



1-1-2005

Introduction: American Association of Law Schools Panel: Panel on the Use of Patients for Teaching Purposes Without Their Knowledge or Consent

Michelle Oberman

Santa Clara University School of Law, moberman@scu.edu

Follow this and additional works at: <http://digitalcommons.law.scu.edu/facpubs>

Recommended Citation

8 J. Health Care L. & Pol'y 210

This Article is brought to you for free and open access by the Faculty Scholarship at Santa Clara Law Digital Commons. It has been accepted for inclusion in Faculty Publications by an authorized administrator of Santa Clara Law Digital Commons. For more information, please contact sculawlibrarian@gmail.com.

PANEL DISCUSSION

AMERICAN ASSOCIATION OF LAW SCHOOLS PANEL: PANEL ON THE USE OF PATIENTS FOR TEACHING PURPOSES WITHOUT THEIR KNOWLEDGE OR CONSENT

INTRODUCTION

MICHELLE OBERMAN*

The history of medical paternalism is long and gory, rich with tales of the use and abuse of patients, undertaken almost always in the name of the greater good, if not for the benefit of the individual patient. In the twentieth century, however, the law rejected that history. In its stead, it embraced a norm of autonomy, empowering patients with rights that, at least in theory, outweighed physicians' justifications that, because their goal was beneficent, they were entitled to make decisions for their patients. After centuries of deference to physicians, suddenly patients were permitted to challenge as a battery any "treatment" rendered without their consent.¹

The shift from a paradigm of beneficence to one of autonomy reshaped medical practice in all contexts – clinical, teaching, and research. "Consent," and more specifically, "informed consent" became a mantra as lawyers, ethicists, and doctors alike came to accept the notion that it was fundamentally wrong to subject an individual to any treatment or contact without first obtaining their permission.²

* Professor of Law, Santa Clara University School of Law, J.D., M.P.H., University of Michigan 1988.

1. See e.g., *Pratt v. Davis*, 118 Ill. App. 161 (Ill. App. Ct. 1905) (awarding punitive damages for removal of patient's vital organs without consent), *aff'd*, 79 N.E. 562 (Ill. 1906); *Schloendorf v. Society of N. Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (recognizing the right to bodily integrity); *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (permitting claims by plaintiffs who argued that, had they understood the risk of this particular bad outcome, they never would have consented to treatment); *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960) (recognizing the fiduciary duty to disclose that is owed to a patient by her physician). See generally PAUL S. APPELBAUM, *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* (1987); JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984).

2. The American Medical Association's ethical and policy guidelines are unambiguous in their support for the right to refuse treatment, even in cases in which refusal means that the patient likely will die for want of a simple medical procedure such as a transfusion. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, *CODE OF MEDICAL ETHICS - OPINIONS WITH ANNOTATIONS*, 8.08, at 134-35 (1998-1999 ed. 1998), available at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-8.08.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-7.05.HTM&nxt_pol=policyfiles/HnE/E-8.01.HTM (last visited June 3, 2005).

Of course, it was easy to condemn as atrocities the “medical experiments” performed by Nazi doctors on Jews during the Second World War. With similar moral clarity, various incidents of the abuse of patients in the United States were unearthed.³ Like the Nazis, U.S. doctors used and abused slaves in the name of science. This practice continued long after the demise of slavery, as is witnessed in the infamous Tuskegee study, in which federal dollars supported research on poor African-American men, who were deprived of treatment for syphilis over the course of four decades, so that doctors could study the disease “in nature.”⁴

It would take longer to garner medical, legal, and ethical deference to autonomy rights in the harder cases – situations in which physicians’ claims to beneficence for the individual patient, or for society as a whole, seemed to be both legitimate and difficult to reconcile with the patient’s autonomy interest. So, for instance, patients struggled for decades to secure autonomy rights in contexts such as life-saving treatment or prenatal care.⁵ Ultimately, though, the law of informed consent has emerged as a cohesive theory, circumscribing the rights of doctors to justify their actions on the basis of goals such as improving the patient’s well-being, or helping society as a whole.⁶ One might say with confidence that there is, today, a normative presumption that consent must be obtained in all interactions between doctors and their patients, and between clinical researchers and their subjects.

