CLASSIC LEGAL CASES AT THE FOUNDATION OF MEDICAL ETHICS IN THE USA[A B]

Karin W. Zucker, MA, JD, LLM[*] Martin J. Boyle, JD[**]

Abstract

The ethics of a people, as demonstrated through public policy, are generally thought to affect that people's legal system and its decisions. The converse is also true: decisions within a legal system impact ethics –specifically medical ethics. The cases discussed in this paper are at the foundation of medical ethics in the United States.

Background

Although ethics is clearly a discipline separate from law, each informs the other and there are many areas of congruence. Numerous U.S. judicial cases deal with medical questions, and medical ethics texts routinely cite judicial opinions. The case format has even been adopted by medical ethics educators, and scenario based education is common.

The purpose of this paper, drawn from a monograph, *Landmarks from the Law: Classic Cases in Medical Ethics*, developed as part of an academic seminar,[1] is to consider some of those cases from the U.S. judicial system which now form part of the basis of medical ethics. Because of the constraints on length, many of the cases in the monograph are not addressed;[2] and only the most significant points of those cases that are reviewed are considered.

---

[a] Disclaimer. Views expressed in this article are solely those of the authors and do not represent policies of the Army – Baylor Graduate Program in Health and Business Administration, the Department of the Army, the Department of Defense, or the Department of Veterans Affairs.

[b] Note on Citation. Because of the limitation on length and in the interest of clarity for readers not familiar with U.S. law, only single, not parallel, citation to cases is used; specifically, the West Reporter System citation is used when citing state cases and federal cases, except for U.S. Supreme Court cases. The official U.S. government citation (U.S.) is used for those.

[*] Karin Waugh Zucker is an Associate Professor in the Army-Baylor University Graduate Program in Health and Business Administration, Ft. Sam Houston (San Antonio), Texas, USA, where she teaches medical ethics (clinical and organizational), health law, and health care contracting. Address correspondence to Prof. Zucker at 5926 Winding Ridge Drive, Windcrest, Texas, 78239, USA or E-mail her at ameddja@aol.com.

[**] Martin J. Boyle is a Senior Attorney in the Department of Veterans Affairs, Office of the Regional Counsel, Houston, Texas, USA, working at Audie L. Murphy Veterans Administration Hospital, San Antonio, Texas. E-mail him at Martin.Boyle@mail.va.gov.

[1] Members of that seminar were Major Tracy Allen, USAF; Ensign Amy Burton, USN; and Captain Vito Smyth, USAF. Research assistance was provided by Martin J. Boyle.

[2] Cases that are in the monograph, but which are not addressed here, include, in chronological order, *Buck v. Bell*, 274 U.S. 300 (1927) (eugenic sterilization); *U.S. v. Karl Brandt*, Military Tribunal I, Nürnberg, Germany (1947) (elucidation of the Nürnberg Code); *Feres v. United States*, 340 U.S. 135 (1950) (generally, servicemembers incident to service or exercising a military privilege may not successfully sue the U.S. government under the Federal Tort Claims Act, 28 U.S.C. § 1346(b)); *Application of President and Directors of Georgetown College, Inc*., 331 F.2d 1000 (D.C. Cir. 1964) (blood transfusion for pregnant Jehovah's Witnesses, pre-*Roe v. Wade*); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (zone of privacy effecting right to use contraception); *Pollard v. United States*, Civ. Action No. 4126-N, M.D. Ala. (1973) (medical research/Tuskegee Experiment); *Parker v. Levy*, 417 U.S. 733 (1974) (the military is a separate society); *Matter of Quinlan*, 355 A.2d 647 (N.J. 1976) (right to refuse care, by surrogate); *Tarasoff v. Regents of the University of California,* 551 P.2d 334 (Cal. 1976) (breach of patient confidentiality for good of another); *Superintendent of Belchertown State School v Joseph Saikewicz*, 370 N.E.2d 417 (Mass. 1977) (right to refuse care, by surrogate); *Matter of Eichner*, 426 N.Y.S.2d 517 (N.Y. App. Div. 1980) (right to refuse care, by surrogate); *Matter of Storar*, 434 N.Y.S.2d 46 (N.Y. App. Div. 1980) (right to refuse care, by surrogate); *Matter of O'Connor*, 531 N.E.2d 607 (N.Y. App. Div. 1988) (right to refuse care, by surrogate); *Georgia v. McAfee*, 385 S.E.2d 651 (Ga. 1989) (right to refuse care); *Moore v.*

