13. Gold, "Conscience Makes a Comeback," 1.
14. *Ibid.*
15. *Ibid.*
16. *Consolidated Appropriations Act, 2005*, H.R. 4818, Title V, Sec. 508(d)(1), (2).
17. See <<http://www.consciencelaws.org/Protection-of-Conscience-Laws.html>>.
18. The Conscience Project's coverage of Australian laws is available at <<http://www.consciencelaws.org/Conscience-Laws/Australia-Conscience-Laws/Conscience-Laws-Australia.html>>. See *Medical Practitioners Act of 1930*, 55E (Australian Capital Territory), *Criminal Code of the Northern Territory of Australia*, § 174 (Northern Territory), *Criminal Law Consolidation Act of 1935*, § 82A (South Australia), *Criminal Code Act of 1924* (Tasmania), and *Infertility Treatment Act of 1995*, § 152 (Victoria).
19. See *Contraception, Sterilisation, and Abortion Act of 1977*, §42 (New Zealand); *The Health (Family Planning) Act of 1979*, Clause 11 (Ireland) and *Regulation of Information (Services outside the State*

- for Termination of Pregnancies) Act of 1995, Clause 13 (Ireland).
20. See <<http://www.consciencelaws.org/Proposed-Conscience-Laws/Canada/PLCanada01.html>>.
21. Ken Baum and Julie Cantor, "The Limits of Conscientious Objection—May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?" *New Engl J Med*, 351 (2004): 2012; *United States v. Macintosh*, 283 U.S. 605, 634 (1931) (Hughes, C.J., dissenting).
22. *Ibid.*, 2009 (emphasis mine).
23. Stephen Wear, Susan LaGaipa, and Gerald Logue. "Toleration of Moral Diversity and the Conscientious Refusal by Physicians to Withdraw Life-Sustaining Treatment," *Journal of Medicine and Philosophy*, 19 (1994): 147-59.
24. Lynn D. Wardle. "Protecting the Rights of Conscience of Health Care Providers," *The Journal of Legal Medicine*, 14 (1993): 189, note 55.
25. *Ibid.*, 214.
26. Baum and Cantor, *supra* note 21, 2008-09. For a critique of the "technician model," see J.F. Childress and M. Siegler. "Metaphors and Models of Doctor-Patient Relationships: Their Implications for Autonomy," *Theoretical Medicine*, 5 (1984): 17-30.
27. For a defense of medicine as a moral enterprise, see Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), chapter 3; Mark R. Wicclair, "Conscientious Objection in Medicine," *Bioethics*, 14 (2000): 213-17.
28. See Baum and Cantor, *supra* note 21, 2010.
29. See, e.g., *Watkins v. Mercy Medical Center*, 364 F. Supp. 799 (D. Idaho 1973, *aff'd*, 520 F.2d 894 (9th Cir. 1975); *Swanson v. St. John's Lutheran Hospital*, 597 P.2d 702 (Mont. 1979); *Kenny v. Ambulatory Centre of Miami Florida, Inc.*, 400 So. 2d 1262 (Fla. App. 1981).
30. See Alison Manolovici Cody. "Success in New Jersey: Using Charitable Trust Doctrine to Preserve Women's Reproductive Services When Hospitals Become Catholic," *NYU Annual Survey of American Law*, 57 (2000): 327. For more on how eliminating the rights of conscience would affect the Catholic system, see Heather Skeeles. "Patient Autonomy Versus Religious Freedom," *Washington & Lee Law Review*, 60 (2003): 1012, note 16.
31. *Emergency Medical Treatment and Labor Act*, U.S. Code 42 § 1395dd (b)(1) (1986).
32. See, e.g., "Toward a New Health Care System," *Summary of an ACLU Public Policy Report*. Available online at <[http://www.skepticfiles.org/aclu/health\\_s.htm](http://www.skepticfiles.org/aclu/health_s.htm)>.
33. See, e.g., the New Jersey Catholic Conference's "Example Letter to All New Jersey Assembly Members." Available online at <<http://www.njcathconf.com/LegActionAlerts/Life%20Issues/A292ExemplarAssembly.htm>>.
34. Jim Doyle, Veto Statement of Wisconsin's Assembly Bill 67, April 21, 2004. Available online at <[http://www.wisgov.state.wi.us/docs/042104\\_Veto\\_AB67.pdf](http://www.wisgov.state.wi.us/docs/042104_Veto_AB67.pdf)>.
35. A comparable situation occurred in Manchester, New Hampshire, to a pregnant woman named Kathleen Hutchins. See the transcript of the CBS News Broadcast of *60 Minutes* from December 10, 2000. Available online at <<http://www.catholicsforchoice.org/new/inthenews/12100060Minutes.htm>>.
36. *Principles of Medical Ethics of the American Medical Association* (1996-1997 Edition) (emphasis mine).
37. *President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research* (1982) (emphasis added).
38. Center for Vulnerable Populations Research, "Who are Vulnerable Populations?" Available online at <<http://www.nursing.ucla.edu/organizations/cvpr/who-are-vulnerable.html>>.
39. See "Pharmacist Refuses Pill for Victim," *Chicago Tribune*, (February 11, 2004): C7; "Pharmacist Fired for Denying 'Morning After' Pill." Available at <<http://www.cnn.com/2004/US/Southwest/02/12/pharmacy.firing.ap/>>.
40. See Rob Stein. "Pharmacists' Rights at Front of New Debate," *Washington Post*, (March 28, 2005), A01. Available online at <<http://www.washingtonpost.com/wp-dyn/articles/A5490-2005Mar27.html>>.
41. Pharmacists for Life International. Available online at <<http://www.pfli.org/main.php?pfli=conscienceclausefaq>>.
42. Baum and Cantor, *supra* note 21, 2008.
43. Sonfield, 3.
44. See "Trends in Brief." Available online at <<http://www.catholicsforchoice.org/pubs/merger99.asp>>.
45. See Liz Bucar. "When Catholic and Non-Catholic Hospitals Merge—Reproductive Health Compromised," (Catholics for a Free Choice, 1998), 3, 15.
46. Directive 48. Available online at <<http://www.usccb.org/bishops/directives.htm>>.
47. *Ibid.*, Directive 45.
48. See, e.g., *Alaska Stat.* § 18.16.010 (b) (1991); *Ark. Code Ann.* § 20-16-601 (2001); *24 Del. Code Ann.* § 1791 (1987); *Fla. Stat.* § 390.0111 (2001); *Ga. Code Ann.* § 16-12-142 (2001); *Haw. Rev. Stat.* § 453-16 (1985); *Kan. Stat. Ann.* § 65-443, 444 (2001). Other states using the term "person" in their conscience clause legislation are Maine, Maryland, Minnesota, Montana, Nebraska, New Jersey, New York, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Virginia, West Virginia, and Wyoming.
49. *24 Del. Code Ann.* § 1791 (1987) (emphasis mine).
50. *Iowa Code Ann.* § 146.1; also see *42 U.S. Code*, § 300a-7(a).
51. See Wardle, *supra* note 24, 182. For purposes of holding property, entering into contracts, and suing in court (or being sued), corporations are "legal persons."
52. See, e.g., *Mass. Gen. Laws Ann.* ch. 112, § 12I ("A physician or any other person who is a member of or associated with the medical staff"); *R.I. Gen. Laws* § 23-17-11. Other states that used "person" or "individual" in this way were Indiana, Iowa, Oregon, Kansas, and Maryland.
53. See, e.g., *22 Me. Rev. Stat. Ann.* § 1591-2; *Pa. Cons. Stat. Ann.* § 3213 (d).
54. Wardle, *supra* note 24, 185.
55. *Ibid.*, 186. Also see *Pembina Consol. Silver Mining & Milling Co. v. Pennsylvania*, 125 U.S. 181, 189 (1888)

