Justice Blackmun and the Good Physician: Patients, Populations, and the Paradox of Medicine

by ANN ALPERS*

In dedicating the seminal textbook *American Health Law* to Justice Blackmun, the editors wrote that the Justice's "deep understanding of the world of medical practice and his empathy for both physicians and patients are a source of inspiration" to all who struggle for justice in health care.[1] As a result, they noted, he successfully and eloquently advocated for patients' rights while simultaneously supporting reasonable autonomy for physicians. Ultimately, Justice Blackmun's affinity for physicians and medical practice and his ability to weave together the often disparate worlds of law and medicine in his opinions are vital to his unique contributions to health law.

I begin this exploration of the Justice's medical jurisprudence by examining the "world of medical practice" that the Justice observed so keenly. Next, I discuss two separate themes that run through his opinions: his rich and sophisticated vision of the doctor-patient relationship and his thorough understanding of empirical data and quantitative methods. Reflection on these two elements of his jurisprudence leads me to conclude that he understood the medical practice both in its most intimate moments—patients' private encounters with their health-care providers—and in its most public mission—to ensure, through epidemiology and scientific innovation, the overall health of the general population. In light of the legacy of the Justice's opinions, I cannot resist speculating about how he would answer the most pressing problem which besets today's physicians: in a world of limited health care dollars, how can doctors reconcile their obligations

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1. AMERICAN HEALTH LAW xxxiv (George J. Annas et al. eds., 1990).

to serve their individual patient's best interests with their obligations to conserve resources so as to promote the health of large populations?

The Dream of Scientific Domination

What world of medical practice had Justice Blackmun observed so astutely and understood so well? Medicine changed dramatically during Justice Blackmun's life. The first era of medicine, during which he was born, was prescientific. It could offer little diagnosis, some degree of comfort, and, through careful attention to the spiritual needs of the ill, some shrewd ways of keeping hope alive in the face of inevitable death. During this long era of human history (an era which has yet to end in some underdeveloped areas of the world), the ideal of the physician's exclusive devotion to the welfare of the patient took shape. It was a paradigm nurtured in the West by the Hippocratic tradition, and with it came the moral requirements of sensitivity and compassion.[2]

The second era of medicine has been dominated by faith in science and medical progress. The pace of medical discovery and clinical application has leapt forward from the great discoveries of Claude Bernard (body as an integrated whole),[3] Pasteur (germ theory of disease),[4] Edwin Chadwick (the English sanitation movement)[5], Marie Curie (theory of radioactivity)[6], and Margaret Sanger (safe and effective birth control)[7] to the post-World War II expectation of unlimited medical advances that promise to save and extend life.[8] With medicine's amazing progress after the inauguration of the antibiotic era, physicians moved to a disease-centered concept of the patient. Medicine became "the physiology and pathophysiology, the immunology and microbiology, the genetics and neuroscience, that deliver a fact-like, quantifiable picture of order and disorder within the body."[9] The new technical ability to understand and study cells and organ sys-

2. *See* DANIEL CALLAHAN, FALSE HOPES: WHY AMERICA'S QUEST FOR PERFECT HEALTH IS A RECIPE FOR FAILURE 27 (1998).

3. *See id.* at 28.

4. *See id.*

5. *See id.*

6. *See generally* SUSAN QUINN, MARIE CURIE: A LIFE (1996).

7. *See generally* ELLEN CHESLER, WOMAN OF VALOR: MARGARET SANGER AND THE BIRTH CONTROL MOVEMENT IN AMERICA (Anchor Books, 1993).

8. *See* CALLAHAN, *supra* note 2, at 28.

9. ALBERT R. JONSEN, THE NEW MEDICINE AND THE OLD ETHICS 25 (1990).

tems relegated the psychological and spiritual needs of individuals to the periphery.

