PEPPERDINE UNIVERSITY

Pepperdine Dispute Resolution Law Journal

Volume 2 | Issue 2 Article 5

2-1-2002

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Truth hath a quiet breast.[1]

The quest for definition is, at its most fundamental level, a search for truth. Ideally, truth is timeless and constant, independent of fickle social change. More recently this notion of truth has blurred into that which is *legally* admissible, that which is *factually* not wrong. Now the quest looks backward, like a moral spell-checker, rather than forward to find the truth. In this era of television waves and sound bites, it is easy to become a receptor of information instead of a seeker. Yet, even a temporal kind of truth can serve an important role in society's pursuit of longer-lasting definition. In legal debates rife with rhetoric and subjective viewpoints, eliminating polarized definitions of key terms and creating more neutral objective meanings effectively encourages settlement.[2] While such definitions may not bind future debates, the compromised meaning of a certain term reached over many disputes may itself create a pattern and assist in uncovering the elusive absolute definition. Such a definition, narrowed bit by bit, will discourage future disputes.[3] In no field is this need more apparent than medical ethics, in which a particular classification is more than mere semantics, but a matter of life or death.

This article explores the significant advantages of ADR techniques when dealing with elusive definitions in medical ethics. Part I briefly explores the meaning of definitional inquiry and justifies its important role in debate and achieving truth.[4] Part II illustrates how confusion associated with certain terms leads to faulty reasoning, even in a recent Supreme Court decision.[5] In Part III, some governmental sources of this confusion are revealed.[6] Part IV illustrates the common use of rhetoric in the right-to-die debate as an appeal

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* B.A. (Vanderbilt), J.D. candidate 2002 (Pepperdine). The author would like to thank Mark J. Bliton, Ph.D., Center for Clinical and Research Ethics (Vanderbilt Medical Center), and his family for their continued support.

1. WILLIAM SHAKESPEARE, THE TRAGEDY OF RICHARD II, act 1, sc. 3.
2. KIMBERLEE K. KOVACH, MEDIATION: PRINCIPLES AND PRACTICE 139 (2d ed. 2000).
3. *See* generally THOMAS E. CARBONNEAU, ALTERNATIVE DISPUTE RESOLUTION: MELTING THE LANCES AND DISMOUNTING THE STEEDS (1989).
4. *See infra* notes 14-29 and accompanying text.
5. *See infra* notes 30-47 and accompanying text.
6. *See infra* notes 48-52 and accompanying text.

to emotion, rather than true meaning.[7] Part V attempts to illustrate why this problem greatly affects the medical field, and will recount major technological developments that have accelerated the field beyond the advances of its ethical limits.[8] Parts VI[9] and VII[10] explain the differences in medical and legal definitions of death. Part VIII[11] illustrates how the standard advantages of ADR apply to this problem. Parts IX-XI[12] will explain how ADR can eliminate confusion, discuss the application of ADR to definitional inquiry, and explain how mediation can integrate the input of the medical, legal, and social communities into a better definition. Lastly, Part XII[13] explores whether an elusive *win-win* outcome is possible.

I. THE SEARCH FOR DEFINITION

Perhaps no single person stressed the importance of an exact definition more than the Ancient Greek philosopher Socrates.[14] According to his teachings, "if [one] couldn't define something with unvarying comprehensiveness, then [one] didn't really know what it was."[15] While his lasting contributions to philosophy are undeniable, the Socratic Method he invented is virtually useless in the positive construction of definition — it serves merely to disprove established beliefs.[16] In fact, his staunch, skeptical pursuit of pure definition often led to absurd and frustrating results.[17] Such failure can be seen in the search for the definition of wisdom in Plato's *Charmides*, when Critias remarks, "Wisdom alone is a science of other sciences and of itself. And of this, as I believe, you are very well aware, and you are only doing what you denied that you were doing just now, trying to refute me, instead of pursuing

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7. *See infra* notes 53-71 and accompanying text.
8. *See infra* notes 72-84 and accompanying text.
9. *See infra* notes 85-93 and accompanying text.
10. *See infra* notes 94-102 and accompanying text.
11. *See infra* notes 103-107 and accompanying text.
12. *See infra* notes 108-133 and accompanying text.
13. *See infra* notes 134-137 and accompanying text.
14. ARISTOTLE, THE PHILOSOPHY OF ARISTOTLE 48 (Renford Bambrough ed., Mentor Books 1963).
15. I.F. STONE, THE TRIAL OF SOCRATES 68 (spec. ed. 1994).
16. *Id.* at 70 (stating that Socrates admittedly never found any of the definitions that he sought).
17. *See* STONE, *supra* note 15, at 69; *see also*, PLATO, THE COLLECTED DIALOGUES OF PLATO 99 (Edith Hamilton & Huntington Cairns eds., Princeton University Press 1961). In the dialogue *Charmides*, Socrates "shows himself a master of quibbling . . . enough to . . . [irritate] the reader, and to leave him after pages of hairsplitting definitions with very little idea of what all the talk has been about." *Id.*

the argument."[18]

