



2014

Patient Autonomy, Physician Obligation, and State Licensing Authority in The Constitutional Right Not to Kill: A Response to Professor Mark L. Rienzi

Jessica L. Roberts

Follow this and additional works at: <https://scholarlycommons.law.emory.edu/elj-online>

Recommended Citation

Jessica L. Roberts, *Patient Autonomy, Physician Obligation, and State Licensing Authority in The Constitutional Right Not to Kill: A Response to Professor Mark L. Rienzi*, 63 Emory L. J. Online 2021 (2014).

Available at: <https://scholarlycommons.law.emory.edu/elj-online/34>

This Response or Comment is brought to you for free and open access by the Journals at Emory Law Scholarly Commons. It has been accepted for inclusion in Emory Law Journal Online by an authorized administrator of Emory Law Scholarly Commons. For more information, please contact law-scholarly-commons@emory.edu.

**PATIENT AUTONOMY, PHYSICIAN OBLIGATION, AND
STATE LICENSING AUTHORITY IN *THE CONSTITUTIONAL
RIGHT NOT TO KILL*: A RESPONSE TO PROFESSOR
MARK L. RIENZI**

*Jessica L. Roberts**

In his article, *The Constitutional Right Not to Kill*, Professor Mark L. Rienzi persuasively asserts that the Fifth and Fourteenth Amendments protect individuals from being forced to participate in government-authorized killings.¹ Drawing from several strands of diverse legal doctrines, including military conscientious objections, capital punishment, physician-assisted death, abortion, and self-defense, he demonstrates the various ways in which the state and federal governments have shielded American citizens from being required to kill against their will.² In fact, Professor Rienzi argues so convincingly in favor of a constitutional right not to kill that he perhaps proves too much. His intricately detailed analysis of the laws designed to prevent individuals from being compelled to kill other human beings establishes such prohibitions as both longstanding and ubiquitous. That said, his well-crafted article remains silent on a point of substantial import: Who would exercise such a right and under what circumstances? Or put differently, when *has* the state compelled one person to kill another?

For the answer to this fundamental question, I turned to another of Professor Rienzi's thoughtful articles, *The Constitutional Right Not to Participate in Abortions*.³ Here I found examples of physicians and pharmacists being forced to perform abortions or fill prescriptions for abortifacients, respectively.⁴ However, the question still remains whether these kind of obligations are appropriate objects of constitutional inquiry. I would like now to focus on a subset of individuals who could potentially benefit from Professor Rienzi's constitutional right not to kill: physicians who do not wish

* Thank you to Josh Blackman, Joseph Blocher, Dave Fagundes, Leslie Griffin, and Teddy Rave for their thoughtful comments. And many thanks to Cecilia Isenberg for research assistance and Emily Lawson for library help.

¹ Mark L. Rienzi, *The Constitutional Right Not to Kill*, 62 EMORY L.J. 121 (2012).

² *Id.* at 130–54.

³ Mark L. Rienzi, *The Constitutional Right Not to Participate in Abortions: Roe, Casey, and the Fourteenth Amendment Rights of Healthcare Providers*, 87 NOTRE DAME L. REV. 1 (2011).

⁴ *Id.* at 5–8.

to perform abortions or to assist patients in dying. Pursuant to a constitutional right not to kill, states could not act in a way that compels physicians to provide these particular medical services.

This Response engages with Professor Rienzi's article as it applies to physicians in treatment relationships with patients who could medically benefit from actions that meet Professor Rienzi's definition of killing. Physicians are not prototypical employees. Their professional status renders them fiduciaries. That is to say they are under both legal and ethical obligations to put their patients' interests above their own. Hence, the central inquiries of this Response are as follows: (1) Should physicians be able to deny certain therapeutically desirable treatments because they find those treatments to be personally morally objectionable? and (2) Would the substantive due process right not to kill undermine the state regulation of medicine by requiring states to continue to license physicians who refuse to act in their patients' best interests? While I am not seeking to resolve these challenging questions in such a brief essay, I do hope to raise them as issues that Professor Rienzi and others could address in their future work. It is my concern that a constitutional right not to kill could have an adverse impact on the practice of medicine under certain, specific circumstances.