What was the result of promoting a biomedical model of patient care over a more holistic one? On a public level, this approach has created what Victor Fuchs calls "the technological imperative," a strong preference for aggressive medical interventions to combat disease.[10] Indeed, from the mid 1970s to the present, medical and health policy literature have noted the deeply interventionist bent of American medicine.[11] In comparison to other countries (including neighboring Canada), the United States generally records high rates of surgery, diagnostic tests, and other procedures. From the perspective of the individual patient, this medical activism has led to impersonal treatment that can be overly burdensome and "unwittingly cruel."[12] Indeed, public fears about facing "death in a technologic cocoon"[13] or becoming "prisoners of technology"[14] have fueled the movement to legalize physician-assisted suicide.[15]

How did Justice Blackmun, born before the antibiotic era and a witness to the explosion of scientific medicine into a biotechnical empire, see the relationship between physicians and patients? For him, the doctor-patient relationship was the foundation of medical care.[16] Thus, he understood the importance of balancing the relationships between doctors, patients, and, ultimately, the state.[17] One of the Justice's most important legal contributions to the Court's application of this balance was his unwavering commitment to patients' medical and

10. VICTOR R. FUCHS, WHO SHALL LIVE? HEALTH, ECONOMICS, AND SOCIAL CHOICE 60 (1974).

11. *See* COMMITTEE ON CARE AT THE END OF LIFE, INSTITUTE OF MEDICINE, APPROACHING DEATH: IMPROVING CARE AT THE END OF LIFE 47 (Marilyn J. Field & Christine K. Cassel eds., 1997).

12. Daniel Callahan, *Frustrated Mastery: The Cultural Context of Death in America*, 163 W.J. MED. 226, 228 (1995).

13. *Id.*

14. Marcia Angell, *Prisoners of Technology: The Case of Nancy Cruzan*, 322 NEW ENG. J. MED. 1226, 1228 (1990).

15. *See generally* George J. Annas, *The Right to Die in America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian*, 34 DUQ. L. REV. 875 (1996).

16. Leading medical ethics commentators agree with the Justice's assessment. For example, the physician/philosopher Howard Brody has argued that the central ethical issues in primary care medicine involve the patient-physician relationship. *See* HOWARD BRODY, THE HEALER'S POWER 55-59 (1992).

17. *See generally* Larry Gostin, *Guest Editor's Introduction*, 13 AM. J.L. & MED. 153 (1987); Harold Hongju Koh, *Rebalancing The Medical Triad: Justice Blackmun's Contributions to Law and Medicine*, 13 AM. J.L. & MED. 315 (1987).

personal privacy.[18] Also vital were his respect for the non-physicians who provide professional health care, commitment to an honest exchange of information, and, above all, a complete sense of the patient as a whole person rather than as an organ system troubled by disease.[19] This deep appreciation of the subtle aspects of the doctor-patient relationship placed him in the forefront of the debate over medical ethics. This accomplishment is all the more remarkable given that even those who supported his commitment to patients' freedom of choice and to women's emancipation criticized as naïve or misplaced the Justice's emphasis on physician autonomy and medical authority.[20]

Respecting Patients by Respecting Confidentiality

In *Ohio v. Akron Center for Reproductive Health*,[21] Justice Blackmun criticized an Ohio abortion law's onerous parental-notification and judicial-bypass provisions. The Justice particularly objected to the statute's requirement that physicians personally give notice to the minor patient's parents that she was pregnant and seeking an abortion.[22] In his opinion, the Justice argued that the State had failed to explain how requiring physicians to violate doctor-patient confidentiality would advance minors' health interests.[23] Even if such a disclosure were proper, he wrote, the State had failed to explain why parents could not be notified by counselors, nurses, or other health professionals.[24] Justice Blackmun proceeded to remark that the notification provision also harmed the interests of doctors by interfering with their "experienced professional judgment."[25] Blackmun wrote:

> If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment, and he should be permitted to exercise that judgment as to whether he or another professional should be the person who will notify

18. *See* Webster v. Reproductive Health Servs., 492 U.S. 490, 539 (1989) (Blackmun, J., dissenting); Planned Parenthood v. Casey, 505 U.S. 833, 922 (1992) (Blackmun, J., concurring in part, concurring in the judgment in part, and dissenting in part); Bowers v. Hardwick, 478 U.S. 186 (1986) (Blackmun, J., dissenting).

19. *See* Colautti v. Franklin, 439 U.S. 379, 387-88 (1979).

20. *See, e.g.*, Andrea Asaro, *The Judicial Portrayal of the Physician in Abortion and Sterilization Decisions: The Use and Abuse of Medical Discretion*, 6 HARV. WOMEN'S L.J. 51, 59 (1983); Note, *The Changing Social Vision of Justice Blackmun*, 96 HARV. L. REV. 717, 719-22 (1983); Gostin, *supra* note 17, at 154; Koh, *supra* note 17, at 318-20.

21. 497 U.S. 502 (1990).

