



The Supreme Court and the Purposes of Medicine

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What role should physicians have in defining the purposes of their profession — the functions that medicine should and should not serve? Many observers hold that medicine's aims are for

doctors and patients to decide, without interference from the state. But in fact, government limits medicine's purposes in many ways. Doctors cannot prescribe mind-altering substances for recreational use or anabolic steroids to enhance athletic performance. Physicians were once barred from terminating pregnancies, and today, in 49 states, they are not allowed to assist the terminally ill in ending their lives. In some jurisdictions, psychiatrists cannot medicate condemned prisoners to make them competent for execution. And though federal law allows clinicians to ration care at the bedside, they can do so only within limits set by state medical malpractice law.

Government restrictions on the role of medicine are often bitterly

disputed, and sometimes the warring parties carry their fights to the U.S. Supreme Court. Abortion, assisted suicide, and rationing of care are among the clinical issues the Court has considered. Commentary on such cases typically emphasizes questions of constitutional and statutory meaning, which vary greatly from case to case. As a result, observers have overlooked an emerging pattern — the justices' deference to the medical profession's understanding of its purposes. This deference has taken several forms: regard for ethical pronouncements by professional organizations when construing ambiguous legal terms, reliance on professional self-regulation (through licensing boards, second opinions, and peer review) to restrain errant practitioners,

and dependence on individual doctors' clinical judgments to safeguard (and balance) patients' rights and government interests.

A case in point, discussed by Annas in this issue of the *Journal* (pages 1079–1084), is the Court's response to the Bush administration's attempt to thwart assisted suicide in the lone state that allows it. Administration lawyers had seized on a federal statute that bars the prescribing of a controlled substance absent a "legitimate medical purpose." They argued that helping a patient to die is not a "legitimate medical purpose," so physicians cannot prescribe controlled substances to abet suicide. The U.S. Attorney General claimed authority to read the statute this way, citing cases that allow the executive branch to define vague legislative terms. But the Court ruled, in *Gonzales v. Oregon*, that the purposes of medicine are not for the attorney general to decide. "The structure and operation" of controlled-substances law,

Justice Anthony Kennedy wrote for the Court, “presume and rely upon a functioning medical profession regulated under the States’ police powers.” Physicians, Kennedy noted, tightly control assisted suicide under the Oregon law that allows it. Second opinions and oversight by professional disciplinary authorities circumscribe the discretion of individual doctors to issue terminal prognoses, determine competence, and prescribe lethal drugs. Congress, Kennedy said, can bar such prescriptions, but it did not do so, and the attorney general cannot impose such a limit. “Medicine’s boundaries,” the Court concluded, are for the profession to determine, within the framework of state law.

What emerges from this and other Supreme Court rulings on the permissible roles of medicine is less a principle than an inclination — a propensity to give physicians a large say over the uses of their craft. This inclination was evident in the Court’s only other engagement with assisted suicide, in two 1997 decisions dismissing constitutional challenges to state laws proscribing it.

Writing for the Court in one of these cases, *Washington v. Glucksberg*, the late Chief Justice William Rehnquist said that states have “an interest in protecting the integrity and ethics of the medical profession” that merits weight when courts consider whether laws that limit personal freedom are “rationally related” to legitimate state interests. Rehnquist cited positions taken by physicians’ groups, including the American Medical Association (AMA), as proof that many in the profession see abetting suicide as incompatible with the doctor’s role as healer.

That *Washington* and *Gonzales* yielded superficially inconsistent

results — one affirming a ban on assisted suicide, the other upholding a law permitting it — reflects the different ways in which the Court defers to professional opinion about medicine’s permissible uses. In both cases, the justices let state laws stand, partly on the basis of input from physicians. In *Washington*, the Court relied on ethical pronouncements from the AMA and other professional groups (and rejected contrary arguments by some ethics scholars) in finding that state laws against assisted suicide have a rational basis and thereby pass constitutional muster. In *Gonzales*, Oregon’s reliance on physicians’ judgment and self-policing influenced the Court’s refusal to permit the U.S. Attorney General to proscribe it.

To be sure, the medical profession doesn’t have carte blanche to determine its own social role.¹ For example, the Court ruled last year, in *Gonzales v. Raich*, that Congress’s power to regulate interstate commerce permits it to bar therapeutic use of marijuana even if state law allows it and clinical judgment (backed by evidence) supports it. Actual and proposed limits on abortion, therapeutic cloning, and technologies that enhance physical and mental performance are other examples.

Yet medical opinion influences such limits through myriad pathways, at the levels of both public policy and case-by-case clinical judgment. Legislative advocacy, expert testimony in court and agency proceedings, and positions taken in pathbreaking litigation are among the means by which the medical profession shapes its social role, in negotiation with other political and legal actors.

