1987

Medicine and Law: Making Excellent Time But Lost

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Problems posed by recent developments in medical science are outstripping the law's ability to articulate consensus-based solutions. Some important values are compromised no matter what is done. Under the circumstances, says the author, the law should abstain from the fray for its own good.

"Good afternoon ladies and gentlemen, this is the pilot speaking. We are flying at an altitude of 35,000 feet and a speed of 700 miles an hour. I have two pieces of news to report, one good and one bad. The bad news is that we are lost. The good news is that we are making excellent time."

Like the aircraft in the story, medicine today is making excellent time. The cures doctors have discovered, the interventions of which they are capable, and the techniques they have developed are truly remarkable. The bad news is that the law, in trying to keep up with these medical miracles, is losing ground. Its responses to problems posed by medical advances are imperfect at best, disastrous at worst, and costly in terms of lost credibility.

The moral problems created by modern medicine have no entirely satisfactory solutions: there is no consensus about how to handle them since some important values will be compromised no matter what is done. If the law takes a clear-cut position in favor of one set of values over another, it is likely to be evaded or ignored by those who think it has decided in favor of the wrong set of values. If the law, instead of taking a clear stand for one set of values over another, takes a compromise position, it is likely to be unworkable when it is applied to actual facts. The dilemmas created by medical advances seem to cry out for resolution but at the same time they resist resolution because there is no certainty or agreement on what resolution is right. On such issues, the law, for its own good, should abstain from the fray and stay silent until it can act on the basis of consensus, secure in the expectation that, because it rests upon consensus, it will be followed and that the solutions it provides will work.

Roe v. Wade: An Historic Compromise?

At the beginning of life, that most controversial issue — abortion — offers a ready example. We look at the abortion dilemma today as demanding a very clear-cut choice between conflicting values — the life of the fetus against the mother's right to self-determination. It is easy to forget that not very long ago abortion was a dangerous procedure for mothers. Then criminal abortion laws could be justified as protecting both mother and child. Modern medicine changed all that. It made abortion early in pregnancy a safe procedure — it is as safe or safer than childbirth. The states, nevertheless, kept their criminal abortion laws on the books; these statutes then represented a clear-cut choice by the law of fetal life over mother's rights. There was certainly no consensus among doctors as to which of these competing values should be preferred nor was there any consensus in society as a whole.

In any event, criminal abortion laws in the United States were evaded or ignored. Abortions continued. If a woman could pay, she could find an American doctor to do the job or she could go abroad. Those who could not afford either option often resorted to doing it themselves with sometimes fatal results.

It was at this juncture that the Supreme Court of the United States decided *Roe v. Wade*.[1] Faced with the question of the validity of the Texas and Georgia criminal abortion laws, the Court, like the state legislatures before it, could have taken a stand in favor of one conflicting set of values over the other. But it didn't. Instead it chose compromise. The justices acknowledged their awareness

> . . .of the sensitive and emotional nature of the abortion controversy, of the vigorous opposing views, even among physicians, and of the deep and seemingly absolute convictions that the subject inspires.[2]

They went on, like Caesar describing Gaul, to divide a pregnancy in three parts. The first trimester they left to the mother — here her right to self-determination was paramount. The second trimester was contested territory — in this period the mother's rights could be restricted by state legislation aimed at protecting, not the fetus, but the mother's health. The Court equated the beginning of the third trimester with the time when a fetus could survive outside the womb. After this point, the Court said, the state could act to protect fetal life, even if it meant proscribing abortion.

Has the Court's historic compromise solved the problem? Of course not. Believers in prolife doctrine bomb and burn abortion clinics, often going unpunished or getting off with lenient treatment. States continue to pass regulations restricting abortion, testing the outer limits of *Roe v. Wade.*

The Supreme Court has invalidated a number of these regulations since 1973,[3] pleasing prochoice forces, but four of its decisions have done much to return the status quo to that which existed before the Court entered the controversy. In 1977, in three companion cases, the Court held that states were not required by either the Constitution or federal law to pay for nontherapeutic abortions[4] and in 1980, that Congress, through the Hyde Amendment, could prevent use of federal funds for most medically necessary abortions as well.[5] The net result is that abortions are available except to poor women in 36 states; 14 states, despite the Court's decisions, continue to fund abortions on their own.

