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The Search for Caring and Justice: The Social Functions of Medicine and Law

Larry I. Palmer

Media reports about the marvels and moral dilemmas of modern medicine as well as scholarly critiques of legal responses to medicine's new dilemmas reflect a groping for a new definition of the relationship between medicine and law. I want to join this discussion by suggesting that we ought to view the argument concerning that relationship not as an intractable conflict between two professions but as a communal search for caring and justice. I suggest that participants in these debates frame the issues facing medicine and law within that broader social context—an institutional context.

Posing the right question is an essential feature of any social response to the moral and ethical dilemmas in medicine and law. We are not simply searching for better health care or even a more humane medicine. Rather, we are searching for concepts that relate our ever-increasing technological capacity to the basic bonds that hold human societies together—a basic concept of caring. When that search for a new understanding of caring creates conflicts, society increasingly turns to law, not to find the right secular answer, but to discover a new form of social harmony—a basic concept of justice.

It seems appropriate to view legal conflicts involving medicine in terms of failure of care. It further seems appropriate to define care broadly as encompassing the whole range of physicians' roles, from healer to technician, and the entire panoply of services provided by institutionalized medicine. As individuals who may become patients ourselves, we want more than mere technical competence from medicine when we are sick. Most of us want the empathy of another human being, as well as a cure, whether we suffer from a slight cold or terminal cancer. Although modern physicians are inculcated with the ethos of science, our idealized image of the physician remains that of the caring "healer," who would bring the greatest insights of modern science to the patient's case but would also alleviate the patient's suffering with emotional and perhaps even spiritual support.

When faced with conflicts involving the practice of medicine, we, as laypersons, want law to embody some notion of "justice." We know, however, that there is widespread moral confusion and uneasiness about modern medicine's role, and we are thus uncertain about which ideas should guide the search for just results. Some people view the concept of justice as derived from ideals about law's obligation to protect individual liberty of action. Others hold a conception of justice that derives from ideals about the law's obligation to provide equality—here, of treatment. Still others evaluate decisions by whether the result helps to enforce those values, such as "respect for life," that are necessary for a just society in the long run.

Existing legal analyses cannot resolve the underlying moral and social issues in medicine or, for that matter, provide us with new ways of thinking about the social functions of medicine. As an alternative I want to propose an *institutional approach* that focuses on the functions of medicine and law.

Medicine from an Institutional Perspective

We should think of medicine first and foremost as a formal institution within society rather than as individual professionals engaged in certain activities. From that perspective medicine is a complex pattern of behavior centering on society's concept of what illness is.

In viewing medicine from the institutional perspective, we need first to take into account the forces shaping modern medicine. Among those forces are increasing specialization among health care professionals, the emergence of a variety of organizations that together constitute medicine as an institution (for example, hospitals, abortion clinics, mental hospitals, HMOs), and third-party insurance, the primary method of financing health care in our society. In addition to those, the force that has overriding influence on the behavior of health care professionals and patients is the ethos of science.

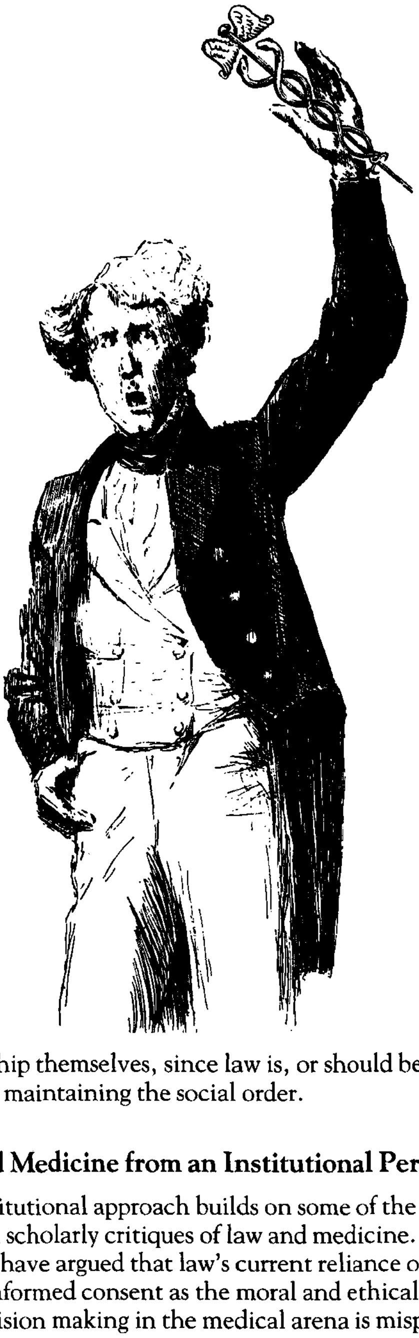
Over the past forty years developments in bioengineering, clinical pharmacology, and molecular biology have radically changed modern medicine and, consequently, the way health care is provided in the United States. (Ironically, with those advances in knowledge and technical capacity we have become more aware of what remains unknown about medical intervention.) Developments in the biomedical research laboratory heavily influence what the medical practitioner does. The modern scientific approach to medicine claims that the advancing technologies resulting from that research justify risk taking and the investment and will eventually lead to greater improvements in health and well-being for society.

