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COMMENTS ON KAMISAR

DANIEL D. POLSBY

Each of us is going hence from this world, and if for no other reason than that it behooves us to think about how our departure might be made less terrible. Professor Kamisar, as a twenty-seven-year-old prodigy in legal studies many years ago, argued that it is illusory to think of the institution of mercy-killing as a way out. I am going to focus my remarks on a narrow point because on the broader question—whether this is a slope too slippery for the law venture upon—it seems to me that Professor Kamisar has utterly routed the opposing arguments. Still, he concedes, as everyone must, that the problem of suffering at the end of life makes demands on the human conscience, and upon public policy, that will not go away—even though the right argument may already have been propounded. It may be that what makes this problem so durable for us is that much of what makes a given case heartwrenching is that it dwells in a world of background legal assumptions and institutions which no longer portray or represent us as we believe we are or would like to be.

In his article forty years ago, Professor Kamisar wrote: "The whole field of severe pain and its management in the terminal stage of cancer is, according to an eminent physician, ‘a subject neglected far too much by the medical profession’." Before the subject of euthanasia becomes apropos, his point was, one must fully exploit less exorbitant means of speaking to the problem of human affliction.

The very same point is still being made today by people interested in the twin questions of euthanasia and assisted suicide, including, ironically, by physicians with special competence and expertise in the management of terminal pain. We do not train residents well enough in palliation, it is said; drug companies do

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not devote adequate funds to research; this is not a priority for the Food and Drug Administration—and so on. If only we could furnish adequate comfort to dying patients, we should be much less likely to think ourselves justified in killing them to save the wrenching of our fastidious hearts; and they should be much less likely to demand that we help them kill themselves. Well and truly, the pith of this moral problem is a problem of technology. Give us the right analgesics and the set of one thousand compelling cases will become a set of one hundred or of fifty. So where are these palliative drugs for which we have been waiting these last forty years? And where are the doctors and healers who can show us how to use them if, God forbid, we need to be shown?

Well, we do know where some of them are. We have known that diacetyl-morphine is a superior pain-management tool for some patients and some conditions, used as such for many years in various parts of the world—but not in America where, under the street name heroin, possession of diacetyl-morphine will get a doctor more legal grief than he would get if he were caught bumping off his patient.

There may be demand for better and stronger pain-killing pharmaceuticals out there, but since when can we expect highly regulated oligopolies like drug companies to respond to market demand? There may be a demand for more hospice care and the like, but when we abandoned fee-for-service medicine in favor of dealing with the customer satisfaction clerk at our friendly, neighborhood HMO, we severed the link between "customer" and "satisfaction" effectively and forever. Because we regard it as somehow an anomaly, as something twisted and grotesque, a declasse libertarian pipe-dream, that a person should be able simply to go out and buy a pain reliever when he is in pain, it is routine and automatic to problematize behavior by a very ill person that carries a very high risk of mortality. By socializing the risk to some extent, we have taken it upon ourselves. And so the question is framed: "When may 'we' allow this" or "when may 'we' compel that," recognizing that, because we have seen fit to burden the medical aspect of life with legalism and regulation and illimitable, fatuous New Deal paternalism, we must be taken to have adopted the decision that Jane Doe and Richard Roe might make for themselves. So it becomes "our" decision, the thing that "we" do, when someone else is dying in pain. Thus is born a problem of public policy, some-
thing that bar association committees have to be appointed to look into, something that chairs in ethics have to be endowed to keep in view, that distinguished lectures have to be commissioned to address, that we have to discuss and plan for in order to make certain that our regulations and regulators are state-of-the-art.

I suggest, though, that it is a chimera to think that a highly regulated world will ever be satisfactory or nearly so. At some point, it seems to me, we have to learn something from experience. Forty years ago, the technological problem was the same as it is today: there is too much pain out there, and while no one actually likes pain, no one has much of an incentive to do that much about it. There is, I believe, a way out of the box: Change the incentives. By legalizing markets in pain relief—markets that are currently highly illegal—one should expect more palliation of morbid pain than one sees currently. Indeed, one should expect to see much more, because these markets are not only regulated but harshly and pervasively regulated, and their outputs must be highly restricted compared with what one would see if regulation were moderated or withdrawn. More palliation means fewer compelling, heartwrenching cases, in all likelihood many fewer. And we should look forward to living, and dying, as free men and women instead of the cringing, housebroken patsies of the administrative welfare state.