The need for exact definition, so important in philosophy 2400 years ago, remains wanting in the legal battles of today. In our modern adversarial system, "It is important to rid arguments of ambiguities, to focus clearly on the actual subject under discussion, so that opposing sides [can] avoid the trap of actually talking about two different things . . . . "[19] Finding this common ground is an essential tool in the negotiation of disputes.[20] By framing a term in a neutral manner, parties tend to de-polarize their views and approach the dispute in a positive manner.[21] However, some terms cannot easily be construed without the acceptance of presupposed concepts.[22] Without such an underlying framework, the definition loses shape.[23] It is here that the right-to-die debate, rich in political and religious rhetoric, incurs fundamental turmoil.[24]

At first blush, the need for an exact definition may seem little more than an exercise in semantics. After all, one may argue, the focus in the right-to-die debate is procedural (*what* to do with the patient) and not merely substantive (*how* to define the patient's condition).[25] In a pragmatic world of ever-changing mores, the argument might follow, a precisely defined classification holds a temporal importance analogous to the latest fashion trend. To illustrate the weakness in this view, one need only consider several 1993 national opinion polls concerning end-of-life decisions.[26]

These surveys asked respondents to decide whether they would continue

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18. PLATO *supra*, note 17, at 112.

19. STONE, *supra* note 15, at 69.

20. *See* WILLIAM URY, GETTING PAST NO 44 (1991). "It is hard to attack someone who agrees with you." *Id.*

21. *See generally* KOVACH, *supra* note 2, at 139. Diction is one of the most effective methods a mediator can use, specifically by identifying, reframing, and restating an issue in neutral terms. *Id.* at 138-41.

22. *See* KAREN GRANDSTRAND GERVAIS, REDEFINING DEATH 1 (1986).

23. *See id.* In establishing criteria for death it is essential to justify the inclusion of each aspect in the underlying framework, otherwise the definition is open to attack. *Id.*

24. For an in-depth discussion of right-to-die rhetoric surrounding Washington Initiative 119, *see generally*, Andrew M. Jacobs, *The Right To Die Movement in Washington: Rhetoric and the Creation of Rights*, 36 HOW. L.J. 185 (1993).

25. *See* BARRY R. FURROW ET AL., BIOETHICS: HEALTH CARE LAW AND ETHICS 209 (1997) (explaining how substantive inquiry for definition often is lost in the procedural scheme).

26. Adam A. Milani, *Better Off Dead than Disabled?: Should Courts Recognize a "Wrongful Living" Cause of Action When Doctors Fail to Honor Patients' Advance Directives?*, 54 WASH. & LEE L. REV. 149, 164 (1997).

medical treatment if comatose and maintained on a life-support system.[27] The results show a significant correlation between the language used to describe the condition and the respondents' willingness to remove support. When told that the diagnosis entailed "no hope of recovering," "a coma with no brain activity," or the respondents were left "terminally ill or in irreversible coma" between seventy-three percent (73%) and eight-five percent (85%) opted to end treatment and chose death.[28] If the condition rendered them "totally dependent on a family member or other person for all their care," fifty-one percent (51%) chose to have life-support removed.[29] When one considers that in both situations the respondent is hypothetically comatose and on life-support, and the gravity involved in the resulting life or death decision, diction and definition played a role in this survey beyond superficial semantics. When a minor change in terms would lead twenty-five to thirty percent of those responding to opt for their own death, the importance of phrasing and semantics is clearly magnified.

Why did the respondents depend so greatly upon the phrasing of very similar diagnoses? Perhaps one explanation is that words do not merely *forecast* the condition, but rather, words *become* the condition. Since the internal condition of the comatose patient is essentially a mystery, a doctor's interpretation labels the patient. In effect, these mere words are much more than a verbal translation of a readily observable phenomenon. They entail deeper social, medical, and legal implications, as this next section shows.

II. THE SUICIDE/HOMICIDE DILEMMA

Consider a second example of the need for exact definition in the right-to-die debate: Justice Antonin Scalia's concurrence in the 1990 case *Cruzan v. Director, Missouri Department of Health*.[30] Nancy Cruzan remained in a "persistent vegetative state" after a serious car accident.[31] She suffered extensive brain damage, deprived of oxygen for twelve to fourteen minutes before medics arrived on the scene.[32] When informed that their daughter possessed virtually no hope of recovery, Nancy's parents asked the hospital to discon-

27. *Id.* Overall, the majority of those asked wished to discontinue treatment if comatose or terminally ill. *Id.*

28. *Id.*

29. *Id.*

30. *See generally* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990).

31. *Id.* at 266. The Court defines "persistent vegetative state" (or "PVS") as "generally, a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function." *Id.*

32. *Id.* Brain damage generally occurs after six minutes of total oxygen deprivation. *Id.*

tinue her life support.[33] Because of a Missouri state statute requiring clear and convincing evidence of the patient's wishes, the doctors refused to do so without a court order.[34] The parents argued that Nancy had expressed her desire to (hypothetically) be removed from life-support once in a casual conversation with a former housemate.[35] This argument failed when Supreme Court upheld the Missouri statute, citing the state's unqualified interest to preserve human life and the irreversibility of the decision to terminate if proved erroneous.[36]

In his concurrence, Justice Scalia rebuts the three-prong argument put forth by Cruzan's parents.[37] The foray into the second argument illuminates the loose language so prevalent in the right-to-die debate. Nancy's family argued that declining treatment would allow her to die naturally, constituting an *inactive* rather than *active* taking of life.[38] Here, Justice Scalia gets caught in a web of semantics and eventually concludes that the distinction between activity and inactivity is logically and legally meaningless.[39] He quotes Blackstone's definition of "suicide" as "one who 'deliberately puts an end to his own existence, or commits any unlawful malicious act, the consequence of which is his own death.' "[40] Justice Scalia argues that logic and the law cannot delineate between activity and passivity when it comes to the termination of life.[41] For instance, in the case that an infant dies of starvation while under her mother's care, the mother cannot reasonably claim the *inactive* absence of feeding as a defense to *actively* committing homicide.[42] Legally, he continues,

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33. *Id.* at 267.