22. *See id.* at 539 (Blackmun, J., dissenting).

23. *See id.*

24. *Id.*

25. *Id.* at 540.

> a minor's parents of her decision to terminate her pregnancy. I have no doubt that the attending physician, better than the Ohio Legislature, will know when a consultation with the parent is necessary. . . . The strictures of this Ohio law not only unduly burden the minor's right to an abortion, but impinge on the physician's professional discretion in the practice of medicine.[26]

For the Justice, the professional discretion afforded to physicians must include the authority to determine for themselves when the violation of confidentiality is in their minor patients' best interest.

Physicians are ethically obliged to assess an adolescent's capacity to make informed decisions and to ascertain the patient's preferences regarding medical care.[27] In almost all cases, physicians urge pregnant adolescents to discuss their pregnancies with their parents and to obtain parental consent.[28] Thus, whenever possible, disagreements over health care are resolved informally between adolescents, parents, and physicians.[29] Blackmun stressed that the well-being of an adolescent must be the physician's first concern and that parental notification is not in an adolescent's best interest when it places her at psychosocial or physical risk.[30] Justice Blackmun, with his pained awareness of "another world 'out there'"[31] inhabited by "frightened and forlorn"[32] adolescents who "lack[ed] the comfort of loving parental guidance and mature advice,"[33] understood that almost no State interest supported jeopardizing the safety and well-being of a minor. In understanding the importance of giving physicians the discretion to assess the needs and interests of the minor patient, the Justice demonstrated a thorough understanding of adolescent medical practice: in order to

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26. *Id.* (citations omitted).

27. *See* Isabel Traugott & Ann Alpers, *In Their Own Hands: Adolescents' Refusals of Medical Treatment*, 151 ARCHIVES OF PEDIATRIC & ADOLESCENT MED. 922, 924 (1997).

28. ANGELA R. HOLDER, LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE 293 (2d ed. 1985).

29. Traugott & Alpers, *supra* note 27, at 926.

30. *See* ETHICAL ISSUES IN MENTAL HEALTH RESEARCH WITH CHILDREN AND ADOLESCENTS 190-91 (Kimberly Hoagwood et al. eds., 1996). Physicians have objected to other mandatory reporting requirements, such as laws requiring the reporting of domestic violence, by noting that retaliation and violence may follow some reports and that health care professionals need discretion to tailor breaches of patient confidentiality to the specific cases before them. *See* Ariella Hyman et al., *Laws Mandating Reporting of Domestic Violence: Do They Promote Patient Well-being?*, 273 JAMA 1781, 1784-86 (1995).

31. Beal v. Doe, 432 U.S. 438, 463 (1977).

32. Ohio v. Akron Ctr. for Reprod. Health, 497 U.S. 502, 541 (1990).

33. *Id.*

respect adolescents as people, doctors must protect their confidentiality as patients.[34]

Justice Blackmun's respect for the confidentiality rights of adolescents presaged the growing consensus that sound ethical practice requires physicians to make case-by-case decisions about how to protect individual patients. Today, the majority of states give physicians discretion as to whether or not to inform a third party—such as a spouse or needle-sharing partner—that a patient has tested positive for the human immunodeficiency virus ("HIV").[35] In contrast, only a handful of states require a health care provider to inform those whom their patients may expose to HIV.[36]

Comprehensive Care Outside Medicine's Hierarchy

Justice Blackmun, whose affection and support for physicians is unquestioned, quickly recognized a reality physicians themselves have been slow to appreciate: patient-centered care demands a multidisciplinary team of "allied health professionals," including advanced practice nurses, genetics counselors, nurse-midwives, and nurse-practitioners. Hence, the Justice objected in *Planned Parenthood of Southern Pennsylvania v. Casey*[37] to the Commonwealth's requirement that only a doctor could provide mandatory information about the nature and the risks of the abortion procedure and the probable gestational age of the fetus.[38] Though he noted that Pennsylvania's law increased costs to the clinics and their patients, cost was merely one of the Jus-

34. *See* Society for Adolescent Medicine, *Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine*, 21 J. ADOLESCENT HEALTH 408-15 (1997).

