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Overview

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OVERVIEW

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Probably no field in the law has expanded more rapidly during the past decade than Health Law. In his article, *Health Law Comes of Age: Economics and Ethics in a Changing World,*[1] a review of *Law, Medicine and Forensic Science,*[2] Clifford Stromberg,[3] former Deputy Secretary of the United States Department of Health and Human Services, had this to say about the development of Health Law in the nation:

> Health Law is booming. This field of legal practice hardly existed twenty years ago; it is now becoming one of the more important legal specialties. Until recently, practice in the "medico-legal" field was largely limited to the defense of hospitals and physicians in malpractice actions and to occasional issues in criminal law. Today, "health law" is a diverse and burgeoning enterprise . . . . These developments reflect the dynamic growth of the health industry. Health care is now the nation's third largest industry (after construction and agriculture), with national health expenditures that exceeded $280 billion in 1981. Health costs have leaped from about 4.0 percent of our gross national product in 1960, to 5.9 percent in 1970, and to 9.8 percent in 1981. Health care constitutes about one third of the service sector and is the fastest growing sector of our economy.[4]

Even in the short span of time since Mr. Stromberg's article in 1982, health care has continued its rapid growth. In 1983, the industry accounted for 10.8 percent of the Gross National Prod-

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1. 92 YALE L.J. 203 (1982).
2. W. CURRAN & E.D. SHAPIRO, LAW, MEDICINE & FORENSIC SCIENCE (3d ed. 1982).
3. A partner in the firm of Dorsey & Whitney in Washington, D.C., formerly Deputy Executive Secretary, U.S. Department of Health and Human Services and consultant on health law and policy to the Federal Trade Commission.
4. Stromberg, *supra* note 1, at 203.

uct with health care costs exceeding $355.4 billion.[5] The steadily increasing expense of health care delivery, which have caused great concern to the government, health care providers, and consumers, accounts for a large portion of the health care boom. But this phenomenal growth stems also from the rapid evolution of medical science into areas unheard of less than a generation ago.

In the past few decades, we have seen such innovations as organ transplants, artificial organs, laser surgery, and highly sophisticated diagnostic and life sustaining equipment, just to name a few. Physicians now have the technology to sustain, often for long periods of time, the lives of patients who only a few years ago would have died in a matter of days or hours. Breakthroughs in reproduction and artificial conception, such as *in vitro* fertilization, embryo transplants, and sperm and ova banking have brought a new dawn of hope to thousands of infertile couples.

Law and morality, however, have not evolved in tandem with science. The state of the law has remained virtually unchanged from biblical times. This has in many areas limited or precluded entirely the efforts of medical scientists and in some instances continues to do so. For more than a decade, the federal government imposed a moratorium on federal funding for research concerning *in vitro* fertilization and the development of human fetuses.[6] Only in the past two decades have laws on artificial insemination emerged; almost half of the United States still do not have laws that address the subject. Guidelines to determine who should choose whether to retain or terminate the life sustaining equipment of irreversibly comatose patients are conspicuously absent from the vast majority of statute books and inconsistently dealt with in caselaw. The great nations of the world, as well as the major religions, have yet to decide on a single definition of "death." Even our own states are in disaccord on this vital matter. The role of psychiatry in the criminal process has not yet been defined by the Supreme Court. It is therefore only fitting that the *Human Rights Annual* explore

5. NATIONAL CENTER FOR HEALTH STATISTICS, U.S. PUBLIC HEALTH SERVICE, PUB. NO. 85-1232, HEALTH, UNITED STATES, 1984 (1984).

6. *See* Bass, *A Barren Time for Infertility Research*, TECH. REV., Aug./Sept. 1984, at 75.

some of these overwhelming issues in health law, and hopefully it will continue and expand upon its inquiry in later issues.

The following three part series of medico-legal articles discusses artificial conception, the withholding or termination of medical treatment for the terminally ill, and the role of the psychiatric expert in criminal law. In these areas perhaps lie some of the most significant conflicts between law and medicine.

New methods of conception, such as artificial insemination, *in vitro* fertilization, and embryo transplants have changed our entire concept of reproduction. In the first of the medico-legal articles, entitled *New Methods of Conception and Their Legal Status,* Harriet Pilpel explains how these new procedures are done and comments upon the problems they have created. Their effects upon our law and morality during the past decade were brought about by a not-so-quiet social and ethical revolution. All fields of law have been affected by these changes. The very status and legitimacy of the child born by these new methods, as well as its inheritance rights, support rights, and parental visitation rights have been called into question. As Ms. Pilpel points out, this is an area that the law can no longer simply ignore. Only fairly recently have some legal communities complied with society's mandate to address these new techniques. Unfortunately, the responses have been slow, inadequate and at times contradictory.