34. *See Cruzan*, 497 U.S. at 268-69. *See also* Douglas O. Linder, *The Other Right-To-Life Debate: When Does Fourteenth Amendment "Life" End?*, 37 ARIZ. L. REV. 1183, 1192 (1995) (summarizing *Cruzan* and the due process interests of a PVS patient).

35. *Cruzan*, 497 U.S. at 285. While Nancy specifically stated she would not wish to live as a "vegetable," the Court found she did not specifically refer to the withdrawal of medical treatment. *Id.*

36. *See id.* at 282-83.

37. *Id.* at 295. Justice Scalia admits in his dissent, "I would have preferred that we announce, clearly and promptly, that the federal courts have no business in this field." *Id.* at 293.

38. *Id.* at 295-96.

39. *See id.* at 296-97.

40. *Cruzan*, 497 U.S. at 294.

41. *Id.* at 296.

42. *Id.* at 297. This rationale illustrates a substantial flaw in Justice Scalia's response — he applies suicide to a homicide situation — the termination of Cruzan's life per substituted judgment. He then uses a hypothetical involving homicide (the mother and child) to explain an aspect of suicide, the distinction between activity and inactivity. The two are not interchangeable.

this distinction is "merely verbal" when held up to Blackstone's definition, as both inactivity and activity may enable one to "put[] an end to his own existence."[43]

From the outset, Justice Scalia's argument incorporates a substantial gaffe in terminology. He bases his entire rebuttal to the second argument upon the self-inflicted act of suicide. Black's Law Dictionary defines "suicide" as "self-destruction; the deliberate termination of one's existence."[44] In a substituted judgment scenario, a person other than the patient decides to discontinue treatment (though theoretically acting with the patient's wishes in mind). Thus, the patient technically does not end his own existence in a substituted judgment scenario, but rather death is caused by a joint decision of family and hospital personnel. The term "suicide" is literally inappropriate when the patient's wishes are unknown, and the patient's incapacitated state virtually eliminates any possibility that the patient will act deliberately in choosing death. The Black's definition continues, "some jurisdictions hold it to be *murder* for one person to persuade or aid another to commit suicide."[45] This case involves *homicide*, as the Supreme Court and Missouri seek to protect Cruzan from the erroneous termination of her life.

The confusion between suicide and homicide in Justice Scalia's argument has produced far-reaching effects. In *Compassion in Dying v. State of Washington*, the Ninth Circuit held the Due Process Clause necessarily entails a right to physician-assisted suicide.[46] The court justified this extension of the Fourteenth Amendment, stating, "we see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life."[47] According to this reasoning, quite reminiscent of Scalia's concurrence in *Cruzan*, homicide (the doctor actively removing the respirator) is by legal definition the same as suicide (a patient using drugs to end his own life). Again, suicide and homicide blur to the extent that inactivity and activity become logically and legally meaningless. The court ignores the identity of the

43. *Id.* at 296-97. "The omission is permitted, the act forbidden, the consequence - death - the same." *See* RICHARD A. POSNER, THE PROBLEMATICS OF MORAL AND LEGAL THEORY 128 (1999).

44. BLACK'S LAW DICTIONARY 1286 (5th ed. 1979).

45. *Id.* [emphasis added].

46. *See* Compassion in Dying v. State of WA, 49 F.3d 586, 594 (9th Cir. 1995). For a general discussion of the impact of this case within the right-to-die debate, *see* Milani, *supra* note 26, at 160-61.

47. *See* Milani, *supra* note 26, at 161 (quoting Compassion in Dying, 79 F.3d at 815-16). In Quill v. Vacco, a federal court held that the right-to-die did not necessarily entail a right to assisted suicide, but did so avoiding the definitional issue completely. *See id.* at 161-62 (citing Quill v. Vacco, 80 F.3d 716, 731 (2d Cir. 1995).

actor, the victim, and the inherent nature of the act itself — essentially eliminating the characteristics that set the two disparate acts apart.

III. Definition and the Right To Die

Despite its unintentional illustration of the confusion in this field, the Ninth Circuit acknowledged that the lack of definition in the right-to-die debate presents enormous problems.[48] Judge Noonan, speaking for the majority, wrote, "a definition of the terminally ill [cannot] be supplied from the Washington statute on the refusal of life-sustaining treatment . . . There are three difficulties: [the considerable variation in definition of terms between states], [l]ife itself is a terminal condition, [and a terminal illness classification can vary with time]."[49]

This Washington statute presents the little guidance that "legalese" definitions bestow.[50] The Washington statute defines "life-sustaining treatment" as "any medical or surgical intervention . . . including artificially provided nutrition and hydration . . . which when applied . . . would serve only to prolong the process of dying."[51] Thus, inexplicably, in Washington life-sustaining treatment prolongs death. The patient remains in the prior state yet suspends in the latter, lost somewhere in between the two.[52]

IV. Rhetoric as a Definition-Avoiding Tool

In 1991, supporters of the right-to-die movement in Washington State introduced Initiative 119 to the ballot, a measure that guaranteed the enforcement of living wills and the right to physician-assisted suicide.[53] In the months before the election, advocates and opponents of the bill battled for support, using rhetorical devices to polarize the issue.[54] Though the measure eventually failed,[55] this linguistic battle illustrates that while rhetoric appeals

48. *See Compassion in Dying*, 49 F.3d at 593.

