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Medical Judgment in Court and in Congress - Abortion, Refusing Treatment, and Drug Regulation

George J. Annas

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By George J. Annas

This decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently and primarily, a medical decision, and basic responsibility for it must rest with the physician.

—Justice Harry Blackmun, *Roe v. Wade*

Associated Press, AP

A registered medical marijuana user holds up one ounce of marijuana. Congress has authority to enforce its own statutory provisions against marijuana even if it is state-approved, homegrown, and used for medicinal purposes.

Over the past four decades, the courts and Congress have consistently granted almost unqualified deference to physicians (and medical ethics), at least for treatment decisions made in the context of a consensual physician-patient relationship. The primary exception to this harmonious deference is the 2007 abortion decision of *Gonzales v. Carhart*, 127 S. Ct. 1610 (2007), and it is reasonable to review our continuing and seemingly intractable legal debate over abortion and the physician's role in it to determine if it could erode judicial and congressional deference to medical judgment in other areas of medical practice and medical ethics.

Abortion and Medical Judgment

How much deference the law should accord medical judgment was a central aspect of the landmark *Roe v. Wade* decision, 410 U.S. 113 (1973). In that case, the Court struck down a Texas law that made it a crime for physicians to perform an abortion unless it was necessary to save the life of the patient. The law included no exception for the woman's health. The Court held that women have a constitutional right of privacy that is fundamental and "broad enough to encompass a woman's decision . . . to terminate her pregnancy." *Id.* at 153. Because the right is fundamental, states were required to demonstrate a compelling interest to restrict its exercise. The Court ruled that the state's interest in the life of the fetus became compelling only at the point of viability, when the fetus could survive independent of its mother. Even after the point of viability, the state cannot favor the life of the fetus over the life or health of the pregnant woman. Under the right of privacy, in the Court's words written by Justice Harry Blackmun, physicians must be free to use their "medical judgment for the preservation of the life or health of the mother." *Id.* at 165.

On the same day that the Court decided *Roe*, it also decided *Doe v. Bolton*, 410 U.S. 179 (1973), in which it defined health (and medical judgment) very broadly: "The medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment." *Id.* at 192.

The Right to Refuse Treatment

Shortly after *Roe*, the New Jersey Supreme Court decided the case of Karen Ann Quinlan, *In re Quinlan*, 355 A.2d 647 (1976). Quinlan was a young woman in a persistent vegetative state whose parents wanted her ventilator removed. Applying *Roe*'s

right to privacy, the court held that a competent individual had the right to refuse any medical treatment, including life-sustaining medical treatment, and a reasonable way had to be found to permit incompetent patients to refuse treatment as well. Because physicians worried about liability for a patient's death in this context, and because the court worried that liability concerns could interfere with good medical judgment, the court invented a way to provide physicians with legal immunity. It delegated its own immunity-granting authority to local hospital "ethics committees," concluding that there would be no liability for stopping treatment if an ethics committee agreed that the patient had no "reasonable possibility of return to cognitive and sapient life." *Id.* at 669.

Fourteen years later, the U.S. Supreme Court, in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), followed *Quinlan*'s liberty logic (though not its ethics committee mechanism) but did permit states to require clear and convincing evidence of a currently incompetent person's wishes to refuse treatment. Nancy Cruzan had exactly the same medical condition as had Quinlan, except she was not on a ventilator, only requiring use of a feeding tube. As *Quinlan* had energized the living will movement; *Cruzan* energized the health care proxy movement—primarily because Justice Sandra Day O'Connor's concurring opinion had suggested that if Cruzan had simply said something like, "If I'm ever unable to make medical decisions for myself, I'd like my mother to make them for me," that would have been a constitutionally protected delegation of authority.

Fluids and Nutrition

Cruzan did, however, highlight another fighting issue in American politics, although one that still pales when compared to abortion: the provision of artificial fluids and nutrition to incompetent patients. In *Cruzan*, for example, Solicitor General Kenneth Starr argued unsuccessfully that fluids and nutrition should be considered as unique and subject to higher standards regarding refusal. Even though six of the nine justices explicitly found no distinction between fluids and nutrition artificially delivered and any other medical treatment (and none of the other three had anything different to say), the case suggested that this issue might reappear again. And, after lying relatively dormant for more than a decade, it did.

