

Chapter 2

The Legal Framework of Medical Ethics in the United States

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Medical ethical principles are supported by a legal framework. In the United States, a body of law arising from judicial opinions, statutes, and administrative rulings constitutes an important background for an overview of medical ethics in a book such as this one. This chapter provides an overview of the legal foundation of medical ethics likely to be of interest to the student and practitioner.

Each of the 50 states of the United States is its own jurisdiction; the federal government constitutes a 51st jurisdiction. The Supremacy Clause of the US Constitution states that federal law trumps state law, but there are many areas of medical ethics in which there is no federal law or controlling federal judicial ruling. In addition, judicial opinions sometimes change over time. In short, the following selected legal cases and legislative actions are intended to show a range of legal approaches to common problems in medical ethics.

The cases, statutes, and rules described in this chapter are grouped in several general areas of medical ethical interest. Many of the entries involve several ethical principles and highlight the tension between them. Courts and legislatures grant considerable deference to personal autonomy, for instance, but that deference is not absolute. It is hoped that these materials will lead the reader to appreciate the struggle the legal system shares with medicine in determining what right or principle trumps another in a given medical ethical dilemma.

Sources of medical-legal frameworks in US law are established through different mechanisms and provide different expectations in different jurisdictions. Major sources of US law are summarized in Table 2.1.

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Table 2.1 Sources of law

US constitution	Provides basic structure of federal government and (with amendments including Bill of Rights) outlines individual protections. Includes Supremacy Clause, which determines that valid federal law trumps state law in case of conflict
State constitutions	Provide basic structure of each state government and include individual protections—may be more explicit than Bill of Rights—e.g., may include specifically listed right to privacy
Federal statutes	Enacted by US Congress; may apply to entire nation
State statutes	Enacted by state legislatures; apply to individual state
Federal regulations	Enacted by executive branch of US government to give specificity to federal legislative enactments; may apply to entire nation
State regulations	Enacted by executive branch of state government to give specificity to state legislative enactments; apply to individual state
Federal judicial decisions	Clarify uncertain areas of federal law; may determine whether federal statute or state constitution or statute violates US Constitution; US Supreme Court decisions may apply to entire nation
State judicial decisions	Clarify uncertain areas of state law; apply to individual state

Cases, Statutes, and Rules

Decision-Making by Competent Patients

Schloendorff v. Society of New York Hospital

Mary E. Schloendorff was suffering from what the Court of Appeals of New York (the highest court in the state) called “some disorder of the stomach” [1]. She agreed to be treated at the New York Hospital (for \$7 per week) and to undergo an ether examination to determine the nature of a fibroid tumor and allegedly stipulated, “There must be no operation” to remove the tumor. While she was unconscious from the ether, she said, the tumor was removed without her knowledge or consent. In his opinion, Judge Benjamin Cardozo wrote:

In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault for which he is liable in damages.

The court held, however, that the nonprofit New York Hospital was not responsible for the actions of the doctors and nurses in the case and that the patient was not entitled to damages from the hospital.

The language by Judge Cardozo in this case sets the framework for the primacy of autonomy in medical ethics in the United States. It is important to note that he limited his endorsement of patient autonomy in medical decision-making to

competent adults. This case is one of the most frequently cited cases in medical ethics literature.

Application of President and Directors of Georgetown College

Jesse E. Jones, an adult woman suffering from a ruptured ulcer who was a Jehovah's Witness, refused on religious grounds to receive blood transfusions that her doctors felt were necessary to save her life. Her husband (also a Jehovah's Witness) refused to intervene, and Georgetown University Hospital sought permission to give her the transfusions involuntarily [2]. The patient was the mother of a 7-month-old child. The Federal District Court in the District of Columbia refused to authorize transfusions, but a Court of Appeals judge signed an order permitting "such transfusions to Mrs. Jones as might be 'necessary to save her life.'"

This case is an interesting outlier and points out the willingness of some courts (at least historically) to allow exceptions to the general rule of patient autonomy in medical decision-making in situations in which there are particular exigencies, such as the existence of a young child who would lose a parent in an emergent medical situation if a contemplated treatment that is refused by the patient is not given.