With the exception of two cases[3] that address issues unique to the military system, almost all cases in the monograph deal with some aspect of personal privacy, i.e., with the importance of recognizing the autonomy of the individual.[4] Even *Tarasoff v. Regents of the University of California*,[5] and *Matter of Baby M*[6] address personal privacy, although the former deals primarily with the question of when patient confidentiality should be breached and the latter addresses legal issues involved in surrogate motherhood.

Judicial Decisions / Cases

Informed Consent

A requirement for consent of the patient is not found in the Hippocratic Oath or otherwise in ancient medicine. To the contrary, Hippocrates advocated concealment of the patient's condition to avoid agitation;[7] and Rodrigo à Castro, wrote in *Medicum Politicus*, in 1614, that it was right to deceive a patient if it was done with good intent and not for monetary gain.[8] Since the decision in *Schloendorff v. Society of New York Hospital*,[9] it has been generally accepted in U.S. law that *consent* to treatment is required. However, the doctrine of *informed consent*, i.e., the idea that the patient must have a minimum amount of information in order to give legally sufficient consent, developed incrementally until *Canterbury v. Spence*[10] was decided in 1972.

Today, the informed consent of the patient, which includes a requirement for competence and voluntariness, is required in all but a very few circumstances, such as when care is required by law or regulation, ordered by a judge, required by medical emergency, or permitted based on therapeutic privilege.[11] Although arguments can certainly be made that requiring informed consent is beneficent, i.e., that it is for the good of the person concerned,[12] it is generally discussed in conjunction with the principle of autonomy. Beauchamp and Childress caution that it should not be assumed that autonomy has primacy over the other principles (beneficence, nonmaleficence, and justice) simply because it is the first principle they address.[13] However, Brannigan and Boss note that in the United States "[a]utonomy is so important that social values and justice are sometimes overlooked."[14]

Regents of the University of California, 793 P.2d 479 (Cal. 1990) (research misconduct, lack of informed consent, ownership/right of control over bodily tissue); and *Matter of Baby K*, 832 F.Supp 1022 (E.D. Va. 1993) (required care for an anencephalic infant and the applicability to that situation of federal laws regarding handicapped persons and state law regarding child abuse).

[3] *Parker v. Levy* and *Feres v. U.S.*, *supra* note 2.

[4] For more on the importance of the principle of autonomy/respect for autonomy/respect for persons see generally, TOM L. BEAUCHAMP & JAMES F. CHILDRESS, Principles of Biomedical Ethics Ch.3 (5th ed. Oxford Press 2001).

[5] See *supra* note 2.

[6] *Id.*

[7] ROBERT J. BOYLE, "Communication, Truthtelling, and Disclosure" in Introduction to Clinical Ethics 51 (John C. Fletcher, et al., University Publishing Group 1995).

[8] ALBERT R. JONSEN, A Short History of Medical Ethics 51 (Oxford Press 2000).

[9]

[10] 464 F.2d 772 (D.C. Cir. 1972).

[11] KARIN WAUGH ZUCKER & MARTIN J. BOYLE, Health Law for Federal Sector Administrators (8th ed. 2000) (privately printed, US Army Medical Department Center and School).