The fluids and nutrition argument was resurrected in Congress in March 2005 in the infamous case of Terri Schiavo. Schiavo was in the same medical situation as Cruzan had been in, and the trial court had ruled, on more than one occasion, that there was clear and convincing evidence that if she could talk she would want her feeding tube removed. Every judge who reviewed the case agreed on the law (she had a right to refuse treatment) and on the facts (there was clear and convincing evidence that she would refuse continued feedings if she could). There was no legal dispute, just a continuing political one over whether artificially delivered fluids and nutrition should be treated the same as any other medical treatment, a position endorsed by organized medicine and the courts alike. The spectacle of Congress debating Schiavo's diagnosis and prognosis was nauseating and caused Congressman Barney Frank (D-MA) to observe, in the midst of the floor debate, "We're not doctors, we just play them on C-SPAN." A day after Congress passed a statute (shortly after midnight on Palm Sunday) granting the federal courts jurisdiction, U.S. district court Judge James D. Whittemore issued a careful opinion properly denying a request to reinsert a feeding tube into Schiavo on the basis that the parents had failed to demonstrate "a substantial likelihood of success on the merits." *Schiavo ex rel. Schindler v. Schiavo*, 357 F. Supp. 2d 1378, 1383 (M.D. Fla. 2005).

Controlled Substances

The Supreme Court twice refused to be drawn into the Schiavo case—and quite properly, as the law regarding treatment refusals is well settled. Shortly after Schiavo died, however, the Court did hear two unrelated cases addressing physicians and judicial deference to medical judgment. One case was constitutional, and the other involved statutory interpretation. Together, they can be seen as making a case for federal regulation of medical care. The first, *Gonzales v. Raich*, 545 U.S. 1 (2005), involved the state of California and its medical marijuana law that permits patients to possess and use marijuana for medicinal purposes upon the recommendation of their physicians. The federal government seized and destroyed all six marijuana plants a patient was growing for her own use in compliance with the California law. The question before the Court was whether the federal Controlled Substances Act, 21 U.S.C. § 801 *et seq.*—which prohibits the possession of marijuana and specifically classifies it as a Schedule I drug that has no medical use—proscribed California's scheme.

The Court decided it did because Congress, under the Commerce Clause, has authority to enforce its own statutory provisions against marijuana—even state-approved, homegrown, noncommercial marijuana used within the state only for medicinal purposes on a physician's recommendation. The Court adopted the logic of the famous wheat case, *Wickard v. Filburn*, 317 U.S. 111 (1942), deciding that the Commerce Clause gave Congress the same power to regulate homegrown marijuana for personal use that it had to regulate homegrown wheat for personal use. Most relevant to the issue of medical judgment, the Court specifically found that the recommendation of a physician should not be an exception. The Court's discussion of this point may be the most disturbing aspect of the case, certainly for physicians. Instead of concluding that physicians should be free to use their best medical judgment and that it was up to state medical boards to decide whether specific physicians were failing to live up to reasonable medical standards (the conclusion of the Court in *Doe v. Bolton*, for example), the Court took a totally different approach. In the Court's words, the broad language of the California law

allows "even the most scrupulous doctor to conclude that some recreational uses may be therapeutic. And our cases have taught us that there are some unscrupulous physicians who over-prescribe when it is sufficiently profitable to do so." 545 U.S. at 31.

In 2006, in *Gonzales v. Oregon*, 546 U.S. 243 (2006), the Court considered whether the same federal act prohibited Oregon from determining that the use of prescribed controlled substances for suicide was a "legitimate medical purpose" under specific circumstances, even though the U.S. attorney general had ruled otherwise. The Court decided that the statute did not delegate the authority to define legitimate medical purposes for drugs to the attorney general, and that the attorney general therefore did not have the power to revoke the Drug Enforcement Administration certificates of Oregon physicians who followed the provisions of the Oregon Death with Dignity Act, OR. REV. STAT. § 127.800–.955.

Nonetheless, the Court found "at least reasonable" the attorney general's contention that physician-assisted suicide is not a legitimate medical practice because it violates the position of prominent medical organizations, the federal government, and forty-nine states. The Court concluded that Congress, and not medical ethics, determines the law. In other words, the Court ruled that Congress could, if it wanted, outlaw the use of controlled substances by physicians for suicide—but that it had not done so.