The public, however, is increasingly uncomfortable with that scientific ethos of modern medicine. The most poignant manifestation of discomfort is the growing concern that medicine has now gained control over the process of death itself, destroying the concept of a "natural death." That discomfort reveals society's lack of consensus about the purposes of modern medicine. While most individuals no longer accept preservation of life at all costs as a goal of medicine, we are as yet unwilling to embrace an alternative goal that allows medical professionals actively to "dispense" death in certain cases.

Law from an Institutional Perspective

From an institutional perspective law should be viewed as designed both to preserve the social order and to allow its evolution. The evolutionary function of law in relation to modern medicine must be emphasized because the dynamic force of medicine is transforming the entire social order; its influence on our ideas of life, death, and health is inestimable. At the same time, law also has an influence on behavior (even when there is no active legal intervention), since it is an integral part of society's and the individual's consciousness of the social order. Legal professionals adjudicate disputes, promulgate rules and policies, and administer regulations in accordance with some implicit and explicit concepts of the social order's evolution.

Adopting that institutional perspective would change the role of legal intervention in health care decisions dramatically. Judges, lawyers, legislators, and administrative officials would first seek to understand the social and organizational context of the controversy before making any decisions regarding medicine. As legal decision makers come to understand the larger social context, they will recognize that law's influence on medical practice is necessarily limited, while law's influence on medicine's role in the social order is potentially very great. Rather than seek to regulate the individual doctor-patient relationship, law would aim to influence and direct the institutional structure of modern medicine. The ultimate goal of such an approach would be to increase the capacity of health care organizations, particularly hospitals, to regulate the doctor-patient relationship themselves, since law is, or should be, a last resort for maintaining the social order.



Law and Medicine from an Institutional Perspective

This institutional approach builds on some of the more profound scholarly critiques of law and medicine. Those critiques have argued that law's current reliance on the concept of informed consent as the moral and ethical basis of legal decision making in the medical arena is misplaced for two reasons.

First, granting to an individual the power to be a sole decision maker concerning a severe physical or mental illness has destructive social and psychological consequences. When law relies on a model of exclusive decision-making power resting in the patient, the decisions lead to psychological isolation of the patient. The perception of exclusive decision-making power is thus anticommunal because law is used to fracture others' sense of social connections to the person most in need of societal care, the patient. To avoid those adverse consequences, law must seek to acknowledge a certain amount of its own uncertainty when it intervenes in medical decisions and must, therefore, leave ultimate decision-making authority uncertain.[1]

A second problem is that the informed consent approach does not address the fact that physicians traditionally rely on silence rather than dialogue in their contacts with patients. The physicians' own doubts in the face of the inherent uncertainty of modern medical intervention are not shared with patients because such sharing is seen as contrary to the physicians' ideal of what it means to be a professional. To have true dialogue, both patient and professional must come to acknowledge those inherent uncertainties and learn to share the risks of treatment or no treatment.

Given such uncertainty in both law and medicine, I will not use existing biological concepts of health or illness. I take issue with the conventional view that health ought to be viewed primarily as a biological concept. A biological concept of health as either the absence of disease or the reconstruction of a fracture fits well with modern medicine's conception of intervention as its primary task. Further, because biological indices are more quantitative, a biological definition of health might be useful to those wrestling with intractable ethical or policy issues such as uncompensated health care or cost containment. We must recognize, however, that the biological conception of health is not necessarily congruent with medicine's actual social functions in any given society.

My institutional approach views health as a relational or social concept for two reasons. First, all societies in general have some definitions about illness and death that relate to their basic beliefs about social relations. A social definition of health allows us to understand that the medical conflicts we increasingly ask law to resolve are not simply technical questions but matters of our social beliefs. A social definition of health, for instance, will help us to understand why societies with the same basic form of medicine and a similar legal system to ours (such as Canada and the United Kingdom) do not have the same kinds of conflicts that we have in this country over issues such as malpractice.