49. *See id.*

50. *See generally* Wash. Rev. Code § 70.122.020 (1999).

51. *Id.* at § 70.122.020(5).

52. The confusion between these two terms extends far beyond the state of Washington. In general, "vitalists" (those that protect life from termination) have failed to distinguish between *sustaining life* and *death prolonging*. *See* John Kleinig, Valuing Life 220 (1991).

53. Jacobs, *supra* note 24, at 187-88.

54. *See id.* at 189.

55. *See id.* Jacobs claims the highly publicized assisted-suicides by Dr. Jack Kevorkian and

strongly to emotions, definitional limits are needed lest the right-to-die debate run amok.

Supporters of Initiative 119 used rhetoric to frame the debate as a matter of personal choice.[56] By publicizing the sentiments of terminally ill patients, proponents attempted an appeal to authority.[57] Some groups bootstrapped the right-to-die debate to abortion rhetoric, especially because Initiative 120, the next vote on the ballot, attempted to codify *Roe v. Wade*.[58] In another strategy, supporters used a television campaign portraying the viewer in a situation in which a loved-one was terminally ill and on life-support, essentially "constructing problems to justify solutions."[59] This tactic borrowed the gruesome consequence-oriented rhetoric of gay-rights supporters protesting "gay bashing" and anti-homosexual violence.[60] Finally, supporters appealed to religious faith, testing the voters' convictions. Reverend Dale Turner told fellow-advocates, "God has given to each of us free will and intellectual powers to enable us to make life's choices."[61]

Those opposing Initiative 119 couched the debate in terms of strict religious and legal interpretation.[62] Touting "Thou shalt not kill" and "[euthanasia] is plain old homicide,"[63] opponents of 119 portrayed the Initiative as old wine in a new bottle.[64] Local religious leaders portrayed medically assisted suicide as "break[ing] the covenant of life which God has shared with us."[65] These tactics exemplify *in-group* rhetoric, defining issues in terms of a group's shared conception.[66] Accordingly, opponents argued that man should

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the suicide of Hemlock Society leader Derek Humphry's wife shortly before the vote played a large part in the failure of 119. *See id.* at 211.

56. *Id.* at 189.

57. *See id.* at 189-90 (quoting Pat Nugent, a cancer patient, who stated, "No one has the right to deny me that choice," in *Initiative 119-Should Aid-in-Dying Be Allowed? Yes.*, SEATTLE TIMES, Oct. 27, 1991, at A21).

58. Jacobs, *supra* note 24, at 190.

59. *See id.* at 191 (citing MURRAY EDELMAN, CONSTRUCTING THE POLITICAL SPECTICAL 21-23 (1998)).

60. Jacobs, *supra* note 24, at 191.

61. *Id.* at 192-93 (citing Dale Turner, *A Wise Plan: God Gives Us Free Will to Make Choices, Including Act of Dying*, SEATTLE TIMES, Oct. 26, 1991, at C9).

62. *Id.* at 194.

63. *Id.* at 196 (quoting Susan Loveberg, *Grayest County Wrestles with 119; 'Death with Dignity' Initiative is Very Real to Rural Senior Citizens*, SEATTLE TIMES, Oct. 25, 1991).

64. *See* Jacobs, *supra* note 24, at 194-96. Religious groups spent nearly $500,000 on advertising to defeat 119 and 120. *Id.* at 195.

65. *See id.* at 195 (citing Charles E. Brown, *Initiative 119, 120 Denounced in Mass by Archbishop Murphy*, SEATTLE TIMES, Oct. 7, 1991).

66. Jacobs, *supra* note 24, at 198.

work within God's plan rather than hubristically take control and play God.[67]

Both constituents used *pathos* rhetoric in an effort to inflame the emotions of the voting public.[68] In reality, the fear of a compassionate system without controls may have turned the tide against Initiative 119.[69] Best said, "[those for euthanasia] claim that slopes are only as slippery as you make them, that skilled and sensitive skiers can stop even on steep slopes . . . ."[70] Clearly, the public was not ready to extend this trust. More interesting, however, is the polarization of the issue that took place. Though the opponents of Initiative 119 prevailed, when the smoke cleared no one was the wiser as to what the debate was truly about.[71]

V. THE PRECIPITOUS DEVELOPMENT OF MEDICAL TECHNOLOGY

The confusion that surrounds the right-to-die debate is hardly novel. For thousands of years, people have struggled with ways to appropriately define various aspects of the dying process.[72] In Socrates' time, the inquiry was primarily philosophical because life expectancy was short, and the medical community did little more than obey the first tenet of the Hippocratic Oath: "First of all, do no harm."[73] In Plato's *Pheado*, Socrates describes the Ancient Greek metaphysical concept of death:[74]

> [Socrates:] Do we believe that there is such a thing as death?
>
> [Simmias:] Most certainly . . .
>
> [Socrates:] Is it simply the release of the soul from the body? Is death nothing more or less than this, the separate condition of the body by itself when it is released from the soul, and the separate condition by itself of the soul when released from the body? Is death anything else than this?