I'll begin with whether physicians should be capable of raising moral objections to therapeutically desirable treatment options. Patient autonomy is a core value of modern Western medicine. Patients, therefore, get the ultimate say in deciding what medical care they receive. Yet this norm is not confined to the realm of medicine. It also extends into the law. Patient autonomy forms the foundation of many legal doctrines, including medical malpractice,⁵ informed consent,⁶ and the right to refuse treatment—a constitutional liberty interest that runs so deep it allows a patient to decline even life-saving treatment and against her doctor's recommendations, if she so desires.⁷

To balance patient autonomy, physicians in the United States enjoy broad discretion in deciding how to specialize, whom to treat, and which medical

⁵ See Ingrid H. Heide, *Negligence in the Creation of Health Babies: Negligent Infliction of Emotional Distress in Cases of Alternative Reproductive Technology Malpractice Without Physical Injury*, 9 J. MED. & L. 55, 60 (2005) ("Medical malpractice has historically been used to protect the individual's interest in physical autonomy from interference and injury.").

⁶ See Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 430–31 (2006).

⁷ See Alan Meisel, *Managed Care, Autonomy, and Decisionmaking at the End of Life*, 35 Hous. L. REV. 1393, 1397, 1400, 1402 (1999).

services to offer.⁸ We even depart from the practices of many of our sister countries by failing to recognize a legal duty to treat those in need of emergency medical care.⁹ Hence, doctors are free to design the scope of their practice to their liking. For example, a physician who is morally opposed to abortion is well within her professional and legal rights to opt not to offer elective abortions. Yet the more interesting issue arises when one considers what the state, or for that matter the Constitution, might require of a physician who morally opposes abortions or physician-assisted death when one of those treatment options holds the greatest therapeutic value for an existing patient.

Let us start with abortion. While the constitutional abortion right as articulated in *Roe v. Wade* centers on a woman's procreative autonomy,¹⁰ not all abortions fall neatly within the bounds of mere reproductive choice. Some abortions are deemed medically necessary for the health of the mother. For example, imagine that a couple has planned a pregnancy and is looking forward to starting a family when the couple discovers that the fertilized egg has stayed in the mother's fallopian tube, resulting in an ectopic pregnancy. The proper medical treatment is to end the pregnancy, either medically or surgically. Not only is the embryo unlikely to survive, but allowing the pregnancy to proceed would put the woman at risk of death. In such a scenario, that woman would find herself choosing between having an abortion and saving her own life. Now imagine that her obstetrician is morally opposed to abortions and as a result does not offer elective abortions as part of her regular medical practice. However, the physician's unwillingness to provide abortions did not deter this particular patient because the patient did not foresee her eventual need to terminate her pregnancy for unanticipated medical reasons. The right not to kill as advocated by Professor Rienzi would provide a

⁸ Physicians have broad discretion in deciding the scope of their practices. See Harvey L. Gordon & Stanley J. Reiser, *Do Physicians Have a Duty to Treat Medicare Patients?*, 153 ARCHIVES INTERNAL MED. 563 (1993); B.F. Kiker & Michael Zen, *Relative Income Expectations, Expected Malpractice Premium Costs, and Other Determinants of Physician Specialty Choice*, 39 J. HEALTH & SOC. BEHAV. 152, 152–56 (1998); Barbara J. Safriet, *Closing the Gap Between Can and May in Health-Care Providers' Scopes of Practice: A Primer for Policymakers*, 19 YALE J. ON REG. 301, 306 (2002). In fact, there is no common law duty to treat. HEALTH CARE LAW: A PRACTICAL GUIDE § 13.03 (2d ed. 2013); see also Dorothy M. Allison, *Physician Retaliation: Can the Physician–Patient Relationship Be Protected?*, 94 DICK. L. REV. 965, 967–72 (1990) (discussing physicians' rights to decline to treat groups of patients prone to litigation).

⁹ See Dieter Giesen, *A Right to Health Care?: A Comparative Perspective*, 4 HEALTH MATRIX 277, 284–85 (1994); see also Karen Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21, 22, 25–33 (1989) (examining “the major legal factors that contributed to the delay in creating a duty to treat” in the United States).

¹⁰ 410 U.S. 113, 129, 153 (1973); see also LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 1352 (2d ed. 1988) (identifying autonomy, not privacy, as the governing norm in *Roe*).

constitutionally sanctioned basis for the obstetrician to abandon her patient and at a time when that patient needs the support of her physician most profoundly.¹¹ Openly pro-life physicians recognize the difficulty inherent in those cases when the mother's health is at substantial risk, and they themselves recommend that her life should take precedence.¹² Moreover, between twelve and twenty-five percent of women who have had abortions in the United States cite health reasons.¹³ Given the legal and ethical prohibitions on patient abandonment, it is not clear that a physician who refuses to perform a medically necessary abortion for moral reasons would be immune from discipline by the state medical board, should the board decide to pursue an action. However, as will be discussed more below, a constitutional right not to kill could trump such board actions, thereby restricting the ability of the states to regulate their health-care providers. Because state regulation is one of the primary mechanisms to ensure quality of health care, infringing on this ability could have far-reaching implications for the practice of medicine, specifically with respect to physician-patient relationship.