[12] This was the concept argued in *Arato v. Avedon*, 858 P.2d. 598, 609 (Cal. 1993) when plaintiff's counsel asserted that had Mr. Arato's physicians given him the grim statistics on length of life after a diagnosis of pancreatic cancer he would have better used his remaining days and would have gotten his financial affairs in order. The court ruled for the defendant doctors holding that the purpose of the doctrine of informed consent was to allow patients to make medical choices, and that it did not mean that there was a duty "to disclose every contingency that might affect the patient's nonmedical rights and interests."

[13] See *supra*, note 4 at 57.

[14] MICHAEL C. BRANNIGAN & JUDITH A. BOSS, Healthcare Ethics in a Diverse Society 41 (Mayfield Publishing 2001).

Schloendorff v. Society of New York Hospital[15]

Mary Schloendorff presented to the Society of New York Hospital, a charitable institution founded in 1771, with a medical problem likely related to her stomach or abdomen. We are told that she consented only to an *examination under ether* and was instead operated upon.

Schloendorff is cited today not for a legal rule or for its discussion of the doctrine of charitable immunity[16] but for Judge Cardoza's statement, which may be the most often quoted phrase in American medical law, that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."[17] That phrase can be applied to the right to abortion, to dangerous procedures intended only to improve appearance, to surgery for body dysmorphic disorder, to refusal of medical care, and to the right to die. It may well be considered as the legal equivalent of the ethical principle of autonomy, respect for autonomy, or respect for persons.

Canterbury v. Spence[18]

Canterbury is a much more recent case involving a young man, still a minor under the 1959 law of the District of Columbia, who assented to, and underwent, a laminectomy with resultant, severe complications. The case reads as a law review article might. After a brief recital of the facts and a procedural note giving the history of the case, the court begins to examine the doctrine of informed consent; and by this time it is not a matter of mere *consent*, as arguably it was in *Schloendorff*; it is truly a matter of *informed* consent. The court reviews the history of the requirement for disclosure by physicians; considers the scope of the requirement of disclosure; looks at the rare privilege not to disclose; and reviews the requirement for expert testimony in such cases, as well as the role of causality in liability for failure to obtain informed consent.

Citing *Schloendorff*, the court makes it clear that consent is required but then goes on to address what must be disclosed –what information, if given, would be sufficient. Clearly, *full* disclosure is not required; the disclosure required is something less than that, but the patient must be given "enough information to enable an intelligent choice."[19] The physician's disclosure is to be measured, then, by what a reasonable patient, in the specific circumstance, would find material when making a decision as to whether to accept or forego treatment. In addition to the proposed treatment itself, i.e., what the proposed procedure is and what the hoped for benefits are, the patient must also be told of "the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated."[20]

Abortion

The first anti-abortion law in the United States was passed by the State of Connecticut in 1821. During the middle of the 19th Century, the American Medical Association adopted a

[15] See *supra* note 9.
[16] This was a doctrine which held charitable institutions legally blameless for their negligent acts.
[17] See *supra* note 9 at 93.
[18] See *supra* note 10.
[19] *Id*. at 786.
[20] *Id*. at 787.

resolution against abortion and states followed with restrictive laws. During the 1960s, much dissatisfaction was voiced with regard to these laws, even though most contained a therapeutic exception. The American Medical Association reversed its position and six states and the District of Columbia repealed their restrictive laws.[21] It is estimated that, during this period, 5,000 to 10,000 women died each year following illegal abortions.[22] The issue moved from the states into the federal courts in the 1970s and, in 1973, *Roe v. Wade* reached the United States Supreme Court. No medical-legal issue remains more divisive for the United States than abortion.[23]

Roe v. Wade[24]

This case presented a challenge to the abortion laws of Texas, Art. 1191-96 Tex.Rev.Stat.Ann. After reviewing the historical background of abortion and abortion law, the Court turned to the U.S. Constitution, finding that a fundamental right to privacy, including abortion, did exist but was limited. While pointing out that the Constitution recognized as *persons* only individuals born alive, the Court also noted that the state's interest in protecting potential human life increases as the pregnancy progresses.