Cases in which doctors or researchers claim the right to treat a patient without consent are exceedingly rare. Typically, they involve populations that are, in some way, vulnerable and subordinate. For example, pregnant women long have been subjected to unwanted medical treatment in the name of their doctor’s interest in treating their fetuses.⁷ Once they are subjected to critical analysis, these

3. See Judith Areen et. al., LAW, SCIENCE AND MEDICINE 907-25 (2d ed. 1996).

4. The Tuskegee Syphilis experiment is described in Annette Dula’s article: *African American Suspicion of the Healthcare System is Justified: What Do We Do About It?*, 3 CAMBRIDGE Q. HEALTHCARE ETHICS 347, 347-48 (1994). For a comprehensive survey of the abuse of African Americans by the U.S. health care system, see W. Michael Byrd & Linda A. Clayton, AN AMERICAN DILEMMA: A MEDICAL HISTORY OF AFRICAN AMERICANS AND THE PROBLEM OF RACE – BEGINNINGS TO 1900 (2000).

5. See e.g., John F. Kennedy Mem’l Hosp. v. Heston, 279 A.2d 670 (N.J. 1971) (asserting the hospital’s right to force life-saving treatment on a nonconsenting patient). This case was superseded by later rulings supporting the right of competent, and even incompetent, patients to reject treatment. See e.g., *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976); *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 278 (1990). For a summary of doctors’ efforts to impose treatment upon their pregnant patients, see Michelle Oberman, *Mothers and Doctors’ Order: Unmasking the Doctor’s Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U.L. REV. 451 (2000).

6. Oberman, *supra* note 5, at n.8 and accompanying text.

7. Oberman, *supra* note 5; see also *Ferguson v. City of Charleston*, 532 U.S. 67 (2000) (holding drug tests performed without the patient’s permission, and subsequent arrests of pregnant women or new mothers, violates the 4th Amendment of the U.S. Constitution).

exceptional cases typically emerge as unjustifiable, and the law requires informed consent prior to treatment.

In this light, the topic of this symposium may be viewed as an important step toward rooting out yet another vestige of a by-gone era. Doctors acknowledge that they long have used their unwitting patients as “teaching material,” permitting medical students to perform unnecessary medical procedures upon them. As several of the articles in this symposium powerfully conclude, such a practice cannot be justified, as it is irreconcilable with a patient’s right to autonomy.

Read together, however, these articles do more than merely expose yet another instance of doctors’ failure to respect their patients’ autonomy rights. By providing a probing analysis of the manner in which doctors use patients for training purposes, and at the same time, exploring the practical, ethical and legal problems generated by this practice, these articles expose the limitations on consent as a panacea to the problem of overreaching by doctors.

I. THE ARTICLES

All of the articles in this symposium proceed from the assumption that it is impermissible to perform medically unnecessary procedures on live patients without their consent. What complicates this issue is the fact there are procedures for which human models provide the best, and in some cases, the only, means for training student doctors. Thus, the debates considered in these articles revolve around the extent to which the obligation to obtain consent may interfere with the ability to provide training for doctors.

A. Performing Minimally Invasive Procedures on the Newly Dead

Kenneth V. Iserson’s article, “Teaching Without Harming the Living: Performing Minimally Invasive Procedures on the Newly Dead,” discusses the vital importance of teaching lifesaving techniques, particularly endotracheal intubation, on the newly dead. As a professor of emergency medicine, Dr. Iserson is well-situated to understand both the critical significance of this procedure, as well as the difficulty of teaching doctors and others to perform it. His central argument is that the newly dead patient is ideal for such training, because their bodies are identical to those of live patients, and yet, they cannot be harmed by those just learning to perform this delicate procedure. He forcefully argues that the price of requiring the family’s consent in this context, in terms of time lost and the impact on the human corpse, likely would render the practice unworkable.

Inherent in his work is an open challenge to the “consent” paradigm: Is it necessarily the case that consent must be sought from the family of the deceased, just as it would from a patient? He notes that the rights that are protected by such a requirement are by no means synonymous with those at stake with live patients.

Moreover, he notes that we cannot embrace these broader “quasi-property” rights without also accepting the negative consequences of this value choice: Doctors will be less skilled when performing this technique in emergency situations, when human lives are at stake. By arguing that it should be permissible to use patients who are no longer alive to help prepare doctors to preserve the lives of future patients, Dr. Iserson’s article revives the notion of general beneficence as a counter-point to autonomy. In so doing, the reader is forced to recognize that it is far from clear that consent must always trump the doctor’s imperative toward beneficence.