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67. *See id.* at 197.

68. For an in-depth discussion of the evolution in classical rhetoric, *see generally* Michael Frost, *Introduction to Classical Legal Rhetoric: A Lost Heritage*, 8 S. CAL. INTERDIS. L.J. 613 (1999). There are three types of arguments: those based on logic (logos), emotion (pathos), and the credibility of the advocate (ethos). *Id.* at 619.

69. Jacobs, *supra* note 24, at 199-200.

70. KLEINIG, *supra* note 52, at 216.

71. *See* Jacobs, *supra* note 24, at 212-13.

72. *See generally* PLATO, *supra* note 17, at 39-88 (Socrates discusses death shortly before his execution). *See also* GERVAIS, *supra* note 22, at 6-14 (explaining the problems in the attempt to medically and legally define death).

73. *See* FURROW, *supra* note 25, at 209. The doctor owes a "negative [duty] of nonmaleficience" to the patient. *Id.*

74. PLATO, *supra* note 17, at 47.

[Simmias:] No, just that.

In the last century, medical technology has advanced so drastically that it is now possible to artificially extenuate human life beyond its so-called "natural limits."[75] While the notion of delaying bodily "death" perhaps seemed far-fetched in Socrates' day, artificial life-support is today a common option in medical protocol.[76] The explosion of this topic, and consequently the lack of preparation of the legal, ethical, social, and medical communities when dealing with terms within the debate, parallels the exponential development in medical technology in the last half-century.

For instance, according to Plato, Socrates' cohorts knew he was dead when he turned cold and failed to respond to his bailiff's questions.[77] In our country, the Framers of the Fourteenth Amendment[78] understood that "personhood" ended when the heart and lungs stopped working, presumably resulting in the individual turning cold and no longer breathing.[79] Thus, in a span of over 2100 years, the medical community had made virtually no change to this standard. Death meant lack of blood and oxygen flow.

During the last half of the twentieth century, the medical community made significant developments in both practice and hospital procedure.[80] In 1939, an estimated thirty-seven percent (37%) of the American population died in hospitals or nursing homes.[81] In the late 1950s and early 1960s, the iron lung and positive-pressure respirators were developed and became common modes of treatment.[82] In 1960, cardiopulmonary resuscitation ("CPR") was introduced as an emergency procedure for treating cardiac arrest, and soon became standard for all patients suffering from heart failure.[83] The common trend in these examples is that fringe techniques for saving life in specific emergency situations have become default treatments. Partially due to these developments in life-saving procedures, the percentage of Americans who died in hospitals or nursing homes in the 1980s swelled to over eighty percent (80%).[84] The result is a crisis: more and more patients are dying in

75. Milani, *supra* note 26, at 158 (citing California's Natural Death Act of 1976).

76. *See id.* at 151-52.

77. *See* PLATO, *supra* note 17, at 98. Jacques Louis David depicted this death scene in his painting, *The Death of Socrates*.

78. The Fourteenth Amendment states, "No State shall . . . deprive any person of life, liberty, or property, without due process of law . . . . " U.S. CONST. amend. XIV § 1.

79. *See* Linder, *supra* note 34, at 1188.

80. *See* Milani, *supra* note 26, at 151.

81. *Id.*

82. *Id.* at 152.

83. *Id.*

84. *See id.*

hospitals while on life-support.

VI. THE BRAIN DEATH STANDARD

As medical progress evolved, so too did the well-established criteria for death.[85] In 1959, two French neurologists proposed a "brain death" standard over the circulatory and respiratory criteria.[86] The 1968 Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death adopted the term "irreversible coma," commonly considered identical to the brain death standard.[87] The Committee set forth three criteria for determining brain death: "when a patient exhibits: (1) unreceptivity and unresponsivity; (2) no movements or breathing; and (3) no reflexes."[88] Advances in technology have allowed patients devoid of any brain activity to continue breathing and circulating blood for several days, a phenomenon the medical community later recognized as "ventilating a corpse."[89] In a field where blood and oxygen flow once indicated life, the brain death standard has prevailed as a more practical means for determining death.

The inquiry did not end here, as researchers found that upper and lower brain death are wholly separate phenomena with particular effects. Upper brain death takes place when the cerebral cortex ceases to function.[90] With this phenomenon, "all psychological attributes of personhood — emotion, awareness of environment, and the ability to entertain thought or experience pain cease."[91] Though the upper brain is dead, the brain stem may live on, enabling the patient to "laugh, cry, grimace, yawn, swallow, and open their eyes."[92] In order to avoid the dilemma of terminating a seemingly alive patient, a Presidential Commission endorsed a "whole brain death" standard in 1983.[93]

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85. *See* Linder, *supra* note 34, at 1183-84. In an amusing display of rhetorical euphemism, a government hospital regulation used the term "negative patient care outcome" instead of "death." *See* Thomas R. Haggard, *The Scrivener*, 9 S.C. LAW. 13 (1997).

86. *See* Linder, *supra* note 34, at 1184.