The Court struck down the Texas statutes as too broadly restrictive. It went on to summarize its logic by setting forth three stages of pregnancy and a rule regarding abortion with regard to each stage: (1) From conception to approximately the end of the first trimester, the decision is to be between the woman and her doctor; (2) from approximately the end of the first trimester to viability, a state may regulate the procedure but only to protect the woman's health; and, (3) from viability to birth, a state may regulate abortion, and may even prohibit it, except where it is necessary for the woman's life or health.

The Supreme Court has decided many abortion cases[25] since *Roe v. Wade*. Some may be viewed as explaining the decision; others as restricting it. But, *Roe* has not been overturned.

Maher v. Roe[26]

This case presented the question of whether the Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., requires a state participating in the Medicaid

---

[21] See *supra* note 14 at 181-182.

[22] Janet Benshoof, *The Dismantling of Choice*, NCJW, Spring 2002, at 12.

[23] LAURENCE H. TRIBE, Abortion: The Clash of Absolutes 6 (W.W. Norton 1990).

[24] 410 U.S. 113 (1973).

[25] Among these cases are *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976) (upheld a provision of Missouri's abortion law that required the written consent of the woman, struck a provision requiring the consent of the spouse, and struck a provision requiring the written consent of a parent when the pregnant female was a minor); *Bellotti v. Baird*, 443 U.S. 662 (1979) (held that parental consent to a minor's abortion could not be required unless there was a judicial bypass provision –a way for the minor to seek judicial authorization for the abortion); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 846 (1992) (upheld the three primary parts of the *Roe* decision, identified as (1) a woman's right to an abortion before viability without *undue interference* from the state, (2) the state's right to restrict abortion after viability with exceptions for the woman's life and health, and (3) recognition of the state interest in protecting the life of the woman and "the life of the fetus that may become a child"); and *Stenberg v. Carhart*, 530 U.S. 914 (2000) (struck a Nebraska statute that criminalized partial birth abortion but did not include an exception to preserve the life and health of the woman).

[26] 432 U.S. 464 (1977).

program to pay for abortion if it pays for childbirth. A Connecticut Welfare Department regulation limited benefits to medically necessary first trimester abortions. The question was considered under the Equal Protection Clause of the 14th Amendment[27] to the U.S. Constitution. The Court found no requirement for a state to fund such abortions, holding that –

> An indigent woman who desires an abortion suffers no disadvantage as a consequence of Connecticut's decision to fund childbirth; she continues as before to be dependent on private sources for the service she desires. . . . [28]

And, it went on to point out that the indigency was not created by the State of Connecticut and is not a category, or status, requiring special treatment under the 14th Amendment.

Funding cases since *Maher* have held that even medically necessary abortions need not be funded by states or the federal government.[29] Further, states may prohibit the use of their personnel and facilities in performing abortions.[30]

The Right to Refuse Care

The right to refuse care is something apart from the right to die. It is a common law right grounded in the principles of self-determination and privacy. In some states the right is also found in statutory law. Whatever its basis, it is not without limits. [31]

In the Matter of Karen Ann Quinlan[32]

In 1975, for reasons never made completely clear, Karen Ann Quinlan, age 22, stopped breathing for at least two periods of approximately 15 minutes each. Her friends attempted to resuscitate her; and she was taken to a hospital, where she remained throughout this litigation. At the time this case reached the Supreme Court of the State of New Jersey, experts stated that she was in a persistent vegetative state. Her father sought judicial determination of her incompetency and appointment as her guardian. He specifically asked that the letters of guardianship contain an express power authorizing him to discontinue extraordinary medical care, which all concerned expected to end her life.