Decision-Making for Incompetent Patients

Strunk v. Strunk

The mother and "committee" (guardian) of Jerry Strunk, an incompetent 27-year-old man with severe intellectual disability, petitioned a Kentucky court for permission to authorize the transplant of one of Jerry Strunk's kidneys into his brother Tommy Strunk, a 28-year-old part-time college student who suffered from chronic glomerulonephritis [3]. The case was heard by the Court of Appeals of Kentucky (which was at the time the highest court in the state), which authorized the transplant, finding that donating the kidney to his brother was in the best interest of Jerry Strunk. The court believed that giving his brother the chance to live would benefit Jerry, given the close tie he felt with his brother Tommy.

In re Quinlan

Karen Ann Quinlan entered a persistent vegetative state after a period of anoxia. She was maintained on life support, including a mechanical ventilator [4]. She was not brain dead, but her father, applying to act as her guardian, asked to have her ventilator removed. There was little evidence as to what the patient would have wanted done had she been able to decide for herself what care to receive. The Supreme Court of New Jersey, citing the privacy rights of the incompetent patient and the

desire of her father to exercise what he believed to be the proper substituted judgment as to what she would have wanted done, decided the following:

Upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefore on the part of any participant, whether guardian, physician, hospital or others.

Superintendent of Belchertown State School and Another v. Joseph Saikewicz

Joseph Saikewicz, an incompetent 67-year-old man with severe intellectual disability, suffered from acute myeloblastic monocytic leukemia [5]. The Supreme Judicial Court of Massachusetts (the highest court in the state) upheld a probate judge's ruling that chemotherapy not be administered to the incompetent patient. The court held that the proper rule for consenting to or declining medical treatment for an incompetent person was that of substituted judgment, in which the decision-maker attempts to apply the wishes of the incompetent person. Mr. Saikewicz had never been competent, so he had never had the chance to enunciate his wishes regarding medical treatment. The court wrote that that the probate judge had properly relied in declining the treatment for him, in part, on the fact that Mr. Saikewicz was incapable of fully understanding the purpose of intrusive chemotherapy but would nevertheless suffer from the side effects of such chemotherapy.

Interestingly, by the time the Supreme Judicial Court of Massachusetts issued its opinion in the case, Joseph Saikewicz had already died of bronchial pneumonia as a complication of his leukemia.

Cruzan by Cruzan v. Director, Missouri Department of Health

Nancy Cruzan was a young woman who was rendered incompetent when she was in a severe car crash in Missouri [6, 7]. She was in a persistent vegetative state when her parents asked to have her artificial nutrition and hydration stopped, citing Nancy's conversation with a housemate before her accident, in which she had said that she would not want to continue life if she could not live at least somewhat normally. The US Supreme Court upheld the Supreme Court of Missouri's right to require "clear and convincing evidence" of Nancy's desire to have life-sustaining treatment discontinued in order for her treatment to be stopped.

Eventually, Nancy Cruzan's parents were able to present sufficient evidence of Nancy's wishes to meet the "clear and convincing evidence" standard required by the Missouri courts, and she died after her life-sustaining measures were stopped.

Patient Self-Determination Act of 1990

The US Congress, taking up issues raised in the *Cruzan* case as it made its way up the ladder of appellate review, mandated that hospitals, nursing facilities, home health agencies, hospice programs, and health maintenance organizations receiving federal funding inform patients of their right to make advance directives to appoint healthcare agents or to write living wills [8].

Rights of Infants – “Baby Doe Rules”

Following a series of controversies, including one involving “Baby Doe,” an infant born in Bloomington, Indiana, with Down syndrome and esophageal atresia with tracheoesophageal fistula who died after the parents declined to authorize corrective surgery, the US Congress passed legislation in 1984 authorizing the Department of Health and Human Services to write federal regulations intended to safeguard the rights of handicapped infants [9, 10]. The rules continue to be in force to prevent child abuse, although a number of legal challenges have limited the ways the federal government can enforce them.

The current rules call for a notice such as the following to be posted at federally funded healthcare agencies caring for infants:

Principles of Treatment of Disabled Infants

It is the policy of this hospital, consistent with Federal law, that nourishment and medically beneficial treatment (as determined with respect for reasonable medical judgments) should not be withheld from handicapped infants solely on the basis of their present or anticipated mental or physical impairments.