87. *See* GERVAIS, *supra* note 22, at 8.

88. *Id.*

89. *See* Linder, *supra* note 34, at 1184.

90. *Id.* at 1193.

91. *Id.*

92. *Id.*

93. *See id.* The whole brain death standard is far easier to diagnose than upper brain death. *See id.* at 1194. For a critical review of the brain death standard, *see generally* Tom Stacy,

VII. DEFINITION AND LEGAL STATUS

One cannot simply classify a patient medically as "terminally ill" or "brain dead" without ramifications in other fields; such classifications necessarily affect a patient's legal rights, social standing, and medical priority.[94] While a medical definition is diagnostic, a legal definition must be functional.[95] Legally, a patient loses rights guaranteed by the Fourteenth Amendment when "personhood" ends.[96] Searching for answers, the legal debate has focused on constitutional interpretation, calling upon the Framers' intent, the original text, and applicable case law.[97]

Unfortunately, the notion of a comatose patient on life-support was technologically unthinkable to the drafters.[98] As one author wrote, "[o]ne might as well ask whether framers of the Fourteenth Amendment considered 'persons' to include Martians."[99] This gap has caused many to demand that individual states assume the power to choose.[100] In her concurrence to the *Cruzan* decision, Justice Sandra Day O'Connor called for the Court to grant deference to "the laboratory of the States."[101] In his separate concurrence, Justice Scalia agreed that the states should have as much say as the Court, writing, "It is quite impossible (because the Constitution says nothing about the matter) that those citizens will decide upon a line less lawful than the one we would choose . . . (because we know no more about 'life and death' than they do) . . . ."[102]

VIII. THE ADVANTAGES OF ADR

The high cost, binding effect, and competitive nature of traditional litigation make it an inappropriate medium for definitional inquiry. In contrast, the cooperative negotiations of alternative dispute resolution provide an ideal setting. Cooperation is essential when the parties have common interests, depend

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Death, Privacy, and the Free Exercise of Religion, 77 CORNELL L. REV. 490 (1992) (adopting a consciousness standard).

94. *See* FURROW, *supra* note 25, at 208.

95. *See id.* at 180.

96. *See* Linder, *supra* note 34, at 1187-88.

97. *See id.* at 1188-89.

98. *See id.* at 1188.

99. *Id.* at 1198. Looking back, we simply cannot tell whether the Framers would have considered comatose patients as persons. *See id.* at 1197.

100. *See* Linder, *supra* note 34, at 1196-97.

101. *See Cruzan*, 497 U.S. at 292.

102. *Id.* at 293.

upon each other, and share limited resources.[103] Negotiations potentially lead to common understanding between the parties and joint-decision making.[104] In addition, dispute resolution is generally less expensive, faster, and more private than traditional litigation.[105] The results are significantly more stable, as the parties themselves strike the deal, rather than an adjudicated result that one party might find wholly unfair.[106]

Most importantly for definitional inquiry, dispute resolution sets loftier sights than merely who wins and who loses. Traditional litigation encourages confrontation and competition, yet dispute resolution teaches civil harmony and future cooperation. Here the search for truth may flourish. Cooperative negotiations "strive to accomplish ends that go beyond achieving finality . . . [and] transcend the rendering of adjudicatory outcomes that have sufficient legal truthfulness . . . ( ) Adjudication's greater truth and the legal system's core responsibility as a social process reside in an essential pedagogical mission."[107] In the right-to-die debate, there is much to learn.

IX. DEFINITION THROUGH DISPUTE RESOLUTION

Because opening this power to define will inevitably lead to disparate definitions amongst the states, a system must exist in which non-binding definitions may arise.[108] In order to maintain the integrity of the medical profession and honor the intentions of the Framers, such definitions cannot be unbounded.[109] For instance, unless one has a family member in a "vegetative" state, those not in the medical community presumably lack the understanding to properly conceive of these technical terms.[110] However, the emotional input of the layperson is clearly essential to the debate. If the social setting is ignored, the definition may prove "inapplicable or cumbersome."[111] As previ-

103. *See* MICHAEL PALMER & SIMON ROBERTS, DISPUTE PROCESSES: ADR AND THE PRIMARY FORMS OF DECISION MAKING 76 (1998).

104. *See id.* at 18.

105. *See id.* at 156-57 (quoting Lord Woolf).

106. *See id.* at 144.

107. CARBONNEAU, *supra* note 3, at 8.

108. *See* Linder, *supra* note 34, at 1196-97. In his *Cruzan* dissent, Justice Stevens accuses the Missouri statute of attempting to define life rather than protect it. *See Cruzan*, 497 U.S. at 344.

109. *See id.* at 1197.

110. *See id.* at 1206.

111. *Id.* at 1201.

ously stated in Part VII, exactly how this definition is worded can have profound effects on a patient's legal status and rights, and thus the legal community must take place in this endeavor as well. Clearly, a classification in this field presents specific difficulties which can only be solved if lawyers, doctors, and social groups fully integrate and work together.