The court reviewed the Harvard Criteria for Brain Death[33] and agreed that, although in a persistent vegetative state, Karen Quinlan was alive. The court took notice of the fact that the experts believed that she could not survive without the respirator and that were it to be removed she would soon die. It also noted that, according to a friend of the court brief filed

---

[27] The 14th Amendment states in pertinent part –"1. . . . No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property without due process of law, nor deny to any person within its jurisdiction the equal protection of the laws."
[28] See *supra* note 26 at 495.
[29] *Harris v. McRae*, 448 U.S. 297 (1980).
[30] *Webster v. Reproductive Services*, 492 U.S. 490 (1989).
[31] J.STUART SHOWALTER, The Law of Healthcare Administration 323 (Health Administration Press 4th ed. 2004).
[32] 355 A.2d 647 (N.J. 1976).
[33] The Harvard (Brain Death) Criteria are set forth and commented upon in *Defining Death*, a 1981 report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *available at* http://.bioethics.gov/reports/past_commissions/defining_death.pdf

by the New Jersey Catholic Conference, were she to die when the respirator were turned off, it would not constitute euthanasia.

Addressing the right of privacy and citing *Griswold v. Connecticut*[34] and *Roe v. Wade*, *supra*, the court noted that were Karen Quinlan *miraculously lucid* she could make the determination to have the respirator disconnected, even if it meant her death. Finding a right of privacy that could be exercised by a competent individual, the court held that the right could also be exercised by a third party on behalf of an incompetent.

Bouvia v. Superior Court of California[35]

Elizabeth Bouvia was described as a mentally competent, 28-year-old, who suffered from cerebral palsy and was quadriplegic, capable of moving only a few fingers on one hand. She sought the removal of a nasogastric feeding tube which had been inserted and was maintained over her objection.

The court reviewed some case law and made reference to the California Natural Death Act, California Health and Safety Code § 7185 *et seq*., which, while not strictly applicable since it pertained only to the terminally ill, clearly showed the intent of California law in giving competent individuals the right to make decisions about their medical care. The court then went on to state: "The right to refuse treatment does not need the sanction or approval of any legislative act."[36] The court also quoted a 1986 statement entitled, "Withholding or Withdrawing Life Prolonging Medical Treatment," issued by the Council on Ethical and Judicial Affairs of the American Medical Association:

> The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other the choice of the patient or his family or legal representative, if the patient is incompetent to act in his own behalf, should prevail. Life prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition, or hydration. . . .[37]

State of Georgia v. McAfee[38]

Larry James McAfee, a quadriplegic dependant upon a ventilator, attempted on several occasions to end his life by turning off the ventilator but, when he did so, he suffered severe pain when deprived of oxygen. In this case, he filed a petition asking not only that he be allowed to turn off his ventilator but that he be given a sedative to alleviate the pain he anticipated would occur as he died. The court noted that the State of Georgia recognized that "a competent adult has the right to refuse medical treatment in the absence of a conflicting state interest."[39] It further held "that Mr. McAfee's right to be free from pain at

[34] See *supra* note 2.
[35] 225 Cal.Rptr. 297 (Cal.Ct.App. 1986).
[36] *Id*. at 302.
[37] *Id*. at 303-304.
[38] 385 S.E.2d 651 (Ga. 1989).
[39] *Id*. at 652.

the time the ventilator is disconnected is inseparable from his right to refuse medical treatment."[40]

Fosmire v. Nicoleau[41]

In a situation where withholding or withdrawing care might reasonably be expected to result in the death of the individual concerned, the state's interests must be weighed against the individual's right to autonomy. The state's interests[42] which potentially conflict with an individual's right to refuse care, whether exercised personally or through a surrogate, are discussed in numerous cases,[43] but all are set forth very clearly in *Fosmire*. These interests are "(1) the preservation of life, (2) the prevention of suicide, (3) the protection of innocent third parties, and (4) the maintenance of the ethical integrity of the medical profession."[44]

It is the discussion of the important state interests which makes this case classic, not its facts. Denise Nicoleau, a Jehovah's Witness, who had specifically refused blood products, was nonetheless transfused shortly after the birth of her child. Officials of the hospital had applied to a court and had obtained an *ex parte* order[45] permitting transfusions. In this action, Mrs. Nicoleau requested that the order be vacated, and it was. The court also noted that the lower court had erred in issuing the order.