The rules go on to give guidance on the care of handicapped infants as follows (including the first paragraph below), quoting the “Principles of Treatment of Disabled Infants” promulgated by a coalition of organizations, including the American Academy of Pediatrics and the Association for Retarded Citizens:

When medical care is clearly beneficial, it should always be provided. When appropriate medical care is not available, arrangements should be made to transfer the infant to an appropriate medical facility. Consideration such as anticipated or actual limited potential of an individual and present or future lack of available community resources are irrelevant and must not determine the decisions concerning medical care. The individual’s medical condition should be the sole focus of the decision. These are very strict standards.

It is ethically and legally justified to withhold medical or surgical procedures which are clearly futile and will only prolong the act of dying. However, supportive care should be provided, including sustenance as medically indicated and relief of pain and suffering. The needs of the dying person should be respected. The family also should be supported in its grieving.

In cases where it is uncertain whether medical treatment will be beneficial, a person’s disability must not be the basis for a decision to withhold treatment. At all times during the process when decisions are being made about the benefit or futility of medical treatment, the person should be cared for in the medically most appropriate ways. When doubt exists at any time about whether to treat, a presumption always should be in favor of treatment.

Ethics of Reproductive Health

Griswold v. Connecticut

The US Supreme Court considered a case in which the executive director of Planned Parenthood of Connecticut and a Yale Medical School professor challenged a Connecticut statute under which they were arrested in 1961 for providing contraception (to married persons!) and eventually found guilty [11]. The majority opinion in the case, written by Justice William Douglas, invalidated the Connecticut statute on the grounds that it violated a right to privacy which the court found was protected by the “penumbra” of specifically delineated guarantees in the Bill of Rights. Justice Douglas wrote:

The present case, then, concerns a relationship lying within the zone of privacy created by several fundamental constitutional guarantees. And it concerns a law which, in forbidding the use of contraceptives, rather than regulating their manufacture or sale, seeks to achieve its goals by means having a maximum destructive impact upon that relationship. Such a law cannot stand in light of the familiar principle, so often applied by this Court, that a governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms.

NAACP v. Alabama, 377 U.S. 288, 307. Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives? The [p486] very idea is repulsive to the notions of privacy surrounding the marriage relationship.

We deal with a right of privacy older than the Bill of Rights – older than our political parties, older than our school system. Marriage is a coming together for better or for worse, hopefully enduring, and intimate to the degree of being sacred. It is an association that promotes a way of life, not causes; a harmony in living, not political faiths; a bilateral loyalty, not commercial or social projects. Yet it is an association for as noble a purpose as any involved in our prior decisions.

This landmark case identified the constitutionally protected right to privacy that has been the basis for many other medical cases since 1964, including the 1973 case of *Roe v. Wade* [12]. In light of current views in society, it is remarkable that a physician could be convicted in Connecticut for prescribing contraceptives—the case illustrates the relatively recent legal recognition of a medical right to privacy which we now take for granted.

Roe v. Wade

The US Supreme Court considered the constitutionality of the Texas statute criminalizing abortion, and in one of the most famous and controversial US Supreme Court opinions in history, Justice Blackmun wrote the majority opinion, striking down the law as a violation of the right to privacy contained in the penumbra of the Bill of Rights [12].

A single woman from Texas using the pseudonym Jane Roe found in 1970 that she was unable to obtain a legal abortion in Texas. She sued to overturn the Texas law that prohibited her from obtaining one, and the US Supreme Court held that because the normal length of a pregnancy is shorter than the length of the typical legal appellate process, the case was not “moot” (i.e., there was still an active controversy about the case) when it addressed the issues raised by her suit years later. The majority opinion ruled that the constitutionally protected right to privacy forbids a state from criminalizing abortion early in pregnancy. States are permitted increasing discretion in regulating abortions later in the course of pregnancy and may criminalize it after the stage of pregnancy at which the fetus becomes viable, except in cases in which abortion is necessary to preserve the life or health of the mother.

Hastening the End of Life

Oregon Death with Dignity Act

The voters of Oregon passed a ballot initiative in 1994 permitting physician-assisted suicide in the state [13]. After a series of challenges, the Death with Dignity Act became law in Oregon in 1997, making Oregon the first US jurisdiction to allow physician-assisted suicide. It makes the following provision:

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.

