Legal Decision-Making in A Clinical Setting

Or

How courts are likely to think about the relationship between providers and patients

Tuesday, February 19, 2019

Bioethics Institute at Loyola Marymount University

**A Supplement and Companion to Workshop Slides (Summaries and Clarifications):**

1. **Negative Rights vs. Positive Rights:**
	1. While for the most part the “rights” courts are likely to recognize and enforce on behalf of patients are negative rights (e.g., a right to be left alone), there is one limited exception.
	2. In California and elsewhere, courts have afforded patients a right to receive information regarding the risks and benefits of treatment options that the patient may undergo or avoid undergoing.
		1. The standard for judging whether the information provided satisfies the patient’s right is not the actual individual needs of the patient; nor is it what would enable the patient to fully comprehend the treatment options he or she is facing.
		2. Rather, the standard for judging whether the information provided satisfies the patient’s right is what a reasonable person – in the actual patient’s position – would find material and relevant in making a treatment decision. *Cobbs v Grant* establishes, in California, this rule.
		3. While courts have created this right to information because they believe that the physician’s/provider’s relationship with the patient is not a typical (commercial) “arm’s length transactions,” court have not formally recognized, or consigned to physicians and providers a legal duty to engage in a collaborative decision-making process with the patient. Such a collaborate approach to decision-making may be good professional practice and it may even be an ethical duty for the physician/provider, but it is currently not a legal expectation or duty.
		4. Consider the court’s opinion in *Bouvia v. Superior Court*:

“Here Elizabeth Bouvia's decision to forego [sic] medical treatment or life-support through a mechanical means belongs to her. It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. It is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is her’s [sic] alone.”

* 1. It is interesting to wonder why American courts have not created legal duties that closely parallel what might otherwise be considered good professional practices; as well as “the ethically right thing to do.”
		1. Carl Schneider, and others, have opined that American courts have conceived of their involvement with the physician/provider-patient relationship as a circumstance requiring the protection of the individual against powerful institutions which might otherwise undermine or act against the best interest of the individual.
		2. For example, Schneider writes:

“…[The]… law has historically flourished in one paradigmatic situation-where a single individual confronts the state. Virtually all rights thinking in American law is organized around that paradigm. ‘In such conflicts,’ as I once wrote, ‘we are predisposed to favor the person, out of respect for his moral autonomy and human dignity. That predisposition also rests on our assumption that the state can bear any risks of an incorrect decision better than the individual can.’"

* + 1. So conceived, courts might unintentionally – and perhaps, even unawares – position the individual patient standing against the physician/provider and not the physician/provider standing with the patient.
		2. In the case of Moore v. The Regents of the University of California, Dr.Golde should have, perhaps, included Mr. Moore in the good financial fortunate he was about to enjoy from the Mo cell line, but the California Supreme court required only that Mr. Moore be told about Golde’s financial good fortune.
		3. And in the case of Thor v. Superior Court, Dr. Thor might very well have felt an ethical duty to work with the prisoner, Howard Andrews, to try as best he could to assist Andrews to work through his depression and to delay any precipitous decision Andrews might be inclined to make. However, the California Supreme court directed Dr. Thor to provide Andrews with information and leave it at that.
		4. One extraordinary anomaly to this trend was the New Jersey Supreme Court opinion in the matter of Karen Ann Quinlan. There the court ordered what in effect was a collaborative decision-making process in order to vindicate Karen Ann Quinlan’s right to privacy. The court order that Joseph Quinlan, Karen Ann’s father, was to collaborate with her physicians, as well as the hospital’s ethics committee (which probably didn’t exist) in making any decision to discontinue her ventilatory support. This approach was, however, short-lived as courts quickly moved to directing very individual, and individualized, decision-making processes.
1. **Common Law Rights vs. Constitutional Rights:**
	1. The rights that citizen enjoy as a protection of the Constitution are more secured, “better rights,” than those they enjoy under Common Law traditions of precedent and stare decisis.
		1. The reasons for this difference are the following:
			1. Once established, Constitutional Rights are not subject to the actions of legislatures, but only to the actions of Courts competent to change those rights (e.g., the US Supreme Court) and to changes to the Constitution by ratification of Amendments.
			2. Common law rights are subject to change by actions of a legislature as well as courts not otherwise bound by those rights.
	2. A patient’s common law right to refuse medication treatment is founded in the common law right to control access to one’s body and the common law right to undergo treatment only upon the giving of informed consent.
		1. Unconsented touching is the traditional common law “tort” (private harm) of battery.