The Court's compromise solution is certainly not perfect and may very well be impermanent. Congress could initiate a constitutional amendment to overrule the Court. At least two newpaper columnists have concluded

that in the wake of the last election, there is an antiabortion majority in the House of Representatives and the Senate is too close to call on the question.[6] Or the Court could overrule itself: when the Supreme Court decided *Roe v. Wade* in 1973, the prochoice margin was five[7]; now it is one.[8]

Quite apart from legislative or judicial action, the Court's compromise is vulnerable to developments in medicine. Medical advances make fetuses born earlier than the second trimester more and more viable. As the period of viability increases, does the period in which abortion is permitted decrease? And what does the Court's reasoning look like in view of the possibility of ectogenesis? *In vitro* fertilization has become commonplace; the ability to grow a baby to term under laboratory conditions is reliably reported to be just around the corner.[9] When that happens, the reasoning of *Roe v. Wade* will be completely obsolete and its credibility not merely diminished but down to zero.

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In the Matter of Baby M: Solomon Revisited

Divorcing the generation of human life from human sexuality is hardly new anymore. It began with artificial insemination and if it does progress to its ultimate conclusion, will pose a number of profound questions. Consider the impact of a new nonbiologically related progenitor, the embryologist-geneticist-doctor, and a new home for generation, the laboratory rather than the womb, on traditional legal definitions of families and the rights and duties that flow from family relationships. Whose legal responsibility will these nontraditional babies be? And who will be liable for any physical or emotional defects resulting from the nontraditional way in which they were made?

These issues are foreshadowed by the current use of artificial insemination to facilitate so-called "surrogate motherhood", a practice which surfaced in the United States about 1976 and which has become increasingly popular since then. In a contemporary surrogate motherhood arrangement, a childless couple typically pays a surrogate to be artificially inseminated with the husband's sperm. The wife, unable to have her own baby, then adopts the baby because the law regards the surrogate as the legal mother. The surrogate, for her part, agrees to donate her egg and womb and, on birth of the baby, to relinquish custody immediately. (Under a less common but increasingly frequent arrangement, the surrogate is just a carrier who has consented to be impregnated with a fertilized egg and who has no genetic connection to the baby she bears).

Is this "giving life" as those who approve the practice vociferously say or is it "selling babies", as those who condemn it argue? The question has

been widely publicized lately in connection with *In the Matter of Baby M*,[10] a case in which a surrogate mother, after signing a surrogate agreement of the usual kind (she donated her egg and womb), changed her mind. She refused the money and made off with the baby. The natural father and his wife sued to recover it. Here, as in the case of abortion, is a dilemma which, no matter how it is decided, will compromise some recognized values. On the plaintiff's side are the right to procreate and the rights of the natural father to his children; on the defendant's side are the same rights of the natural mother to her children, as well as a public policy embodied in adoption and other laws against selling babies or making them the subjects of ordinary contracts. And, as on the subject of abortion, there is fierce disagreement in this society about which values are most important in arriving at a solution. Under the thesis of this article, this makes surrogate motherhood a subject which the law should not address. So far, state legislatures have stayed away from it but the Baby M case is now squarely before a court. What might the court do?