B. Pelvic Examinations Under Anesthesia

The remaining two articles in this series discuss the problem of pelvic examinations under anesthesia. Jennifer Goedken’s article, “Pelvic Examinations Under Anesthesia: An Important Teaching Tool,” takes as its central task the explanation, in lay terms, of the reasons why it is preferable that medical students be taught to perform pelvic exams on women who are anesthetized. As Emory University’s Director of Medical Student Clerkships in Gynecology and Obstetrics, Dr. Goedken draws on her personal expertise in commenting upon the course of training doctors. She notes that technological innovations such as virtual reality models may eventually eliminate the need to use live patients, but that such techniques remain at least twenty years off. In the meantime, Dr. Goedken makes a compelling case for the benefits of training doctors to perform these procedures on women who are anesthetized in order to undergo some other procedure. She concludes that the only ethically permissible manner in which to accomplish this goal is by obtaining specific informed consent.

Robin Fretwell Wilson’s piece, “Autonomy Suspended: Using Female Patients to Teach Intimate Exams Without Their Knowledge or Consent,” provides the legal and ethical foundation for understanding that it is imperative that doctors obtain consent prior to using patients as teaching material. She begins by discussing the surprisingly widespread extent of this problem, showing evidence that generations of medical students have been trained to perform pelvic examinations by taking advantage of anesthetized women patients. Although her aim is to demonstrate the need for consent in these particular cases, Professor Wilson also recognizes the broader implications of her argument by situating this inquiry in the context of the more general problem of medical students posing as doctors in order to gain access to patients while they are in training. Indeed, as she notes, one 1995 study found that “every medical student surveyed had been introduced to a patient as ‘doctor’ by a hospital staff member at some point.”⁸

8. Robin Fretwell Wilson, *Autonomy Suspended: Using Female Patients to Teach Intimate Exams Without Their Knowledge or Consent*, 8 J. HEALTH CARE L. & POL’Y 240, 247 (2005).

Professor Wilson's article provides a critical analysis of the medical profession's feeble attempts to justify the practice of using women patients without their knowledge or consent. She exposes the analytical flaws in each of the justifications, and offers evidence suggesting that, were they to be consulted, women overwhelmingly would consent to participate in the training of doctors.

Perhaps the most striking and troubling information surfaced by Wilson's article is the extent to which the burden of training doctors is disproportionately borne by poor, uninsured patients of color, few of whom actually may be aware of the fact that they are being treated at "teaching hospitals." Wilson presents considerable evidence demonstrating that poor patients are much more likely to receive care in teaching facilities than in private, non-teaching hospitals.⁹ Moreover, even within teaching hospitals, doctors acknowledge a greater inclination to use their public patients, as opposed to their privately insured patients, as "teaching material."¹⁰ Finally, Wilson cites studies showing that patients in teaching facilities do not necessarily know that these facilities are used in part for training purposes.¹¹ Indeed, given the extent to which teaching hospitals increasingly are affiliated with hospitals that do not indicate their medical school affiliation in their name, it seems quite plausible that patients would have little reason to suspect that they were obtaining care from a facility used to train doctors.¹² Wilson uses this information to argue against the proposition that patients who obtain care at teaching hospitals implicitly consent to being involved in the process of training physicians.

II. CONCLUSION

Even the most committed advocates of informed consent as a fundamental right will find that this symposium raises deeply troubling questions about the limited reach of consent as a solution to the problems relating to the treatment of the vulnerable in our health care system. The use of patients as "teaching material" happens disproportionately in teaching hospitals. As such, this practice disproportionately affects poor people, people of color and, given the specific protocols common to training physicians to perform pelvic examinations, women. The "consent" solution merely enlists the relatively disenfranchised as volunteers in the service of the greater good of training new doctors.

As such, this symposium demonstrates that the norm in favor of autonomy is both vital and limited. These papers help move us toward a more universal

9. *Id.* at 248-49.

10. *Id.* at 248.

11. *Id.* at 249-56.

12. *Id.*

consensus that consent must be obtained, even as they push us to think carefully about the precise scope of that right. Moreover, they teach us about the inherent inability of “consent” to redress harms that grow out of the deeply-entrenched problems of inequality and subordination.