- ("[C]orporations are merely associations of individuals united for a special purpose, and permitted to do business under a particular name, and have a succession of members without dissolution.").
56. *Ibid.*, 187. Also see *First Nat'l Bank of Boston v. Bellotti*, 435 U.S. 765, 778-84 (1978); *N.A.A.C.P. v. Button*, 371 U.S. 415, 428-31 (1963); *Pacific Gas and Elec. Co. v. Public Utilities Comm'n of California*, 475 U.S. 1, 9-12 (1986); *Federal Election Comm'n v. Massachusetts Citizens for Life, Inc.*, 479 U.S. 238, 260-62 (1986).
57. An example is a Nevada clause that protects "a registered nurse, a licensed practical nurse, a nursing assistant or any other persons employed to furnish direct personal health services to a patient" against having "to participate directly in the induction or performance of an abortion." See *Nev. Rev. Stat.* § 632.475.
58. Wardle, *supra* note 24, 188.
59. See "ACLU Files Lawsuit Against Illinois Ambulance Service," News Release by The Protection of Conscience Project, (May 7, 2004). Available online at <<http://www.consciencelaws.org/Repression-Conscience/Conscience-Repression-34.htm>>.
60. See "Fired EMT Sues After Refusing to Transport Woman for Abortion," News Release by Free Republic. Available online at <<http://freerepublic.com/focus/f-news/1134472/posts>>.
61. See "Discrimination case against health department settled," *Daily Chronicle*, May 28, 2004.
62. 18 Empl. Prac. Dec. (CCH) ¶ 8871 (Pa. C. P. De. Cty.), *aff'd*, 395 A.2d 998 (Pa. 1978).
63. 137 Cal. App. 3d 389, 394, 187 Cal. Rptr. 164, 168 (1982).
64. See, e.g., *Cal. Health & Safety Code* § 25955(d); *Ill. Ann. Stat.* ch. 111½, ¶ 5306, 5309; *Iowa Code Ann.* § 146.1; *Kan. Stat. Ann.* § 65-444; *Md. Health—Gen. Code Ann.* § 20-214 (Supp. 1991); *Nev. Rev. Stat.* § 632-475.
65. E.g., Wardle, *supra* note 24, 194.
66. *Ibid.*, 195.
67. Two states, Kentucky and Pennsylvania, already have such exceptions. See *Ky. Rev. Stat.* § 311.800 and *Pa. Cons. Stat. Ann.* § 3213.
68. See Wardle, "Health Care Providers' Rights of Conscience Protection Act" in the appendix to "Protecting the Rights of Conscience of Health Care Providers," 229, Sec. 6(c); also see The Projection of Conscience Project's draft legislation, "The Protection of Conscience Act," 8, note 15. Available online at <<http://www.consciencelaws.org/Conscience-Archive/Conscience-Project-Documents/Model%20Statute.pdf>>.
69. A number of states require that the objector "state" the objection. See, e.g., *Fla. Stat. Ann.* § 390.001(8); *Mich. Comp. Laws Ann.* §§ 333.20182 to 333.20183; *N.C. Gen. Stat.* § 14-45.1.
70. See, e.g., *Ariz. Rev. Stat. Ann.* § 36-2151; *Cal. Health & Safety Code* § 25955; *Colo. Rev. Stat.* § 18-6-104.
71. See Wardle, *supra* note 24, 199.
72. Department of Defense Directive 1300.6, *Conscientious Objectors* (20 August 1971), § III(a), § III(B).
73. See *Clay v. United States*, 403 U.S. 698 (1971); *Welsh v. United States*, 398 U.S. 163 (1970); *United States v. Seeger*, 380 U.S. 163 (1965).
74. See *Lemon v. Kurtzman*, 403 U.S. 602 (1971); *Allegheny County v. ACLU*, 492 U.S. 573 (1989); *Wallace v. Jaffree*, 472 U.S. 38 (1985).
75. See *Lynch v. Donnelly*, 465 U.S. 668 (1984).
76. In *Swanson v. St. John's Lutheran Hospital*, 597 P.2d 702 (Mont. 1979), two Montana Supreme Court justices dissented because they believed a nurse's reasons for refusing to participate in sterilizations were more emotional than moral.
77. See Bonavoglia, *supra* note 8, 4.
78. From the *American Pharmaceutical Association Report of the House of Delegates*, policies adopted by the 1998 APhA House of Delegates.
79. See 410 *Ill. Comp. Stat.* 70/2.2 (2002).
80. Skeeles, 1018.
81. *Ibid.*, 1019, notes 57 and 58.
82. Baum and Cantor, *supra* note 21, 2009.