Justice Joseph Cardoza in 1914 wrote: “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. This is true except in cases of emergency, where the patient is unconscious and where it is necessary to operate before consent can be obtained.” *[Schoendorff v. Society of New York Hosp.](https://biotech.law.lsu.edu/cases/consent/Schoendorff.htm%22%20%5Ct%20%22_blank)*[, 105 N.E. 92, 93 (N.Y. 1914)](https://biotech.law.lsu.edu/cases/consent/Schoendorff.htm%22%20%5Ct%20%22_blank) - not included in workshop material.

* + 1. The common law right to informed consent gives rise to a “tort” of negligence if a patient can prove that whatever consent was given was not “informed.”
			1. See Cobbs v. Grant and Canterbury v. Spencer.
	1. A patient’s Constitution Right to refuse medical treatment might be considered either a Right of Privacy or a 14th Amendment Liberty Interest.
		1. Many states – California Included – have an explicit provision in their (State) Constitutions that guarantees the state’s citizens a right of privacy. In most cases, this right of privacy would easily and naturally cover a patient in a healthcare setting.
		2. While the US Supreme Court did once recognize and enforce a federally guaranteed right of privacy, this right seen in the penumbra of the Bill of Rights has given way to a 14th Amendment Due Process liberty interest which patient may enjoy. The analysis recognizing this right would run something like the following:

If in the social, political, and legal history of the American Republic, citizens traditionally enjoyed the liberty to seek medical care or to avoid medical care, then the Supreme Court will consider that traditional liberty as a right guaranteed by the 14th Amendment due process clause – a right that cannot be denied or infringed without due process of the law.

* + 1. In Cruzan v. Director, Missouri Department of Health, the majority opinion did not actually rule that Americans have in fact this 14th Amendment liberty interest. It said only that if we (the Court) **were to assume** such a constitutional protection existed, the Missouri law requiring clear and convincing evident of an incompetent’s patient’s treatment wishes would not necessarily violate that right or interest. The court ruled:

“If the State were required by the United States Constitution to repose a right of ‘substituted judgment’ with anyone, the Cruzans would surely qualify. But we do not think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself…All of the reasons previously discussed for allowing Missouri to require clear and convincing evidence of the patient's wishes lead us to conclude that the State may choose to defer only to those wishes, rather than confide the decision to close family members.”

Notice how under this analysis, the Supreme Court – as would other courts – views the current situation regarding a decision to forgo or not treatment not as a “family matter” – which in many ways it really was – but as an individual’s – albeit an incompetent individual’s – exclusive personal matter.