The Right to Die

Another look at the four preceding cases should make the distinction between the right to refuse care and the right to die clearer. In each of the right to refuse care cases the patient or the patient's surrogate sought to remove a medical device which was prolonging life and without which, it was believed, life would then end naturally. In the right to die cases, individuals or their representatives seek the authority to take an action which will itself end life, and that action is something other than withholding or withdrawing a life prolonging medical intervention.

Washington v. Glucksburg[46] and *Vacco v. Quill*[47]

In both the States of Washington (*Glucksburg*) and New York (*Vacco*) refusal of medical care, even life-saving medical care, was accepted by state law. Likewise, in both states, there was a prohibition on assisting with suicide. This prohibition on assisting with suicide generated legal challenges from two perspectives. *Glucksburg* challenged the prohibition on due process grounds, i.e., that it was violative of the Due Process Clause of the 14th

---

[40] *Id.*
[41] 536 N.Y.S.2d 492 (N.Y. App. Div. 1989).
[42] Although the interests are identified by the court as *compelling* state interests, this is inartful language. Were they truly *compelling*, they would take primacy over the individual's interest and there would be no need to weigh and balance the two. *Important* or *significant* state interests seems a more accurate characterization.
[43] See supra note 41 citing, among other cases, *Matter of Eichner*, *supra* note 2; *Application of President and Director's of Georgetown College*, *supra* note 2; *In re Osborne*, 294 A.2d 372 (D.C. App. 1972) and *Matter of Delio v. Westchester County Medical Center*, 516 N.Y.S.2d 677 (N.Y. App.Div. 1987).
[44] See supra note 41 at 495.
[45] An *ex parte* order is one obtained without notice to the individual concerned.
[46] 521 U.S. 702 (1997).
[47] 521 U.S. 793 (1997).

Amendment; *Vacco* challenged it on equal protection grounds, i.e., that it was violative of the Equal Protection Clause of the 14th Amendment to the U.S. Constitution.[48]

In each case, although its analysis differed, the Supreme Court found the distinction between killing and letting die to be meaningful and supported in the law. The Court upheld the State of Washington's ban on assisted suicide, when it stated that –

> The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct.[49]

In *Vacco*, the Court noted that while states must treat like cases alike, "[t]he law has long used actor's intent or purpose to distinguish between two acts that may have the same result." [50]

Conclusion

The right to privacy, a right not explicitly found in the U.S. Constitution, is a clear and unifying theme throughout these cases. Indeed, in *Roe*, the Court stated that a right of privacy has been recognized in cases decided as early as 1891. Having noted that, there are cases which do not deal primarily with the right of privacy but which nonetheless have greatly affected the development of medical ethics. *Tarasoff v. Regents of the University of California*[51] is such a case. While Justice Tobriner clearly recognized the importance of the physician - patient relationship and the significant part trust plays in that relationship, he found the public's right to disclosure necessary to its protection even more important. He saw that there are situations when, for the greater good, confidentiality must be breached. His assertion that "[t]he protective privilege ends where the public peril begins"[52] is generally accepted across the United States, except in Texas.[53] In *Matter of Baby M*,[54] which dealt with surrogate motherhood and parental rights, the court recognized that there are rights above those set by contract and that, in the end, it is the best interest of the child which must be determinative of custody.
Taken together these cases demonstrate balance between the rights of individuals and the rights of society. Moreover, they show the tension that will forever exist in medical ethics among the principles of autonomy, beneficence, nonmaleficence, and justice.

[48] See *supra* note 27.
[49] See *supra* note 46 at 725.
[50] See *supra* note 47 at 802.
[51] See *supra* note 2.
[52] See *supra* note 2, *Tarasoff* at 347.
[53] Texas does not follow *Tarasoff*; see *Thapar v. Zezulka*, 994 S.W.2d 635 (Tex. 1999).
[54] See *supra* note 6.