The court might refuse to hear the case, saying this is not one of the situations for which the law provides a remedy, and direct that the parties be left to settle the dispute themselves. (At least four other similar cases have been settled quietly outside court.[11]) The court could look on this as merely an aspect of an already well-settled situation — that which occurs when a husband, instead of a wife, is unable to have a baby. Sperm is donated to the would-be parents and the wife is artificially inseminated with her husband's consent. In those cases statutes make it clear that the sperm donor has no rights to the baby.[12] The court could stretch that solution to apply to donations of an egg and a womb. If it did so, it would give the baby to the father and his wife. The court could treat the case as an ordinary contract matter and employ usual contract

rules. It might find that the surrogate mother breached the contract. It could then require her to pay damages or to return the baby. Or the court could treat the contract as unenforceable because the payment to the surrogate mother violates laws prohibiting the sale of babies. This would leave the baby with the surrogate mother. (The opposing lawyer, of course, would argue that the payment was not for the baby but for services rendered or rent.) Or the court could decide the case as if the baby were the product of a divorcing couple's union. The standard for awarding custody then would be the best interests of the child.

The court, so far, has ordered the surrogate mother to turn the baby over to the father and his wife pending its ultimate decision, but it has awarded the surrogate mother visiting rights. Perhaps it is on the verge of a Solomonic solution, dividing the baby in half, or awarding it jointly to both contesting families.

"Given some consensus about surrogate motherhood, legislators can act. Their laws would then have a good chance of being followed."

The first option, that the court decline to act and leave the parties to their own devices, is to my mind preferable. But any of these possibilities is better than a statute on the subject. A judicial decision, unlike a statute, affects only the parties to it. It can be overruled by the court which made it; it doesn't bind coordinate or higher courts or courts in other jurisdictions. They could reach other solutions to similar problems. When, as a result of experience, differences of opinion give way to some consensus about surrogate motherhood, legislators can act. Their laws would then have a good chance of being followed.

The Limitations of "Baby Doe"

At the other end of the spectrum, dying, similar issues arise. Doctors can control death: for almost any condition that makes a person terminally ill, some medical intervention is available that can postpone death. Cardiopulmonary resuscitation, blood transfusion, machines that breathe and perform other bodily functions for people who can no longer perform them for themselves, sophisticated methods for transplanting natural and artificial body organs and parts — these are but a few of the options available. Of course, doctors can hasten death as well, making it swift and painless.

In October 1986 a seven-month-old child, Lance Tyler Steinhaus, was brought to University Hospital (Minneapolis) after his own father assaulted him.[13] Lance's heart was beating and he was breathing. He was not "brain dead" but doctors said that the upper part of his brain, which controls thought and personality, was so severely damaged that he had no hope of recovery. The question was how to treat him. Should he be kept alive, using all the medical marvels at hand, or should some of them be withheld allowing him to die? The child's father, mother, doctors, and welfare officials

couldn't agree. These are the facts. What of the law?

The law, both state and federal, says that "withholding medically indicated treatment from a disabled infant with a life-threatening condition" is child abuse and neglect unless, "in the treating physician's ... reasonable medical judgment ... the infant is chronically and irreversibly comatose."[14] These federal and state laws are so-called Baby Doe laws. They were the legislative response to the practice of leaving the fate of defective newborn babies to their doctors and families. The specific cases that triggered their enactment were those of an Indiana couple who, in 1982, let their Downs Syndrome baby die, and of a New York couple who, in 1983, refused to consent to surgery for their baby who had spina bifida and hydrocephalus.[15] The statutes, though triggered by problems arising with defective newborns, are not restricted in application to them.

The Baby Doe laws do not choose one set of values over the other; like *Roe v. Wade*, they reflect compromise — an uneasy and imprecise political compromise between fiercely disagreeing groups: those who believe that life, whatever its quality, must be preserved, and those who believe that life without hope of recovery is no life at all. It is no wonder then that when the laws were invoked to solve the impasse between Lance's mother and doctors, on the one hand, who wanted to withhold aggressive medical treatment, and his father and the Welfare Department, on the other, who wanted to keep the child alive, they didn't work. Lance, according to his doctors, showed some characteristics of a person "in a permanent vegetative state". Under the Baby Doe laws, withholding medical treatment from him if he were in this condition would be child abuse and neglect; doctors would have to continue to treat him aggressively. Lance also showed some characteristics of a person in "chronic and irreversible coma". Under the Baby Doe laws, withholding medical

treatment from him if he were in this condition would not be child abuse and neglect; doctors would be able to withhold treatment.