Psychiatric Treatment

Lessard v. Schmidt

Alberta Lessard, a Wisconsin schoolteacher, challenged the state’s civil commitment law under which she had been detained, alleging that the statute denied her due process of law in permitting her detention up to 145 days without a hearing, in failing to give a right to counsel at a reasonable time, in allowing hearsay evidence in proceedings, and on other grounds [14]. A three-judge panel of federal judges in Milwaukee agreed with her in most respects and stated:

We conclude that the Wisconsin civil commitment procedure is constitutionally defective insofar as it fails to require effective and timely notice of the “charges” under which a person is sought to be detained; fails to require adequate notice of all rights, including the

right to jury trial; permits detention longer than 48 hours without a hearing on probable cause; permits detention longer than two weeks without a full hearing on the necessity for commitment; permits commitment based upon a hearing in which the person charged with mental illness is not represented by adversary counsel, at which hearsay evidence is admitted, and in which psychiatric evidence is presented without the patient having been given the benefit of the privilege against self-incrimination; permits commitment without proof beyond a reasonable doubt that the patient is both “mentally ill” and dangerous; and fails to require those seeking commitment to consider less restrictive alternatives to commitment.

The court’s judgment in the *Lessard v. Schmidt* became the basis for Wisconsin’s revised civil commitment statute and was very influential in other jurisdictions as well. The requirement of proof beyond a reasonable doubt was later changed to a requirement of proof by clear and convincing evidence after the US Supreme Court permitted that standard in *Addington v. Texas* [15]. *Lessard v. Schmidt* set the tone for heightened skepticism of laws mandating coerced psychiatric treatment in the years since it was decided; the opinion has been criticized for “criminalizing” procedures for civil commitment, even using the term “charges” (quotes in original) to describe the allegations leading to civil commitment proceedings.

Vitaly Tarasoff et al. v. The Regents of the University of California

Pronsenjit Poddar, a student at the University of California Berkeley, told his mental health caregivers at the student health center there that he planned to kill Berkeley resident Tatiana Tarasoff, who had not requited his love for her. The student health center did not take sufficient action to protect Ms. Tarasoff, and Poddar did in fact kill her. Her family sued the university.

The Supreme Court of California issued two opinions in the case [16, 17]—in 1974, the court found there was a “duty to warn” identifiable likely victims of violent mental health outpatients. On reconsideration of the case in 1976 after much controversy and confusion arose from its 1974 decision, the court refined its opinion to state that there is a “duty to protect” identifiable likely victims of reasonably foreseeable violence perpetrated by mental health outpatients in California, which might be fulfilled by warning the victim or by ensuring adequate secure treatment of the likely violent patient. Many other jurisdictions have followed or refined the California rule set in this very influential decision, which summarized its limitation to patient confidentiality as follows:

We conclude that the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins.

Confidentiality

Rule on Confidentiality of Alcohol and Drug Abuse Treatment Records

Health Insurance Portability and Accountability Act of 1996

The US Congress mandated in the 1996 Health Insurance Portability and Accountability Act (HIPAA) that the Department of Health and Human Services formulate privacy and security rules for protected health information [18–20]. The rules took effect over a graduated period from 2003 to 2006 and provide a layer of federal protection to the confidentiality of protected health information and emphasized the importance of security in the electronic transmission of health records. HIPAA rules extend federal confidentiality protection to patients receiving health-care in general; the previously enacted Rule on Confidentiality of Alcohol and Drug Abuse Treatment Records continues to provide special protection to those patients receiving care for substance use disorders. Release of information forms often provide special checkmarks so that patients can indicate if they wish their substance use disorder treatment records, protected under 42 CFR Part 2, to be included in materials released by a healthcare agency.

Conclusion

The judicial opinions and legislative actions described in this chapter comprise some of the most important and interesting responses of the US legal system to the problems physicians and other healthcare workers face in grappling with difficult clinical situations that involve the need to respect persons, to do what is helpful and to avoid doing harm, and to attempt to do so in a just manner. The questions and answers that constitute the bulk of this book explore the application of these ethical principles in a wider variety of clinical contexts; the legal framework of bioethics gives some guidance but does not give all the answers to medical ethical dilemmas.

Review and Reflect: Ask Yourself and Talk with Colleagues

For each of the following scenarios, ask yourself and talk with colleagues about the following questions: What ethical tensions exist in this situation? What legal obligations, if any, are present? What are the clinician's next steps?