Physician-assisted death provides another useful example of a situation in which killing, as defined by Professor Rienzi, could be in the best interest of the patient. As Justice Stevens so eloquently stated while concurring in judgment in *Washington v. Glucksberg*, at certain point "a terminally ill patient [is] faced not with the choice of whether to live, only of how to die."¹⁴ Modern medicine may be miraculous in its ability to facilitate healing but it is incapable of cheating death. There may come a time in a physician's treatment of a patient when there is quite simply nothing left to do. Additional care

¹¹ Patient abandonment violates a physician's legal and ethical obligations. Julie E. Kass & Joshua J. Freemire, *Ethics—Patient Abandonment*, in HEALTH LAW HANDBOOK § 3:13 (Alice G. Gosfield ed., 2013) ("Almost every state has, in some form or another, laws or regulations prohibiting 'patient abandonment'—the act of refusing to care for a patient who has come to rely on the availability of that care."); 3 MODERN TORT LAW: LIABILITY AND LITIGATION § 25:13 (2d ed. 2008) (describing the duty of continuing attention).

¹² *Are There Rare Cases When an Abortion Is Justified?*, ASS'N PRO-LIFE PHYSICIANS, <http://www.prolifephysicians.org/rarecases.htm> (last visited Mar. 9, 2014) ("When the life of the mother is truly threatened by her pregnancy, if both lives cannot simultaneously be saved, then saving the mother's life must be the primary aim. If through our careful treatment of the mother's illness the pre-born patient inadvertently dies or is injured, this is tragic and, if unintentional, is not unethical and is consistent with the pro-life ethic. But the intentional killing of an unborn baby by abortion is never necessary.").

¹³ M. Antonia Biggs et al., *Understanding Why Women Seek Abortion in the US*, BMC WOMEN'S HEALTH 1, 7 (Jul. 5, 2013), <http://www.biomedcentral.com/1472-6874/13/29>; Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative & Qualitative Perspectives*, 37 PERSP. ON SEXUAL & REPROD. HEALTH 110, 112–13 (2005).

¹⁴ 521 U.S. 702, 746 (1997) (Stevens, J., concurring).

would hold no chance of medical benefit.¹⁵ Thus, it may be in the patient's best interest to secure a comfortable death, and that patient's physician is often uniquely situated in facilitating such an outcome. Beyond the issue of physician-assisted death, end-of-life care may involve treatment that hastens death. A prime example would be terminally ill patients in serious pain. Their physicians may prescribe what are considered lethal doses of painkillers to ease the patients' suffering as they near the end, the very same means by which physicians legally assist death.¹⁶ While the intent is not to kill, it may be the result. Thus, at the end of life, there is a fine line between medical treatment that facilitates death and medical treatment that hastens it. A physician who morally objects to aiding in dying could likewise object to administering death-hastening care. Either way, at the point of medical futility, conventional medical care becomes relatively useless, and the best option for the patient may be to bring that patient closer to death. Thus, the constitutional right not to kill would shield physicians from their professional obligation to do what is in their patients' best interests. As in the context of medically necessary abortions, such a right allows a physician to abandon her patient when that patient is particularly vulnerable. That degree of self-interest seems incompatible with fiduciary role of the physician.

While perhaps rare, physicians may nonetheless encounter circumstances where abortions or aid in dying are the most therapeutically desirable options for their patients. Is it not the very purpose of construing the physician as fiduciary that she must put aside her own interests, and do what would provide the most medical benefit to her patient? Part of becoming a physician is agreeing to suppress your own personal concerns and acting in a way that best serves your patient. It is consequently a thornier issue to consider a physician's right not to kill—which could include patient abandonment if the morally opposed action is therapeutically necessary—than that same right invoked by non-physicians, including other kinds of medical professionals like pharmacists, because those individuals lack comparable fiduciary duties.¹⁷ In

¹⁵ See Mark Strasser, *The Futility of Futility?: On Life, Death, and Reasoned Public Policy*, 57 MD. L. REV. 505, 514–48 (1998) (discussing different approaches for defining medical futility).