A second reason for using a relational concept of health is that it helps to overcome the assumption implicit in most biological concepts that health is a condition that scientifically trained physicians dispense. The biological conception of health undermines the notion that individuals have some responsibility for self-care and discourages full discussion of the role of prevention of illness in the context of modern medicine.[2] A relational concept of health emphasizes the social context of doctor-patient transactions, including the fact that many patients do not share their physician's view as to the best way to restore health or to care for their illnesses.[3] A relational concept of health helps us to understand that many legal controversies are disputes about the authority of individuals to take risks with their own lives or the lives of their children or wards.

In addressing specific conflicts in medicine that have been brought to law for resolution, I intend to demonstrate that more-appropriate social solutions could be achieved if those cases were viewed from an institutional focus. I will argue that our society would be better able to cope with the social and moral implications of those cases if we were asking questions about the nature of the social order and about what we should realistically expect from our various institutions and the organizations within those institutions.

My goal in analyzing the interaction of medicine and law by what I have termed the institutional perspective is to help all of us—laypersons, physicians, lawyers—better understand what we are trying to achieve through that interaction. With a greater understanding of the institutional contexts of both medicine and law, we will resist the growing tendency to use polemics in judging individual situations that are actually part of the larger context.

Caring and Justice in Individual Disputes

The search for the high ideals of caring and justice in individual disputes partially explains why there is so much conflict in the interaction of medicine and law today. The concept of caring continues to evolve with successive biomedical advances. For some, the advent of test-tube babies has challenged their entire concept of life and health. They expect law to offer more than an exegesis of technical legal rules. They long for a resolution that both recognizes the legitimate interests of others—who may desperately want children, for instance—and encompasses their own conception of how best to respect life. Since law is dependent on other social institutions for its evolving notion of the social order, it is no surprise that there is no consensus of what justice is in legal interactions with medicine.

I do not purport to offer a definitive answer to what modern caring or justice is when medicine interacts with law at the institutional level. Rather, my contention is that the search for those ideals must be kept alive while we broaden our perspective to encompass the larger context in which conflicts in values are taking place. That perspective will help us devise ways of restructuring the fiscal foundations of medicine, reforming the malpractice system, and modifying professional education. To illustrate the institutional approach, let me briefly discuss caretaking institutions in our society—how we define them and what their responsibilities are.

Modern culture, including law, enjoins us to "take care of" patients. Caring is defined as protecting the "best interests" of patients and providing them with the ordinary sustenance of life: food, water, and shelter. That caretaking function of medicine is crucial to understanding many legal and medical encounters. At an institutional level medicine's caretaking function is so widespread that we consider any social ills that require caretaking to be within medicine's jurisdiction. Institutions for the mentally retarded are a prime example of organizations infused with that medical ethos, although it is not clear whether there are at present any medical cures in the traditional sense. On a broader social level, a number of institutions provide caretaking in a generic sense and thus share with medicine some caretaking functions in society. Nursing homes are medically related institutions that are clearly caretakers. Families, at least with respect to children, are expected to provide the care necessary not only to sustain life but also to protect the health of their members.

The caretaking function of medicine and its relationship to the other caretaking institutions in our society are best illustrated by examining a specific example. The dispute I want to discuss involves the issue of withholding medical treatment in one of the early cases.

Joseph Saikewicz, sixty-seven years old and severely retarded, was discovered to have an incurable form of leukemia. His case presented two additional problems that made him a difficult patient: his mental retardation was so severe that he was unable to speak, communicating with others only by gestures and grunts. His IQ was estimated to be ten, and, according to the court's opinion, he had a mental age of two years, eight months.[4] In other words, by the time his case came to court, Joseph Saikewicz was a "silent patient."[5] Furthermore, the members of his available immediate family expressed no interest in attending the hearing that decided the course of his treatment. So no one provided the physicians with traditional family support in dealing with a life-threatening condition. Joseph Saikewicz had effectively become a ward of the state—the state institution had become his parent and his family.