The Supreme Court’s recent efforts to shore up the states’ authority vis-à-vis the federal government have enhanced medicine’s

influence. Medical societies hold considerable sway with state legislatures — a level of influence underscored by the proliferation of state laws reining in managed care and limiting medical liability. And state law governing malpractice and review of denials of medical coverage looks to medical custom as the primary source of standards of care.²

Even when the justices have treated federal law as controlling, they have shown remarkable deference to the medical community, to the point of allowing the profession’s understanding of its role to shape the content of federal constitutional rights. In holding that a hospital’s disclosure to law-enforcement authorities of the results of patients’ drug tests constituted an unreasonable search under the Fourth Amendment (*Ferguson v. City of Charleston*), the Court relied on the contention by the AMA and other medical groups, in an amicus brief, that such results should be confidential.

In other cases, the justices have extended such deference to individual doctors. Indeed, the right affirmed in *Roe v. Wade* was not a woman’s right to abortion itself but, rather, her right to her doctor’s unfettered medical judgment regarding pregnancy termination. Reliance on individual caregivers to shape the content of constitutional rights has been strongest in decisions involving the rights of the mentally ill. The Court has looked to clinical judgment to protect patients’ constitutional interests in freedom from unreasonable physical restraints (in *Youngberg v. Romeo*) and, in prison settings, unwanted psychiatric medication (in *Washington v. Harper*). In a series of decisions on prisoners’ rights to refuse medication, the Court rejected calls for strict due-process safeguards. Psy-

chiatric assessment suffices, the Court has said, to take account of prisoners' "medical interests" and civil liberties, as well as the government's interest in prison safety and securing defendants' competence to stand trial.

The Court's deference to medical authority has drawn fire from dissenting justices on both the left and the right. With regard to the treatment of prisoners, Justice John Paul Stevens criticized the Court for withholding procedural safeguards, allowing psychiatrists to conflate therapeutic and security purposes, and thereby enabling them to medicate inmates for "institutional convenience" under therapeutic cover. And Justice Antonin Scalia has repeatedly insisted that the purposes of medicine are not for the profession to decide. Scalia's dissent in *Gonzales v. Oregon* (joined by Chief Justice John Roberts) drew a bright line between the profession's technical expertise and social role. The latter, he says, is a matter of "public morality," the province of elected officials.

Will Scalia's view gain traction? He has already brought the

new chief justice on board, and many expect Justice Samuel Alito to concur with Scalia, Roberts, and Justice Clarence Thomas on questions of public morality, including those that implicate medicine. For some, this is a chilling prospect, portending an era of Big Brother intrusion into the doctor-patient relationship. For others, the promise is one of democratic empowerment — the making of moral choices by popularly chosen leaders instead of technocratic elites.

We may soon learn whether Scalia's perspective will prevail. The justices' decision last month to consider a congressional ban on so-called partial-birth abortion poses the question of medicine's authority in stark form. Six years ago, the Court struck down a similar state law because it lacked an exception for maternal medical need. But Congress tried an end run around this ruling, in the form of a "finding" that such abortions are "never medically necessary." Physicians who perform abortions say otherwise. Lower courts have deferred to their views, dismissing this "finding" as unreason-

able and concluding that the congressional ban is unconstitutional.

Proponents of the ban insist that Congress, not the medical profession, is entitled to deference on the question of clinical need. Abortion-rights advocates counter that pregnant women's health needs are for them and their doctors to determine. Central to the latter claim is the premise that the medical judgment to which a woman is entitled encompasses the moral dimensions of the decision to abort. Should the former view prevail, public authority over medicine's morality and purposes will greatly expand. The justices would do well to weigh the consequences for caregivers' ability to address patients' varying needs.

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1. Bloche MG. Medical ethics in the courts. In: Danis M, Clancy C, Churchill LR, eds. Ethical dimensions of health policy. New York: Oxford University Press, 2002:133-56.
2. Henderson JA Jr, Siciliano JA. Universal health care and the continued reliance on custom in determining medical malpractice. *Cornell Law Rev* 1994;79:1382-404.

The Growing Burden of Chronic Kidney Disease in Pakistan

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A Pakistani tailor, the sole breadwinner for a family of eight, had received diagnoses of type 2 diabetes and hypertension at 31 years of age. For the next 15 years, although he felt well and visited his primary care practitioner twice a year, his conditions were poorly controlled. When he was 46, he began to notice fatigue and loss of appetite. After several weeks of the gradual progression of these symptoms, the man sought med-

ical attention and was found to have a serum creatinine concentration of 5.2 mg per deciliter (460 μ mol per liter), a blood urea nitrogen concentration of 87 mg per deciliter (31 mmol per liter), an estimated glomerular filtration rate (GFR) of 10 ml per minute per 1.73 m² of body-surface area, urinary albumin excretion of 1.5 g per day, and mildly shrunken kidneys. Twice-a-week sessions of hemodialysis were initiated, but

the patient had to take out a loan to pay for them and soon was unable to afford to continue treatment. He has been lost to follow-up ever since.

Given pressing medical concerns such as infectious diseases and malnutrition faced by developing countries, why should we even talk about chronic kidney disease in such places? The fact is that many developing countries are facing a silent epidemic of