1. **The right to physician-assisted suicide (or aid in dying) vs. a right to health care as such:**
	1. In the 1990s, and following failed attempts to have legislatures act or to pass state referenda, efforts were launched to establish, through the courts, a federally-guaranteed right to the assistance of a physician in ending one’s life. The assistance would be in the form of medications used to shorten one’s life; and not simply the discontinuation of treatment needed to continue life. The “right” for which federal constitutional protection was sought was variously styled as a “right to die,” “right to control the timing and manner of one’s death,” “right to aid in dying,” “right to physician-assisted suicide,” etc.
		1. These efforts were launch in federal courts in two circuits: the 9th Circuit and the 2nd Circuit. The advocates had chosen these assuming that their “liberal” district courts judges and circuit court judges would be inclined to find such a right in 14th Amendment guarantees.
		2. If the 14th Amendment guaranteed such a right then the state laws (in these cases, Washington and New York) that prohibit physicians from providing such assistance would be unconstitutional.
	2. The two cases eventually ended up in the US Supreme Court on appeal, with the district courts and circuit courts below all finding for a right to physician-assisted suicide (or aid-in dying). Even though the lower courts had found such a right on different theories, the Supreme Court decided both cases simultaneously. In two unanimous opinions, published on the same date, the Supreme Court ruled that there was no such right; and thus the state laws prohibiting physicians from providing this assistance were not unconstitutional.
		1. The one set of cases – from the 9th Circuit on the West Coast – had found the right to physician-assisted suicide in the liberties guaranteed in the Due Process Clause of the 14th Amendment. The Supreme Court said “not so.” See *Washington v. Glucksberg.*
		2. The other set of cases – from the 2nd Circuit in New York – had found that the Equal Protection Clause of the 14th Amendment guarantees patients needing active assistance in shortening their lives the same rights as patients who may shorten their lives by directing the discontinuation of, e.g., ventilators and feeding tubes. Again, the Supreme Court said “not so.” See *Vacco v. Quill.*
	3. One implication, I take, from the Supreme Court’s decisions in these cases is that the Court is likely to leave the question of whether patients might enjoy a “right” to healthcare services in the hands of legislatures (Congress and state legislatures) and not in the hands of federal and state courts.
		1. “Medicare for all” or a mandate for universal health care coverage are unlikely to occur on the basis of either Common Law or Constitutional Rights.
		2. American courts will likely continue to be generous in extending to patients “negative rights” enabling them to avoid healthcare services and stingy in extending any “positive right” to get the healthcare services they need or want.
	4. There is one curious exception to the above: the federal legislation and enabling federal regulations that go by the acronym EMTALA (The Emergency Medical Treatment and Active Labor Act). It’s hard to reconcile this “right” to services in an emergency room setting with the overall legal framework in which health care operates. But this is a story for another day.
2. **Ethical Analysis vs. Legal Analysis**:
	1. Notice then how the field of bioethics is differently conceived by, e.g. Beauchamp and Childress and American courts.
		1. As we saw in the first workshop, Beauchamp and Childress describe the field of bioethics as defined by four multifaceted, equally obligatory “Values” or “Principles”: Autonomy, Nonmalificence, Benevolence, and Justice. The four constitute a “common morality” for those who work in the field and for those who might otherwise have different philosophical or theological notions of right and wrong, good and evil.
		2. American courts, on the other hand, describe the field, implicitly in their opinions, as defined by the value of patient autonomy and the negative and limited positive rights that specify that single value.
		3. The conflict here is not necessarily between competing and opposed notions of patient autonomy but rather between competing and opposed notions of the field of bioethics as an inquiry into the duties and rights that operate in the physician/provider-patient relationship.
	2. While there are a number of individuals, include Dan Callahan at the Hastings Center, who have identified this conflict and its implications for engaging in bioethics, perhaps the most vocal and consistent critic of the law’s narrow conception of bioethics is Carl Schnieder.
		1. A more recent attempt by Schnieder to give an account of the law’s failing to see more to bioethics than just the value of patient autonomy can be found in “Rethinking Health Law; Article and Essay; After Autonomy”; 41 Wake Forest L. Rev. 411 (Summer 2006).
		2. One of his more interesting observations is that those who practice bioethics mostly from the law’s perspective (aka healthcare attorneys) “…[have]… been so preoccupied with liberating patients from medical imperialism that…[they have]…hardly noticed the earnestness with which patients take their moral lives and obligations.”
		3. It may then be worth the effort to review this article and its criticisms to see for yourselves how convincing or not so Schneider (himself a healthcare attorney) may be, in preparation for upcoming workshops on “Withhold and Withdrawing Treatment in Clinical Care,” “Deciding for Others in Clinical Care,” and “Serving the Common Good in Clinical Care.”

Prepared by David C. Blake, PhD, JD

February 20, 2019