¹⁶ See Katherine A. Chamberlain, *Looking for a "Good Death": The Elderly Terminally Ill's Right to Die by Physician-Assisted Suicide*, 17 ELDER L.J. 61, 86–87, 92 (2009) (describing the use of medication in physician-assisted death).

¹⁷ See 28 C.J.S. *Drugs and Narcotics* § 99 (2013) (explaining that while "[t]he transaction between a pharmacist and a customer involves the principal characteristics of a fiduciary relationship—dependency and influence," "a patient's relationship with a pharmacy is not the equivalent of a doctor-patient relationship"); 2 DAN B. DOBBS ET AL., *THE LAW OF TORTS* § 328 (2d ed. 2011 & Supp. 2013) (explaining the judicial hesitance to find pharmacists liable for negligence).

the context of physicians, the right not to kill could effectively become the right to let the patient suffer or even die.

Finally, after having considered the interests of the patient and the physician, I now consider the interests of an essential third party: the state. State action is an essential aspect to any constitutional challenge.¹⁸ However, Professor Rienzi notes that “there has been no suggestion from historians on either side [of the abortion debate] that providers were forced by the government to participate in abortions.”¹⁹ Physician-assisted death has also not been the subject of a state mandate. Professor Rienzi explains that “the general consensus against assisted suicide precludes the state from forcing an unwilling person to assist a suicide.”²⁰ Of the states permitting physician-assisted death, “[t]o date, none . . . has attempted to impose any affirmative requirement that the healthcare providers participate in an assisted suicide,”²¹ and the states that have authorized physician-assisted death by statute include conscience provisions that allow physicians to opt out.²² Consequently, it seems unlikely that states would suddenly about-face and require that physicians provide those highly controversial medical services by law. I suspect Professor Rienzi would agree. Although Professor Rienzi uses the consensus around these issues as evidence in favor of his right, the absence of state action compelling individuals to kill makes it unclear when physicians might invoke his proposed constitutional right. Likewise, if a private hospital were to say to a physician, “Perform abortions or you will be fired,” there is little the Constitution can do to intervene, even in light of a substantive due process right not to kill.²³ I can, however, think of at least one area in which a

¹⁸ See 1 CIVIL ACTIONS AGAINST STATE AND LOCAL GOVERNMENT § 7:38 (2008); see also MARTIN A. SCHWARTZ, SECTION 1983 LITIGATION CLAIMS AND DEFENSES § 3.09 (4th ed. 2005).

¹⁹ Rienzi, *supra* note 1, at 148.

²⁰ *Id.* at 144.

²¹ *Id.* at 145.

²² See *FAQs About the Death with Dignity Act*, OR. PUB. HEALTH DIVISION, <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/faqs.pdf> (last visited Mar. 9, 2014); *The Patient Choice and Control at End of Life Act: Frequently Asked Questions*, VT. DEP'T HEALTH, http://healthvermont.gov/family/end_of_life_care/documents/Act39_faq.pdf (last visited Mar. 9, 2014); *Death with Dignity Act: Frequently Asked Questions*; WASH. ST. DEP'T HEALTH, <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/FrequentlyAskedQuestions.aspx> (last visited Mar. 9, 2014).

²³ Conversely, such a requirement from a public hospital could trigger constitutional scrutiny. Moreover, states could intervene should they choose to prohibit such practices. See, e.g., CAL. HEALTH & SAFETY CODE § 123420(a) (West 2012) (providing that “[n]o employer or other person shall require a physician, a registered nurse, a licensed vocational nurse, or any other person employed or with staff privileges at a hospital, facility, or clinic to directly participate in the induction or performance of an abortion, if the employee or other person

right not to kill might intersect with state regulation: medical licensing and discipline.

Some states may opt to deal with a physician's refusal to administer therapeutically appropriate medical care through their health and safety codes or their medical boards' licensing authority. Let us assume that if a state chooses to withhold a professional license under certain circumstances, it would be sufficient to fulfill the state actor requirement and thereby trigger constitutional concerns. While the majority of states immunize a physician from board discipline for failing to provide an abortion and do not support physician-assisted death, the states in the minority on both issues maintain the ability to establish what constitutes the valid practice of medicine according to their desired parameters.²⁴ Further, even states that allow conscience objections may not permit them in all cases. For example, California law provides that "[n]o such employee or person with staff privileges in a hospital, facility, or clinic shall be subject to any penalty or discipline by reason of his or her refusal to participate in an abortion,"²⁵ but that "[t]his section shall not apply to medical emergency situations and spontaneous abortions."²⁶

I now turn to my second question for Professor Rienzi: Would the constitutional right not to kill impede the state regulation of medicine? Specifically, would such a right create a constitutional basis for patient abandonment that would be immune from any type of disciplinary action?