Because Lance's condition didn't fit precisely into the statutory exception, the court ordered doctors to continue treatment despite their better judgment.[16] The case was settled only when the five lawyers, one for each parent, one representing Lance, one representing the Welfare Department, and one representing the doctors, agreed on the child's treatment. Lance would continue to receive food and water. If he stopped breathing or if his breathing became difficult or if his heart stopped beating he would not be resuscitated or have a tube put down his throat to aid breathing; nor would be be put on life support machines. The lawyers involved in the case were quoted as agreeing that the Baby Doe laws didn't work well.[17] So were the doctors. Said one: "The courts are trying to make decisions in a vacuum in abstract terms on day-to-day medical decisions. . . ."[18]

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Refusals Ignored and Gifts Refused

A few months before Lance's problems were being aired in the news, reporters were following another case — that of Kathleen Farrell.[19] Farrell, a 37-year- old mother of two teenagers, was suffering from Lou Gehrig's disease. She was not in a hospital or nursing home but rather in her own home. She was sustained by a respirator which breathed for her and she was being fed liquids through a syringe. She was mentally competent, though completely paralyzed except for her eye muscles and lips. She wanted to stop her treatment.

Here the law has taken a clear stance about which set of conflicting values is to provide the solution. Mrs. Farrell, it says, as the patient, has the right to refuse treatment though her refusal will result in her death. It finds this answer in the common law right of self-determination and the constitutional right to privacy.[20] But despite the law, neither Mrs. Farrell's doctor nor her husband was willing to take responsibility for carrying out her wishes.

Here, again, is an issue on which members of our society disagree. Any resolution requires a compromise of some accepted values. There are those who believe that disconnecting Mrs. Farrell's respirator would be "undertreatment of the living" tantamount to murder, and those who believe that to keep her attached to it, especially against her will, would be "overtreatment of the dying" and an unjustifiable violation of her right to death with dignity.

Though the intermediate appellate court of Mrs. Farrell's state upheld her right to refuse treatment, it stayed its own judgment till the lawyer representing her two children could appeal to the next highest court.[21] Mrs. Farrell remained hooked to the respirator till she died,

just one day before that court was to hear the argument in her case.

Mrs. Farrell is not an isolated example: blood transfusions and other forms of medical treatment have been imposed on competent patients despite their efforts to refuse treatment because their families, doctors, or hospitals did not agree with their decisions or because the doctors, families, or hospitals were afraid of legal action from others who did not agree. Despite the law's clear position, the right of a competent patient to refuse medical treatment if that refusal will result in death is still more theory than practice.

Another area in which the legal response to medical change has fallen short is the area of organ transplantation. Obviously the new organ transplant technology has made body parts valuable, and the demand for them greater than the supply. While ordinarily such economic problems are solved by the market, there is fierce disagreement in our society on the correctness or rightness of recognizing property rights in, and of letting a free market operate to increase the supply of, body parts available for transplant. Here again the law has jumped prematurely and irrationally into the fray. It has taken a position, through a combination of federal and state law, which says, in a nutshell, that a person's body parts are property which that person may not sell. Whether one agrees or disagrees with the underlying value judgment that "organ markets" are not desirable, it seems naive to think that a law which prohibits the sale of human organs will make them valueless.

A series of recent newspaper articles[22] reflects the folly of such an approach. They report that 30 percent of all kidney transplants in several hospitals were performed on foreigners who were allowed to jump to the head of the line of waiting Americans. The articles also reported that in the foreigners' cases, the surgeons' fees were four times, and the hospital charges two times, those charged Americans in similar cases.