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## RECENT ARTICLES OF INTEREST

### —ABSTRACTS—

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**Scott C. Idleman, "The Concealment of Religious Values in Judicial Decisionmaking," 91 *Virginia Law Review* 515-534 (2005).**

"There was a time in the United States when the explicit invocation of religious values...in judicial decisionmaking was generally tolerated...." That is not so today, but "an important contemporary issue is whether the attempted exclusion or omission of religion from the judicial process...is ultimately as practical, as principled, as benign, or as authentic as commonly assumed." The author is concerned not with the public actions and pronouncements on religion, such as those by Justice Antonin Scalia and Alabama's former Chief Justice Roy Moore, but with the actual influence of religion in judicial decisionmaking. But though religious considerations are usually not evident in judicial decisions, it is likely that they are influential—but concealed (though usually without an intent to deceive).

While the overt avoidance of religious influence has benefits, there are nevertheless costs of concealment: it may deprive litigants of the opportunity to make effective arguments, it may raise questions of a judge's integrity (even religious citizens may have such concerns), and it may make a judicial decision less explicable or predictable. The author suggests that judges need to be more reflective about "the possible relationship between religious inputs and their decisionmaking" and that the role of religion in judges' decisional processes should be destigmatized. What is needed is "critical but open-minded assessment" in which the issue is not "why a judge has employed religion in her reasoning, as if it were an extraordinary or bizarre aberration, but instead whether her particular use of religion is reasonable or permissible under the circumstances."