Through their general police power,²⁷ states have the capacity to make laws governing safety, health, welfare, and morals, a power that is certainly broad enough to encompass the legal regulation of health and the formation of medical boards, which function as state agencies.²⁸ To supplement the health and safety laws passed by the legislature, those boards promulgate rules that

has filed a written statement with the employer or the hospital, facility, or clinic indicating a moral, ethical, or religious basis for refusal to participate in the abortion").

²⁴ Forty-seven states currently allow conscience objections to providing abortions. Of the three states that do not, only one—Vermont—is an abortion-friendly state. See NARAL PRO-CHOICE AM. & NARAL PRO-CHOICE AM. FOUND., WHO DECIDES?: THE STATUS OF WOMEN'S REPRODUCTIVE RIGHTS IN THE UNITED STATES 17 (22d ed. 2013), available at <http://www.prochoiceamerica.org/assets/download-files/2013-who-decides.pdf>; see also *id.* at 79 (recognizing Vermont as a pro-choice state).

²⁵ CAL. HEALTH & SAFETY CODE § 123420(a) (West 2012).

²⁶ *Id.* § 123420(d).

²⁷ 16A AM. JUR. 2D *Constitutional Law* § 344 (2013); 3 WILLIAM J. RICH, MODERN CONSTITUTIONAL LAW § 34:2 (3d ed. 2010 & Supp. 2013).

²⁸ *Cf.*, e.g., CAL. HEALTH & SAFETY CODE § 123420(d) (stating exceptions to state law that allows certain health professionals to refuse to participate in abortions).

further define appropriate physician practice in that state, as well as discipline those who transgress board rules or fail to act within the requisite standard of care. It would therefore seem well within the states' police power for legislatures and medical boards to make decisions regarding a physician's obligation to provide the best treatment available for her patient. I can think of few issues that touch upon safety, health, welfare, and morals more than whether a physician should be able to abandon her patient based on her personally held beliefs. States decide whom to license and what to require of those licensed. However, a constitutional right not to kill would prevent state medical boards from disciplining physicians who have personal moral reasons for engaging in abandonment. Physicians could be free to refuse medically beneficial treatment to their patients without any oversight. Taking disciplinary power away from the states would leave physicians unregulated when their objections are from a moral—not a medical—standpoint.

Perhaps Professor Rienzi's response to these thought experiments would be tailoring. He argues that the right not to kill, while fundamental, would not be absolute.²⁹ In those infrequent cases when abortion or assistance in death are the most desirable treatment options, the government could have a compelling interest in the lives of those patients. For example, a state might have a compelling interest in preserving the life of the pregnant mother in the case of a medically necessary abortion. However, if the courts acknowledge the constitutional right not to kill, that state's statutes and regulations might only be sufficiently narrowly tailored in emergency situations, leaving women in need of nonemergency therapeutic abortions to fend for themselves. Similarly, while constitutional precedent acknowledges the right to refuse life-sustaining treatment, it does not likewise support a right to aid in dying.³⁰ There is no government interest in physician-assisted death, let alone a compelling one. In the face of a constitutional challenge pursuant to the right not to kill, one of my examples seems likely to fail the narrowly tailored prong and the other example, the compelling government interest prong, leaving patients vulnerable.

In applying the Supreme Court's substantive due process analysis to the right not to kill, Professor Rienzi astutely observes: "It is generally easier to find historical support for broad rights than for narrow ones, so Justices

²⁹ Rienzi, *supra* note 1, at 178 (stating that "a constitutional right not to kill could presumably be trumped if the government law satisfies strict scrutiny").

³⁰ See ALAN MEISEL & KATHY L. CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* § 12.01 (3d ed. 2004).

opposing new rights tend to define them narrowly, while Justices supporting them argue for broader understandings.”³¹ Perhaps that is precisely the exercise in which I am engaging, defining a right very narrowly to question the validity of its constitutional integrity. To be sure, Professor Rienzi’s generous framing of the interest at stake favors his conclusion, and I have not sought to challenge his assertion of a broadly construed constitutional right to avoid government compelled killing, should such a situation present itself. He argues persuasively in favor of such a right. However, I would love his future work to address in greater detail the intricacies of those narrower rights that always lie within.

³¹ Rienzi, *supra* note 1, at 158.