35. This discretion to physicians is now under reconsideration since New York State recently amended its reporting requirements to require physicians to report HIV-positive individuals to the public health department for contact tracing. *See* Lynda Richardson, *Wave of Laws Aimed at People with HIV*, N.Y. TIMES, Sept. 25, 1998, at A1. New York plans to treat HIV as it treats other sexually transmitted diseases, like gonorrhea and syphilis. *See id.* The new law has been criticized as insensitive to individual privacy and liberty and particularly unrealistic about the stigma of HIV. *See id.* Justice Blackmun raised precisely these concerns about violations of confidentiality in the context of abortion decisions. *See, e.g., Akron Ctr.*, 497 U.S. at 529-31 (Blackmun, J., dissenting).

36. Lawrence O. Gostin et al., *Legislative Survey of State Confidentiality Laws With Specific Emphasis on HIV and Immunization*, at Table 3 (Final report presented to the Centers for Disease Control and Prevention, the Council of State and Territorial Epidemiologists, and the Task Force for Child Survival and Development, Carter Presidential Center, submitted July 2, 1996) (on file with *Hastings Constitutional Law Quarterly*).

37. 505 U.S. 833 (1992).

38. *Id.* at 935 (Blackmun, J., concurring in part, concurring in the judgment in part, and dissenting in part).

tice's concerns—more important were women's personal interests.[39] "[T]rained women counselors," the Justice observed, "are often more understanding than physicians, and generally have more time to spend with patients."[40]

Several research studies support Justice Blackmun's emphasis on the importance of training to make counseling effective. For instance, the Center for Disease Control's Project RESPECT recently demonstrated that interactive counseling sessions delivered by trained HIV counselors helped reduce the rate of sexually transmitted diseases by up to thirty percent—a result even more effective than achieved by an unadorned HIV/STD educational message delivered by a clinician.[41] Human genetics counseling also provides an apt comparison to abortion counseling because genetic counselors also work in an obstetrics setting (where pregnant women and their partners receive prenatal testing).[42] Often, genetics counselors with neither masters nor doctoral degrees educate patients about a single diagnostic category of disease or assist masters-level counselors in overcoming cultural, linguistic, geographic, or economic barriers.[43] By respecting the contributions of diverse clinicians Justice Blackmun understood that often care-givers from a variety of backgrounds could speak more directly to each patient's individual needs and provide more sensitive care to vulnerable individuals than could doctors.

Critical care and hospice literature have also recognized the importance of multi-disciplinary care in resolving disputes between physicians and families. These sources note that social workers, nurses, clergy members, and psychologists often negotiate more successfully

39. *See id.*

40. *Id.*

41. *See* Mary L. Kamb et al., *Efficacy of Risk-Reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases,* 280 JAMA 1161, 1165 (1998); *see also* M.L. Kamb et al., *Quality Assurance of HIV Prevention Counseling in a Multi-Center Randomized Controlled Trial,* 111 PUBLIC HEALTH REPORTS 99, supp. 1 (1996) (describing the procedural aspects of the study).

42. *See* INSTITUTE OF MEDICINE, ASSESSING GENETIC RISKS: IMPLICATIONS FOR HEALTH AND SOCIAL POLICY 59-86 (Lori B. Andrews et al. eds., 1994) [hereinafter ASSESSING GENETIC RISKS] (describing prenatal diagnosis for "hundreds of conditions" and noting that offering prenatal diagnosis is the standard of care for women aged 35 and older); *see also Professional Liability Implications of AFP Testing,* DPL ALERT, (American College of Obstetricians and Gynecologists), May 1985.

43. *See* ASSESSING GENETIC RISKS, *supra* note 42, at 212-13 (1994) (describing genetic aides programs for individuals who serve as single-gene counselors, hemoglobin trait counselors, sickle-cell educators, genetic counseling aides, genetic educators, and genetic interpreters).

with families than can physicians.[44] The presence of therapists, social workers, nurses, and others has also helped the hospice movement make the spiritual and psychological aspects of dying more familiar to Americans and more available to dying people.[45]

A Vision of Informed Consent: Honesty and Beneficence

No aspect of today's health care environment has raised as much public concern as managed care organizations' restrictions on a physician's power to inform a patient about vital medical decisions. Indeed, this concern has spurred a federally proposed patients' "bill of rights"[46] and similar state attempts to shift the power of medical decision-making back to the doctor and patient. These laws would codify a patient's right to receive information about diagnosis and treatment and to make medical decisions with a physician.[47]