**Lior Jacob Strahilevitz, “The Right to Destroy,”**  
*114 Yale Law Journal* 781-854 (2005).

The right to destroy one’s property has frequently been regarded as one of the incidents of ownership—people may destroy, on the one hand, unwanted personal items, and on the other, frozen human embryos. In our burial practices, we may bury people wearing wedding rings and other jewelry, thus effectively destroying them, and also with their valuable, usable organs, again destroying them. On the other hand, “in contested cases, courts have become increasingly hostile to owners’ efforts to destroy their own valuable property,” and further limits on the right to destroy have been proposed. The author defends the right to destroy one’s property in many (though not all) of the cases, particularly in the testamentary context, in which courts have tended the other way.

The main concern of courts that have restricted the right to destroy is the waste of valuable resources; a related concern is the negative externalities that might be associated with destruction. For example, there is a case in which a testator directed that her house be razed and the land sold. Neighbors sought injunctive relief, which the court granted on the ground that there were no good reasons that would offset the waste of resources and damage to third parties. On the other hand, the author maintains, when it comes to burial practices, both law and social norms “encourage the destruction of especially valuable societal resources.” Other cases of property destruction identified by the author include the suppression of a patent for a superior product (when there was thought to be more profit in the inferior product), a waste of resources upheld by the courts; the federal law, passed in the wake of Watergate, abolishing private ownership of presidential papers (thus limiting the right to destroy); and historic preservation statutes (limiting the right to destroy).

There are also cases in which destruction of property is justified on expressive grounds, including First Amendment cases such as flag burning and the pulling down of the statue of Saddam Hussein. On the other hand, the Visual Artists Rights Act prohibits the destruction of certain visual art, even by a purchaser, during the artist’s lifetime, presumably because of expressive concerns, the artist’s taking precedence over the owner’s.

The author argues that a right to destroy should be recognized in many of the cases in which it has been withheld. Certainly where there are strong social norms, as with organs, such a right is appropriate. In many cases of waste, the author argues that there are frequently “ex ante” arguments showing that there is greater waste overall in prohibiting the right to destroy. With regard to the testamentary right to destroy, the author proposes a response to a number of concerns about such a right—to ensure that the owner knows the value of what he wants destroyed and of objections that he would not have to hear when he is dead, the author proposes that “destructive instructions contained in wills shall be honored only if the owner, during his lifetime, notified the public of the opportunity to purchase a future interest in the property.” For, the author says, if no bid met his price, “the owner would have demonstrated that he valued destruction of the property more than anyone else valued its preservation.”

**Gerald Dworkin, “Moral Paternalism,”** *24 Law and Philosophy* 305-319 (2005).

The author’s main purpose in this article is to determine how so-called moral paternalism (the idea of preventing a person from harming himself or herself morally) differs from legal paternalism (preventing a person from harming himself physically or psychologically), and from legal moralism (preventing a person from doing something inherently immoral). For whereas legal moralism holds that a person may be *morally better* if his or her behavior is altered, moral paternalism holds that such a change is *better* for the person. That is, such a person will not only be morally better but better off in the sense of having increased well being.

There is a question, though, of whether an intervention that improves one’s character makes his life better if he does not believe that it does (this is the endorsement thesis: that one must endorse the value that is created in order for it to make his lived life better). For it has been argued (by Ronald Dworkin and Joel Feinberg) that moral paternalism is incorrect precisely because without endorsement a person’s life cannot be better for her. The author maintains, though, that this view has not been demonstrated, and further, that even if a person does not endorse ways in which he is forced to change, so that he does not benefit directly from the change, the change “may have consequences for other aspects of the person’s life that he does endorse.” Thus, moral paternalism may succeed in making the person not only morally better but also better off.

**Judith Resnik, “Jurocracy and Distrust: Reconsidering the Federal Judicial Appointments Process: Judicial Selection and Democratic Theory: Demand, Supply, and Life Tenure,”** *26 Cardozo Law Review* 579-655 (2005).

Issues surrounding the appointment and role of Supreme Court justices in the United States have raised questions about the role of judges in a democracy. Coupling lifetime appointments with judicial supremacy gives rise to what is called the counter-majoritarian difficulty. Though the author shares some of the concerns, much of her article is devoted to documenting the variety of practices related to the appointment, the terms, and the role of judges in the United States and in other democracies. A major contention of the article is that democratic theory can be comfortable with a number of ways of dealing with judges. What democracy requires, she argues, is a commitment to judicial independence and to “constrained and diffused power,” which, the author believes, can be achieved in many ways, some of which are already the practice in the United States and some of which are not.