The law can no longer afford the luxury of looking to precedents conceived in a different age and at earlier stages of medical technology. The modern world is seeing not only a brand new technological era in reproduction, but also the emergence of new attitudes toward its implementation and even toward reproduction itself. The law must be bold in confronting both as their swift progression gives rise to challenging issues of social concern which must be decided on their own unique merits.

Although one can, of course, choose not to participate in the newest methods of conception, one can hardly refuse to make the difficult decision, which we face more and more often today, regarding the termination of life. Professor Stephen Newman probes the flipside of conception in the second medico-legal article, entitled *Treatment Refusals for the Critically and Terminally Ill: Proposed Roles for the Family, The Physician, and the State.*

The law thus far has been fairly uniform in dealing with cases in which patients noncomatose have consciously refused the continuation of life support systems.[7] Courts have by and large determined that the individual may even choose death for religious reasons[8] or to escape the deterioration of the quality of their lives.[9] The real problem, as Professor Newman observes, arises with the severely, irreversibly ill comatose or incompetent patients who are thus incapable of making their own decisions.

Probably the most heralded line of cases spring from *In re Karen Ann Quinlan*[10] and *In the Matter of Conroy*,[11] both of which vest the power to make the life or death decision with a quasi-medical community group called an "ethics committee," along with input from the family and the physician. Other jurisdictions have attempted to reserve the decision making for the courts or court appointed representatives.[12] Still others rely on what the patient had expressed before becoming incompetent or the substituted judgment of family members.[13]

Where should the emphasis lie? Who should play the greatest role in making this critical decision? Professor Newman expounds on the type and extent of input which he believes is needed from the family, the physician and the state. He points out the dangers of leaving the decision to a sole entity, since none can possibly assess all the information necessary for a fair determination for the patient. Close relatives usually have the best knowledge of their loved one's lifestyle, philosophies and values and can make the best evaluation as to what he or she would have wanted. The physician, on the other hand, knows the severity of the illness, its prognosis, the extent and expense of treatment necessary, and what the quality of the patient's lifestyle will be. Courts rarely possess first-hand knowledge of

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7. *See, e.g.*, In re Osborne, 294 A.2d 372 (D.C. 1972); In re Boyd, 403 A.2d 744 (D.C. 1979).

8. *See, e.g.*, In re Boyd, 403 A.2d 744.

9. *See, e.g.*, Satz v. Perlmutter, 362 So.2d 160 (Fla. 1978).

10. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 933 (1976).

11. 98 N.J. 321, 486 A.2d 1209 (1985).

12. *See* Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); In re Spring, 380 Mass. 629, 405 N.E.2d 115 (1980).

13. *See* In re Eichner, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); In re Storar, 52 N.Y.2d 363, 426 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

the patient's condition and base their decisions on hearsay and expert testimony.

Professor Newman reminds us that "legal rules alone cannot dictate the course of complex human interaction" and to that we must add "nor should the emotion of the family members or detached technical judgment of the physician." All three must work together to arrive at the decision which most respects the rights of the comatose patient.

While the first two articles focus on the problems created by the newest medical advances, the third, entitled *The Supreme Court, The Mentally Disabled Criminal Defendant, Psychiatric Testimony in Death Penalty Cases, and the Power of Symbolism: Dulling the Ake in Barefoot's Achilles' Heel* by Professor Michael Perlin, discusses age old medico-legal questions which have yet to be resolved.

The insanity defense in common law has existed for over a century. The evolution of both law and science has made only subtle changes in its use. Through in-depth analysis of three fairly recent Supreme Court cases, Professor Perlin explores the issues that psychiatry has created in criminal law, particularly in cases that involve a life or death decision of another kind—the possible imposition of the death penalty. He discusses the Court's views on the standards of the insanity defense, the appropriateness and extent of psychiatric testimony in both "ordinary criminal cases" and death penalty cases, the indigent defendant's rights to a psychiatric expert witness at state expense, and corollary constitutional issues.

Can the mentally disabled criminal defendant effectively evoke the aid of mental health care professionals? Statistics show that psychiatrists and psychologists rarely arrive at accurate determinations as to the likelihood of a defendant to commit similar crimes in the future. On the other hand, failure to consider and explore the defendant's mental health can result in tragic injustices. Under what circumstances and to what extent, therefore, should courts rely on psychiatric evaluation? The Supreme Court, as Professor Perlin observes, is drawn to cases involving mental disability like moths to the flame, yet despite the myriad of cases it has addressed, is unable to arrive at any workable answers.

The fact that law and medicine do not co-evolve is not in and of itself disconcerting. But the law must not disregard its responsibilities to confront the issues that science presents. Fair treatment in cases involving the insanity defense should be one of utmost concern. Is it strict adherence to out-moded concepts and data, fear of controversy, ambivalence, or lack of knowledge that keeps legislators and courts from acting? These new medical techniques are not fads; they will not go away if we just ignore them; they are scientific innovations involving consequences with which the law must deal.