The real question is why not, given the data that outlawing this use would accurately reflect not only medical ethics but the laws of forty-nine of fifty states. There are at least two answers. The first is the overwhelmingly negative reaction of the American public to congressional and presidential involvement with the Schiavo case. Although it seemed, to the Congress and president at least, that winning "culture of life" versus "culture of death" politics to try to prevent a woman in a persistent vegetative state from being "starved to death" over the objections of her parents was paramount, 70 percent and more of the American public thought that Congress should stay out of family-medical decision making. So, at least outside the abortion arena (and arguably the area of controlling drug diversions), it will be a while before Congress tries to adopt anything like national medical standards. The second reason is historical. Medical practice standards have always been a matter of state law. The fact that the Court has now determined that the Congress has authority under the Commerce Clause to set medical standards—and, I think, to impose national medical licensing—does not mean Congress is likely to act in this area any time soon. Commerce seems a natural authority for regulating drugs (and medical devices), but not necessarily for regulating the practice of medicine.

Medical ethics, of course, is not law, and medical judgment is not always consistent with public policy.

"Partial Birth Abortion"

Abortion is the noteworthy exception to deference to medical judgment, and it is worth trying to both understand why Congress (and, as of 2007, the Supreme Court) see abortion as an exception, as well as whether abortion laws and jurisprudence could have a wider impact on regulating the practice of medicine in the future. The focal point of the debate, since the Court affirmed the basic holding of *Roe* in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), has been over a procedure its opponents have labeled "partial birth abortion," to attempt to conflate childbirth and abortion in the minds of the public and politicians. During the Clinton administration, Congress twice passed, and President Bill Clinton twice vetoed, a bill to outlaw this procedure, denoted by physicians generally and the American College of Obstetricians and Gynecologists specifically, as intact dilation and extraction. More than thirty states had also outlawed the procedure, but in 2000 in *Stenberg v. Carhart,* 530 U.S. 914 (2000), the Court ruled 5–4 that these laws were all unconstitutional because they were too vague to put physicians on notice as to what actions were criminal and because they did not have an exception, required by both *Roe* and *Casey,* for the health of the pregnant woman. After this decision, in 2003, Congress passed a slightly modified law, and President George W. Bush signed it.

In 2007, in *Gonzales v. Carhart*, 127 S. Ct. 1610, the Court decided, 5–4, that this law was constitutional, reaching a conclusion contrary to that reached in *Stenberg*. Justice Anthony Kennedy wrote the majority opinion for himself, Justices Antonin Scalia and Clarence Thomas, and the two newly appointed justices, John Roberts and Samuel Alito. Kennedy substantially adopted his dissenting opinion in *Stenberg* as the Court's new majority opinion. Since the law applies to fetuses both before and after the point of viability, Kennedy conceded that under the 1992 *Casey* decision the law would be unconstitutional "if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." Kennedy found Congress's purpose twofold. First, lawmakers wanted to "express respect for the dignity of human life," *id.* at 1633, by outlawing "a method of abortion in which a fetus is killed just inches before completion

of the birth process," *id.* at 1632, because use of this procedure "will further coarsen society to the humanity of not only newborns, but of all vulnerable and innocent human life . . . ." *Id.* at 1633. Second, Congress wanted to protect medical ethics, finding that this procedure "confuses the medical, legal and ethical duties of physicians to preserve and promote life . . . ." *Id.*

The key to Kennedy's legal analysis is his conclusion that these reasons are constitutionally sufficient state interests to justify the ban. He reasoned that under *Casey* "the State, from the inception of pregnancy, maintains its own regulatory interest in protecting the life of the fetus that may become a child [and this interest] cannot be set at naught by interpreting *Casey*'s requirement of a health exception so it becomes tantamount to allowing the doctor to choose the abortion method he or she might prefer." *Id.* Kennedy then goes on to write that "respect for human life finds an ultimate expression in the bond of love the mother has for her child" and that, "while no reliable data" exist on the subject, "it seems unexceptional to conclude some women come to regret their choice to abort the infant life they once created and sustained. . . . Severe depression and loss of esteem can follow." *Id.* at 1634. Such regret, Kennedy believed, can be caused or exacerbated if women later learn what the procedure entails, suggesting that physicians fail to describe it to patients because they "may prefer not to disclose precise details of the means [of abortion] that will be used . . . ." *Id.*