Scenario 1 A family practice physician provides prenatal care for a woman until her 36th week of pregnancy, at which time she transfers to the obstetrician who will facilitate her delivery. The woman returns to the family physician's office 2 weeks later, stating that she has not felt the baby move for 2 days. She told the obstetrician her concerns the day before, and he assured her once he auscultated fetal heart tones with the Doppler. The woman still felt worried, however. Upon further investigation, the family physician notes that she has suffered an intrauterine fetal demise. The physician is troubled, because the standard practice is to obtain a nonstress test in a patient with a 38-week gestation who complains of decreased fetal movement, and wonders why the obstetrician did not do this test. The test may have indicated fetal distress, at which time delivery or a Cesarean section could have been performed.

Scenario 2 A psychiatrist member of a medical school's committee on rank and tenure is reviewing materials from applicants for promotion in various departments of the school in advance of a committee meeting. He reads the promotion packet for a seemingly well-qualified assistant professor of dermatology who is applying for promotion to the rank of associate professor. The psychiatrist has treated the dermatologist for cannabis abuse and depression but believes that he is doing well currently.

Scenario 3 The sister-in-law of a physician's friend has severe fibromyalgia, which was previously treated very successfully with a novel medication. Unfortunately, she has lost her job, no longer has insurance, and cannot afford the medication. The physician's friend has a job with great benefits and asks the physician if he would prescribe the medication in the friend's name so that he might obtain it under his prescription plan and then give it to his wife.

Scenario 4 A primary care provider treats a 26-year-old man who uses crystal methamphetamine on the weekends and has unprotected sexual intercourse. He is planning a trip to a gay resort and has already obtained methamphetamine for his stay there. The physician worries about how to provide optimal care to this patient.

Scenario 5 A nursing home sends an elderly, wheelchair-bound man who has had a stroke to the hospital because he continually calls the police, saying that Jesus has told him the nursing staff are abusing him. In the hospital, the patient shares a room with a high-functioning man recovering from an orthopedic injury. The following day the elderly patient tells the attending physician that the hospital nursing staff ignore his requests for help to use the bathroom and so he has soiled himself. His roommate confirms his story and adds that he has been helping the patient use the bathroom as a result. The roommate, who is being discharged, is concerned for the elderly man's safety.

Scenario 6 A very helpful colleague asks a physician to write a letter supporting his application for clinical privileges that the physician feels are beyond the scope of his training.

Scenario 7 A 45-year-old diabetic man obtains medical care in a multidisciplinary clinic. He sees one doctor for primary care issues and another for psychiatric issues.

He has been living with diabetes for 20 years and has struggled with diabetic neuropathy in the past. As a result, he takes high doses of pain medications, prescribed by the primary care physician. He is on permanent disability but manages to live a more-than-humble lifestyle. He has developed a trusting relationship with the psychiatrist and finally admits that he sells his pain medications in order to pay his rent and car loan. He takes just enough of the prescribed pain medications to test positive on monthly toxicology screens that the primary care physician has instituted.

Scenario 8 A health promotion nurse and family medicine physician are conducting a smoking cessation class. The attendees begin to talk about their increased irritability and that they find themselves becoming easily frustrated. A single mother reports that her major stressor is her children, especially her 9-year-old son. She notes that he is upsetting her frequently with his behavior and that she is having urges to either smoke or choke the child to death. The urges have become so strong that she has twice had dreams about following through, and on one occasion she put her hands on his neck but did not squeeze.

Scenario 9 A physician treats a man and his wife separately in a general medicine clinic. The man discloses that he is having an affair with a same-sex partner and asks to be tested for sexually transmitted diseases. He reports that he “dabbles” in drug use, specifically methamphetamine, which his male partner supplies. Because of the high rate of unprotected sex and HIV among men who have sex with men using methamphetamine, the physician suspects that the man is at risk for HIV, hepatitis B, syphilis, and other sexually transmitted diseases. The physician believes that the man’s wife is also at risk, because the couple continues to be sexually active and has not used condoms in many years. At the wife’s next appointment, she asks the physician why her husband suddenly has decided to undergo “a bunch of medical tests” and asks if she should be aware of anything regarding her husband.

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Professionalism and Ethics in Medicine

A Study Guide for Physicians and Physicians-in-Training

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