The mediation process provides an appropriate setting for the determination of these elusive definitions, while supplying temporary suggestions en route to the true definition. In the short term, this definition "is not seen as a particular 'truth' that cannot be contested, but as a product of communicative agreement within a particular social context."[112]

X. APPLICATION

By its nature, ADR requires, at minimum, enough initial cooperation between the parties to reach the bargaining table.[113] Representatives from the legal, medical, and social communities must initially agree to seek ADR and voluntarily enter the process.[114] While the aforementioned cost of dispute resolution for definitional inquiry would be substantially lower than that of litigation, some parties essential to this process may not see the necessity in financing this largely philosophical pursuit. Rather, certain social parties opting for more extreme definitions might rather allocate money to advertising and perpetuating polarized rhetoric in an effort to win at the voting booths.[115] Thus the question, put bluntly, is why should the groups involved seek compromised definition rather than stoically defending their positions?

This idea may at first seem a welcome dose of pragmatism in this ethereal exercise. However, it fails to recognize the need that our definitions themselves need be functional and pragmatic. They are inextricably entwined with the way we live, the values we hold, and the judgments we pass. Definition means much more than detached scholarly interpretation. In the realm of medical ethics, "[e]xisting definitions are intended to fulfill the moral function of distinguishing between beings that do and do not deserve a right to life."[116] While winning a proposition might suffice until next year, honing in on a more accurate meaning will have a more profound social effect.

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112. JULIE MACFARLANE, RETHINKING DISPUTES: THE MEDIATION ALTERNATIVE 317 (1997).

113. "Successful negotiation depends upon a mutual desire to compromise, a willingness to concede." ROBERT A. WENKE, THE ART OF NEGOTIATING FOR LAWYERS 3 (1985).

114. *See* STEPHEN PATRICK DOYLE & ROGER SILVE HAYDOCK, WITHOUT THE PUNCHES: RESOLVING DISPUTES WITHOUT LITIGATION 19 (1991) (stating that mediation generally begins when parties agree to seek ADR).

115. *See supra* notes 56-70 and accompanying text.

116. Stacy, *supra* note 93, at 500-01.

Clearly the legal and medical communities stand to benefit most from this process. While clarity in professional standards is the immediate goal, another desirable outcome is that those in the professional fields limit their personal liability. As suggested by the aforementioned Washington Revised Code, current legislation attempting to define such elusive terms as "life-sustaining" and "death-prolonging" is extremely cryptic.[117] Assuming that the statute is even intelligible, an attorney's failure to accurately inform the client, to sue appropriately on the client's behalf, or to prevent unwarranted litigation might give rise to a malpractice action.[118] Thus, professional factions in the legal community could use this process to their advantage by seeking to clarify existing law. At the same time, legislators could avoid writing confusing legalese definitions by incorporating the more pragmatic views of the medical and social contingents, ideally included in the final settled result. Laws must be functional, for "[t]o maintain its credibility, the law must accurately reflect the reality it purports to govern."[119]

Perhaps even more confusing is the role of the doctor when a patient is described as "terminally ill." Engrained in this phrase is the notion that the patient has no hope of recovery, and thus opting for normally administered, life-saving procedures would waste resources. In essence, the patient has lost his or her rights to these procedures. Because of the significant effects of this diagnosis, the doctor interpreting the patient's condition is subject to a potential malpractice claim, much as the lawyer interpreting the law. Additionally, as Justice O'Connor observed in her concurrence in *Cruzan*, performing medical treatment against a patient's wishes is not only punishable under tort law, but also violates the patient's Fourteenth Amendment rights.[120] Scientific definitions alone cannot clarify this dilemma, nor limit liability. An interpretation that is solely biological in nature ignores the moral aim of legal and procedu-

117. *See supra* notes 49-51 and accompanying text.

118. *See* MODEL RULES OF PROF'L CONDUCT. R. 1.4, (2001)(stating "A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation." *See also*, R. 2.1 cmt. (2001), (suggesting "when a lawyer knows that a client proposes a course of action that is likely to result in substantial adverse legal consequences to the client, duty . . . may require that the lawyer act. . . .").

119. Stacy, *supra* note 93, at 491.

120. *See Cruzan*, 497 U.S. at 289. "Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water." *Id.*

ral medical definitions.[121] In fact, "[p]ossessed of no real moral relevance, a purely biological definition thus appears rather useless."[122] Without these legal and moral components, how can a doctor "do no harm"?

The social community presents the greatest challenge to the success of this process, as those present may be more inclined to pursue a specific agenda than make concessions. The selection of an ADR technique is clearly essential. Mediation encourages communication, cooperation, and combats the risk that social groups may try to negotiate rather than discuss.[123] Mediation does entail negotiation; however, the negotiation is subject to formal constraints.[124] Conversely, pure negotiation inherently involves strategy, concealment, and deception, and its adversarial nature can impede the goal of uncovering a more exact definition.[125] Arbitration usually applies when reconciliation is secondary to determining who is right, something that, when searching for absolute definition, we may never know.[126]

XI. DEFINITION THROUGH MEDIATION

Mediation is the key to this process. It is short in duration, closed to the public, cohesive in structure, controlled by a neutral third party, and most importantly, goal oriented.[127] Unfortunately, of all ADR techniques, voluntary mediation is commonly refused or ignored.[128] However, parties in this case may more readily attend given the individual advantages to the medical, legal, and social communities of achieving more accurate definitions in the realm of medical ethics. Here the ideal mediator should possess advanced academic and judicial skills to understand the interaction of law, medicine, and morality.[129] At the outset, the mediator must "build credibility with those in con-

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121. *See* Stacy, *supra* note 93, at 500.