The law may prevent the organ donor from reaping the value of his or her organs but its net result is that organs are free goods that can be harvested by anyone else who can establish a claim to them.

Assume three parties to the usual transaction — a donor, a surgical team, a recipient — and assume further that the donor would be willing to donate for $20,000, the surgical team to do the transplant for $30,000, and the recipient willing to pay the total, $50,000. Despite the law, the organ in question is still worth $20,000. The intent of the law was that the value of the organ be passed on as a gift to the recipient who would pay $30,000 for the transplant instead of $50,000. But we see from the newspaper stories — and they have been confirmed, according to the *New York Times*,[23] by the Department of Health and Human Services — that the medical team or the hospital is getting the $20,000 in value. And even if the law, in its naivete, were to prohibit doctors or hospitals from collecting that value there would be someone else who would in their stead.

"It seems naive to think that a law which prohibits the sale of human organs will make them valueless."

It is beyond the capability of the law to make a scarce resource valueless. The solution, of course, is to bring supply up to demand. The law in its wisdom has attempted to do this by taking the position that an individual has the right to give away his or her organs at death and the law has made it very easy to do so. You can donate organs when you apply for a driver's license in most states; you can donate organs by filling out a readily available "donor" card; you can donate organs by making an ordinary will. This legal response to the shortage has been just as unsuccessful as the law's attempt to devalue the organs themselves.

On this front, the law didn't reckon with relatives of the donor and the medical profession. Though the donor's gift of organs is made according to law, and though when a donor has decided to donate, relatives have no legal rights in the matter, doctors refuse to remove organs if family members object.

Some doctors fear suits from relatives who don't want the organs removed — incidentally for the organs to be usable the donor must still show some of the traditional signs of life — the donor must be breathing and must show a pulse, though certified as "brain dead". Some doctors feel the law is wrong and that family members should have a say in the matter. Some doctors fear adverse publicity if they were to proceed with removal without the family's consent. Obviously the propriety of organ donation is not a subject on which we all agree. Here again the law takes a stand but it is not followed.

A Time to Stay Silent

Some suggest that more laws, both federal and state, can solve these problems. The most intelligent

response I've seen to that was from a *Minneapolis Star and Tribune* reader. He wrote:

> As a dialysis patient awaiting a kidney transplant, the last thing I want is ... legislation ... as your October 5 editorial advocates .... Rather than making appeals for legislation ... you should direct your editorial efforts toward a public awareness program directed at tapping into the large existing pool [of possible organ donors].[24]

So let's have no more legislation on transplantable organs or on any of these other insoluble issues. We might take a leaf from Europe's book on the subject. What I have in mind is what is happening in Holland on the issue of euthanasia.[25] While the national legislature has been wrestling inconclusively with the question, the medical profession has established a procedure for it. Using the procedure Dutch doctors help more than 5,000 suffering patients to die each year. And we could learn as well from an Englishman — Lord Dawson — doctor to King George V. Dawson made the front page of the *New York Times* a couple of weeks ago.[26] Newly revealed there was the fact that, relying on his own conscience, he hastened the king's death with injections of morphine and cocaine.

Despite his own practice of euthanasia, Lord Dawson was deadset against the passage of laws legalizing it. He argued against one in the House of Lords just ten months after he sped King George off to heaven. Lord Dawson thought these matters best left to the conscience of individual physicians rather than to official regulators, as he called lawmakers. He thought that eventually euthanasia — that is making the act of dying more gentle and peaceful even if that involves curtailing life — would become increasingly the custom and ultimately accepted.