The lawsuit technically began when Joseph Saikewicz's caretaker, the superintendent of the institution where he lived, asked the court to appoint someone other than himself to decide whether the potentially life-prolonging treatment, chemotherapy, should be administered in that case. After a hearing in which the judge listened to the testimony of the attending physicians and the attorney for the state institution, the court agreed with the recommendation of the court-appointed guardian that Saikewicz should not receive chemotherapy, the normal treatment for his form of leukemia. While the judges who heard the case discussed several legal doctrines, their real reasoning was that the adverse and unpredictable effects of chemotherapy were not worth the efforts to prolong Saikewicz's life. The court reached that remarkable decision despite repeated disavowals that it was based on the perceived quality (or lack of quality) of Joseph Saikewicz's life. The physicians, for instance, informed the court that in all probability Saikewicz would have to be restrained in order to receive the intravenous treatments and that that could affect their potential for success. The court admitted that some of the medical testimony about the ability of older patients to withstand the side effects of chemotherapy was, at best, questionable.[6] Nonetheless, the judges, lawyers, and physicians seemed convinced that it was in Joseph Saikewicz's "best interests" to die rather than endure the pain of chemotherapy treatments, realizing that he did not understand the reasons for the treatments or his pain and that there was a "low chance at producing remission."[7]

The question of withholding treatment would be difficult to answer in any sixty-seven-year-old patient with an incurable form of cancer, but until recently very few people would have thought legal intervention could help the situation. Given the complicating factors in Joseph Saikewicz's case, one suspects that the administration of the retarded person's institution sought legal intervention not in search of greater wisdom but as a way of sharing professional and moral confusion about law and medicine's caretaking functions.

The court in *Saikewicz* may have assumed that the institution for the mentally retarded shared the same broadly defined goals as the hospital for cancer treatment, since both organizations are frequently called hospitals. The function of facilities for the mentally retarded—actually called hospitals in some states—is unclear because the reasons for placing individuals in them are varied and unclear.

In the traditional sense a mentally retarded person is not someone with a disease that can at present be cured. At best, conditions of mental retardation can be ameliorated by positive social and medical intervention, but, in fact, living in a state institution for the mentally retarded generally causes deterioration of the patient's condition. Such institutions become places that provide care for those whose families and other institutions in society are either unwilling or unable to do so.

In addition, Joseph Saikewicz's fate was shaped by the prospect that were he to enter a hospital for cancer treatment, his grunting, gestures, and possible physical restraint would prove disturbing to the professionals who have an image of the "good patient." All doctors would agree abstractly with the proposition that the hospital ought to care for its patients, but Saikewicz appeared to require too much care. In a sense, he was the kind of patient whom medicine, as an institution, wants to reject as unsuitable since other social institutions, particularly the family, have given up. Medicine's caretaking function seems to take for granted a readily available supporting mechanism outside of medicine that cares for the patient's health and thus shares medicine's goal for the person at risk. Such a support mechanism appeared lacking in Saikewicz's case, and that lack may explain why he was rejected for treatment.

Conclusion

Law must recognize that other social institutions have caretaking functions that must be differentiated from, rather than merged with, those of medicine. By analyzing from the institutional perspective decisions such as those to withdraw treatment, law can encourage us to resist the tendency to equate care with medical treatment. Thus conflicts that involve families and nursing homes, for instance, require courts to define the caretaking functions of those other institutions in relation to medicine. Finally, the attempt to deinstitutionalize mentally disabled and mentally ill persons and integrate them into small-scale community-based organizations points out the need to increase the caretaking capacity of society so that those individuals enjoy the maximum benefits of membership in the human family. With a clearer delineation of functions we will be less anxious to look to medicine for solutions to every social problem that involves some disability.

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1. See generally R. A. Burt, *Taking Care of Strangers: The Rule of Law in the Doctor-Patient Relationship* (Free Press, 1979), and J. Katz, *The Silent World of Doctor and Patient* (Free Press, 1980).

2. W. F. May, *The Physician's Covenant: Images of the Healer in Medical Ethics* (Westminster Press, 1983) 152–57.

3. The best evidence of this divergence are studies that indicate that a large percentage of patients do not follow their doctor's prescriptions or orders as to how to care for their own illness. While that failure to comply might be explained by the failure or inability of laypersons to understand the complexities of the scientific language of modern medicine, the best explanation of that breakdown in communication lies in an analysis of the fundamental aspects of doctor-patient relationships under modern conditions. See Katz, supra, note 1, at xiv.

4. 373 Mass. 728, 370 N.E. 417 (1977).

5. Burt, supra, note 1, at 144–73.

6. In footnote four of the opinion, the court adds that the probate court's decision was acceptable, given that the reports calling into question the evidence regarding chemotherapy's lower success rate with older patients were not before the court. *Superintendent of Belchertown State School* v. *Saikewicz*, 373 Mass. 728, 734, 370 N.E. 2d 417, 421 (1977).

7. Joseph Saikewicz died within four months of the commencement of the litigation of a complication of his leukemia, bronchial pneumonia. In the court's view he died "without pain or discomfort," although as laypersons we may question that conclusion since the court earlier stated that he could not communicate or understand pain.