The author notes that in response to the growing demand for federal judges in the twentieth century the number of life-tenured, Article III judgeships has increased dramatically (eight-fold), yet these constitute only a quarter of federal judges, the majority of which are what the author calls “statutory” judges and include magistrate and bankruptcy judges, who are appointed by the constitutional judges (a process that carries with it its own issues about democratic input) and who do not have life appointments. Beyond that are the “Article I” courts, including the more than 2,000 administrative law judges in the administrative agencies. Thus, within a democratic framework, there are many patterns of judgeships, all thought to be

constitutional, with the most well known and contentious being a very limited category.

On the other hand, the top-tier Article III judges have engendered deep political questions. The author is not opposed to the appointment of these judges being a political process but thinks that these judgeships have become more political than they need to be and that there are mechanisms of control that are compatible with democratic ideas. Not only do top-tier Article III judges serve for growing lengths of time, but the Supreme Court's ability to set its own agenda has made that court more political, since it does not respond, as most courts do, to whatever cases come along, but can decide what areas of law to develop, a tendency that is enhanced by the Court's agreeing to hear a declining number of cases each year.

There are several ways of diminishing the political role of judges that, the author maintains, are compatible with democracy; many of these are used in other democracies. One is to have a supermajority rule for Senate confirmation (in fact, despite some noteworthy conflicts, more than ninety percent of judges nominated in recent years have been confirmed by ninety or more senators). Other possibilities for judicial appointment are merit selection (though this might diminish democratic influence too much); substantial increase in the number of life-tenured judges, which would diminish the political influence of the few; and fixed terms of office (there would probably be constitutional issues with this, but the author thinks it might be compatible with Constitutional prescriptions), or at least legislation creating incentives for judges to serve shorter terms.

The author notes, finally, that despite devices in the United States that are designed to ensure an independent and impartial judiciary, there have been many complaints in recent years about the power of judges and proposals to curb their powers.

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**Benjamin C. Zipursky, "Theories of Taking the Constitution Seriously Outside the Courts: Tempering Supremacy," 73 *Fordham Law Review*. 1463-1476 (2005).**

The author takes issue with some of the arguments of Larry Kramer's book *The People Themselves*, in which Kramer argues that the ultimate power of interpreting the Constitution is the province of *the people*, who have ceded it to the Supreme Court in recent years and need to reclaim it. First of all, if the Constitution is the repository of fundamental law whose meaning is what those who ratified it meant or understood or intended when they ratified it, then what is the case for saying that people living today have special insight into what an earlier generation ratified (and, further, how do we even know what counts as an expression of such a view?)? A related point concerns "how the people could express their interpretive views," for if it is though some other branch of government, in particular an elected branch, then it is not the people themselves interpreting the Constitution but a conflict between branches. Indeed, it is wholly unclear what is to count as the people themselves or their views.

The author argues that there is a convincing argument, along the lines of the *Marbury* argument, for judicial supremacy "in at least some areas of constitutional interpretation." Article I powers such as the commerce clause confer powers (in Hart's sense) on government; without those powers it cannot pass laws. So when a case arises in which the government's power to make a law is questioned, the court must decide whether

there is a valid law, and if it is to make a final decision in the case, as the Constitution contemplates, its decision must be authoritative. This line of thought, however, does not extend to all constitutional provisions, for some (such as in the Bill of Rights) may only impose duties on government but not confer powers. If, for example, the Fourth Amendment is interpreted as imposing duties on Congress but not as limiting its lawmaking power, then the foregoing argument would not imply judicial supremacy. Of course, some provisions of the Bill of Rights might be both duty-imposing and power-constraining.

Finally, the author believes that even though there is no requirement that courts defer to the legislative branch in certain cases, the courts might appropriately decide to abide by a norm of deference, such as in many New Deal era decisions on Article I powers. From this standpoint, some recent decisions (*Lopez* and *Morrison*) do not reflect a misconception of the proper scope of judicial authority but, at most, poor judgment.

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## RECENT BOOKS OF INTEREST

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Barnes, Jeb. *Overruled?: Legislative Overrides, Pluralism, and Contemporary Court-Congress Relations*. Stanford, CA: Stanford University Press, 2004.

Bogira, Steve. *Courtroom 302: A Year Behind the Scenes in an American Criminal Courthouse*. New York, NY: Knopf, 2005.

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