What he said about euthanasia applies to other difficult medical dilemmas which, for solution, require a choice between competing sets of accepted values. Until a practice for resolving them — a custom — is established and accepted, the law, if it steps in, risks a loss of credibility which it can ill afford. If it steps in and takes a stand preferrring one set of competing values over another — as it did on criminal abortion, patients' rights to refuse treatment, and gifts of organs — it will be ignored by those who think it made the wrong choice or evaded; if it steps in and compromises the competing values — as it did in the Baby Doe laws and *Roe v. Wade* — it will be unworkable. This may mean that on certain issues the law will have to stay silent for quite a long time. I think it is infinitely better to be quiet for a long time and considered wise than to speak frequently and ineffectively and be considered, as Mr. Bumble put it, "a ass".[27]

NOTES

1 410 U.S. 113 (1973).

2 Id. *at 116.*

3 See, e.g., City of Akron v. Akron Center for Reproductive Health, Inc. *462 U.S. 416 (1983).*

4 Beal v. Doe, *432 U.S. 438;* Maher v. Doe, *432 U.S. 464;* Poelker v. Doe, *432 U.S. 519.*

5 Harris v. McRae, *448 U.S. 297.*

6 Ellen Goodman, Boston Globe; *reprinted in* Minneapolis Star & Tribune, *October 24, 1986, p. 18A, c. 1. Linda Greenhouse,* New York Times, *Nov. 13, 1986, p. 14, c. 3.*

7 Only Justices Rehnquist and White dissented.

8 Thornburgh v. American College of Obstetricians and Gynecologists, *54 U.S.L. Week 4618 (June 1986) (Blackmun, Brennan, Marshall, Powell, and Stevens. The dissenters were Burger, White, Rehnquist, and O'Connor.)*

9 See *Wadlington, "Artificial Conception: The Challenge for Family Law," 69* Va.L.R. *465 (1983); Andrews, "The Stork Market: The Law of the New Artificial Reproductive Technologies," 70* ABA Journal *(Aug. 1984) p. 50.*

10 FM-25314-86E (Superior Court of NJ, Chancery Div., Family Part). See, e.g., New York Times, *Oct. 1, 1986, p. 19, c. 4;* Minneapolis Star and Tribune, *Nov. 2, 1986, p. 19A, c. 1;* The National Law Journal, *Sept. 29, 1986, p. 1, c. 1.*

11 The National Law Journal, *Sept. 29, 1986, p. 10, c. 2.*

12 E.g., *Minn. Stat. Ann. §257.56.*

13 See Minneapolis Star and Tribune, *October 27, 1986, p. 1, c. 1.*

14 42 U.S.C.A. §§5103(b)(2)(K), 5102(3) (1986 Supp.); Minn. Stat. Ann. §260.015(10)(e)(1987 Supp.).

15 See Bowen, The American Hospital Association, *106 S.Ct. 2101, 2107 (1986);* Weber v. Stony Brook Hospital *467 N.Y.Supp.2d 685,* affirmed *469 N.Y.Supp.2d 63,* cert. denied *464 U.S. 479, 485 (1983).*

16 Minneapolis Star and Tribune, *Oct. 17, 1986, p. 4A, c. 1.*

17 Id., *c. 2.*

18 Id..

19 E.g., New York Times, *June 29, 1986, p. E5, c. 3;* New York Times, *June 30, 1986, p. 13, c. 1.*

20 E.g., Union Pacific Railway Co. v. Botsford *141 U.S. 250, 251 (1891);* Griswold v. U.S. *381 U.S. 479, 485 (1965).*

21 New York Times, *June 30, 1986, p. 13, c.1.*

22 These appeared originally in The Pittsburgh Press *in 1985.* See New York Times, *Aug. 10, 1985, p. 1, c. 4;* New York Times, *Sept. 8, 1986, p. 23, c.3.*

23 New York Times, *Sept. 8, 1986, p. 23, c. 3.*

24 Minneapolis Star and Tribune, *Nov. 4, 1986, p. 8A, c.5.*

25 See New York Times, *Oct. 31, 1986, p. 6, c. 1.*

26 New York Times, *Nov. 28, 1986, p. 1, c. 3.*

27 Dickens, The Adventures of Oliver Twist, *p. 365 (The Folio Society Ed. 1984).*

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