For physicians and their patients, the most important issue is whether the congressional prohibition would "ever impose significant health risks on women," and whether physicians or Congress should make this determination. Kennedy remarkably chose Congress: "The law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community. . . . Medical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts." *Id.* at 1636–37. Furthermore, Kennedy argued, the law does not impose an "undue burden" on women for another reason: alternative ways of killing a fetus have not been prohibited. In his words, "If the intact D&E procedure is truly necessary in some circumstances, it appears likely an injection that kills the fetus is an alternative under the Act that allows the doctor to perform the procedure." *Id.* at 1637.

Writing for the four dissenting justices, Justice Ruth Bader Ginsburg observed, "Today's decision is alarming. It refuses to take *Casey* and *Stenberg* seriously. It tolerates, indeed applauds, federal intervention to ban nationwide a procedure found necessary and proper in certain cases by the American College of Obstetricians (ACOG). It blurs the line, firmly drawn in *Casey,* between previability and postviability abortions. And, for the first time since *Roe*, the Court blesses a prohibition with no exception safeguarding a woman's health." *Id.* at 1641. Ginsburg emphasized her belief that the Court had overruled the conclusion in *Stenberg* that a health exception is required when "substantial medical authority supports the proposition that banning a particular abortion procedure could endanger women's health . . . ." *Id.* at 1642. This conclusion, bolstered by evidence presented by nine professional organizations, including the ACOG, and conclusions by all three U.S. district courts that heard evidence concerning the act and its effects, directly contradicted the congressional declaration that "[t]here is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures." Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, § 2, 117 Stat. 1201, 1204 (2003). Even Kennedy agreed that Congress's finding on this point was untenable.

Abortion and Medical Ethics

The major change in the law that *Gonzales v. Carhart* brings with it is the new willingness of a majority of Congress, the president, and a new majority of the Supreme Court to devalue the health of pregnant women by criminalizing the medical judgment of their physicians. This radical departure from precedent was made possible in the U.S. Supreme Court by categorizing physicians as unprincipled "abortion doctors" and infantilizing pregnant women as incapable of making serious decisions about their lives and health. The majority opinion ignores or marginalizes long-standing principles of constitutional law, substituting the personal morality of Kennedy and four of his colleagues for both medical judgment and medical ethics while simultaneously proclaiming that they are only upholding medical ethics.

The majority of the Court also asserts that giving Congress constitutional authority to regulate medical practice is not new, yet it identifies no case in which Congress had ever outlawed a medical procedure. Its reliance on the more than 100-year-old case of *Jacobson v. Commonwealth of Massachusetts,* 197 U.S. 11 (1905), is especially inapt. *Jacobson* was about mandatory smallpox vaccination during an epidemic. The statute had an exception for "children who present a certificate, signed by a registered physician, that they are unfit subjects for vaccination," *id.* at 12, and the Court implied that a similar medical exception would be constitutionally required for adults. It is not just abortion regulations that have had a health exception for physicians and their patients—all health regulations have.

Conclusion

There is nothing like pregnancy, and therefore nothing like abortion. It is tempting to argue that abortion jurisprudence is likewise sui generis and will not infect other areas of medical practice. I hope this is true. Nonetheless, we have witnessed over the past few years a Congress that is more and more likely to try to make medical decisions (although the fallout from the *Schiavo* case may temper its activism here), and, at least in the area of illicit drugs, more willing to see physicians as potential drug dealers than healers.

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Internet, which has expanded individual access to information and communication in myriad ways, plays a key role for both strategies; transplant tourism companies rely on their Web presence to reach potential customers across the world, and Internet solicitation facilitates the introduction of potential donors and recipients who would otherwise never meet. Just as the Internet is largely unregulated, much of the transplant tourism and Internet solicitation processes occur beyond the laws and structures governing organ transplantation in the United States. As such, participants may be particularly vulnerable, which raises significant ethical concerns and may lead to the need for greater involvement of law and policy makers.

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continued from inside front cover

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