122. *Id.* at 501.

123. In the case of divorce, for example, negotiation settles in ninety percent (90%) of cases, yet may not result in any reconciliation. *See* STUART S. NAGEL & MIRIAM K. MILLS, SYSTEMATIC ANALYSIS IN DISPUTE RESOLUTION 6 (1991). "There is usually too much ego involvement for either side to be willing to come to what an outsider would consider a reasonable agreement." *Id.*

124. *See* DWIGHT GOLANN, MEDIATING LEGAL DISPUTES 516 (1996).

125. "A [skillful negotiator's] sophisticated concession plan may include fictitious issues, as well as an exaggeration of legitimate issues . . . He must do this without it's being apparent. If not, his credibility suffers." WENKE, *supra* note 113, at 14.

126. *See* NAGEL & MILLS, *supra* note 123, at 7.

127. *See id.* at 46.

128. *See id.* at 82. Several studies have shown that in community and interpersonal disputes, people refused mediation in 1,898 of 3,911 cases (48%). *See id.*

129. *See* GOLANN, *supra* note 124, at 516. "Often a former judge or senior practitioner will be available who is recognized and respected as a person of consummate skill and fervent dedi-

flict by developing their expectations that the mediator and the mediation process will help them successfully address the issues in dispute."[130] Once the talks begin, the mediator has the burden of controlling the direction of the proceedings.[131]

Overall, the mediator's greatest tasks are to preserve open channels of communication and diffuse pre-existing hostility. He or she "can [point out] that trust . . . is often restored in mediation by the very nature of the process and the conduct of the parties as they shift from an adversarial stance to one of collaboration on a common problem."[132] Among the social contingents, the risk of impasse is great. For instance, presumably the "religious Right" would protest vehemently to a definition that allows the euthanasia of a biologically living being. Conversely, right-to-die activists would not concede to a definition that in application removes significant aspects of patient autonomy. The mediator must intervene early in the discussion to prevent polarization and "hard-line" commitments.[133] By refocusing attention to the common problems that unclear terminology in medical ethics presents, instead of areas where viewpoints conflict, a skillful mediator can successfully navigate impasse without demanding that social groups abandon ardently held beliefs.

XII. A WIN-WIN SITUATION?

Despite the high risk of conflict among social groups, using mediation for definitional inquiry can result in the ideal win-win outcome. Christopher Moore enumerates six requirements for a win-win situation.[134] Of the six, this process clearly satisfies five elements, and arguably satisfies the sixth. Moore lists that a future relationship must be important, that the stakes for creating a

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cation to assisting parties in resolving disputes through mediation." *Id.*

130. NAGEL & MILLS, *supra* note 123, at 87.

131. *See* WENKE, *supra* note 113, at 29. "No matter what is on the agenda, an effective negotiator should take the initiative and seek to gain control of the direction of negotiations." *Id.* The mediator's task is to intervene to the extent necessary to move the different factions through general problem-solving areas and avoid impasse. *See* CHRISTOPHER W. MOORE, THE MEDIATION PROCESS: PRACTICAL STRATEGIES FOR RESOLVING CONFLICT 76 (1996).

132. GOLANN, *supra* note 124, at 518-19. Additionally, the mediator should attempt to make parties more flexible by pointing out that pooling mediation with seemingly adverse parties produces at least a more informed result. *See id.* at 519.

133. *See* MOORE, *supra* note 131, at 94. "Polarization often results when disputants fail to understand productive means or procedures to resolve their controversy." *Id.*

134. *See generally id.* at 103-04.

mutually satisfactory solution are high, and that the interests of the parties are mutually dependent.[135] Future cooperation between the legal, medical, and social communities is not only important, but also essential to the moral and physical well being of our society. In the balance lies human life; clearly the stakes are very high. In addition, the great independence of the three parties' concerns would draw them to voluntarily enter the mediation.

Next, Moore lists that parties must assertively solve problems, and cooperate in joint problem solving freely.[136] As previously stated, the medical and legal communities possess very similar interests in this endeavor. Without the constraints of professional guidelines, social contingents may also freely participate in problem solving.

The sixth element, arguably satisfied, is that parties not be engaged in a power struggle.[137] While the medical and legal communities seek clarity for the sake of procedure and limiting liability, the mediator must avert hostility between social groups. Again, when the mediator recasts the situation as finding the solution to a common problem, rather than a contest of beliefs, the parties can avoid impasse. Thus, a win-win outcome may occur despite the diverse nature of the attending parties.

XIII. CONCLUSION

Socrates sought absolute definition in his dialogues because without this knowledge one could never know a given subject's true meaning. Though he failed personally in this quest, his method had a very important secondary effect. When his opponents failed to define conclusively an aspect of their claimed expertise, they inevitably realized they in fact knew very little although they acted otherwise. This epiphany of ignorance, always in public, caused embarrassment and harm to their reputation. Patients in the right-to-die contest pay for this lack of clarity with their lives. The debate needs structure, something that the Constitution alone cannot provide. Mediation provides an effective, inexpensive, pragmatic answer to this plague. When one clears away the rhetoric, and seeks absolute truth through definition, however slight, the medical, legal, and social communities may step forward as one. Until then, confusion will hang over this field like a dark cloud, blurring vision.

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135. *Id.*
136. *Id.* at 104.
137. *Id.* at 103.