Justice Blackmun's support for the beneficence of physicians[48] and his insistence on unhindered professional judgment have long promoted the importance of doctor-patient shared, private decision-making—the central tenets of informed consent.[49] Perhaps even more vital, however, was the value the Justice placed on simple honesty. Nowhere is this better illustrated than in his dissent from *Rust v. Sullivan*,[50] wherein the majority permitted the Secretary of Health and Human Services to forbid health care providers in a federally funded clinic from informing or counseling pregnant women about abortion:

> The majority . . . [contends] that "the Title X program regulations do not significantly impinge upon the doctor-patient relationship." That the doctor-patient relationship is substantially burdened by a rule prohibiting the dissemination by the physician of pertinent medical information is beyond serious dis-

44. *See* Thomas J. Prendergast, *Resolving Conflicts Surrounding End-of-Life Care*, *in* 5 NEW HORIZONS 62, 70 (1997).

45. *See* MARILYN WEBB, THE GOOD DEATH: THE NEW AMERICAN SEARCH TO RESHAPE THE END OF LIFE 224 (1997) (comparing hospice to home-birth as a non-medical treatment that "feed[s] back" into medicine).

46. Robert Pear, *White House Says Veto of 'Patient Protection' Bill Is Likely*, N.Y. TIMES, July 24, 1998, at A18.

47. *See, e.g.*, Chronicle Sacramento Bureau, *New Protections for Patients: Wilson OKs Bills on Mastectomies, Surgical Repair*, S.F. CHRON., Sept. 25, 1998, at A21.

48. *See* Doe v. Bolton, 410 U.S. 179, 197 (1973) ("The good physician – despite the presence of rascals in the medical profession, as in all others, we trust that most physicians are 'good' – will have sympathy and understanding for the . . . patient . . . .").

49. *See* BERNARD LO, RESOLVING ETHICAL DILEMMAS: A GUIDE FOR CLINICIANS 24-35 (1995).

50. 500 U.S. 173 (1991).

> pute. . . . A woman seeking the services of a Title X clinic has every reason to expect, as do we all, that her physician will not withhold relevant information regarding the very purpose of her visit. To suggest otherwise is to engage in uninformed fantasy.[51]

To the Justice, any intrusion "upon the physician's exercise of proper professional judgment . . . [with] compelled information is the antithesis of informed consent."[52] Thus, requiring a doctor to obtain a hospital committee's approval before conducting an abortion[53] or to give a woman information about fetal development[54] interfered with the ability of a patient to make private and informed decisions about her health.[55] The Justice noted that state-mandated information may serve only to confuse and punish the patient and to heighten her anxiety, contrary to accepted medical practice. "[It] may be out of step with the needs of the particular woman and thus places the physician in an awkward position and infringes upon his or her professional responsibilities . . . [and] the dialogue between the woman and her physician."[56]

Justice Blackmun's insistence on a physician's autonomous ability to tailor informed consent conversations to each patient is particularly relevant in light of what some commentators view as the excesses of managed care organizations. Some managed care contracts restrict doctors from giving patients information about potentially relevant medical interventions not covered under the plan, information about non-plan-approved specialists who might help manage the patient's condition, or information about the economic incentives the plan offers to physicians who perform or order fewer interventions.[57] I suspect that at best Justice Blackmun would be quite suspicious of such contracts, and might very well be appalled. His sentiments in *Bolton*, *Thornburgh* and *Rust* seem to have presaged today's tensions about physician autonomy and a patient's need for information. Justice Blackmun recognized that informed consent requires time, patience, understanding, and trust.

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51. *Id.* at 212 n.3 (Blackmun, J., dissenting) (internal citations omitted).

52. Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 764 (1986) (striking down a Pennsylvania law that required physicians to provide certain information about the abortion procedure to their patients, report certain information to the state, try to preserve the life of the fetus, and have a second physician present during an abortion performed when the fetus might be viable).

53. *See Bolton*, 410 U.S. at 197-98.

54. *See Thornburgh*, 476 U.S. at 762-73.

55. *See* Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416, 444 (1983).

56. *Thornburgh*, 476 U.S. at 762.

57. *See* Ruth Faden, *Managed Care and Informed Consent*, 7 KENNEDY INST. ETHICS J. 377, 377-78 (1997).

To the Justice, informed consent was more than an abstract ethical ideal to uphold or a bald legal duty to discharge. Rather, it was a chance to build patient-doctor trust and foster an environment conducive to intensely personal decisions: ultimately, informed consent was vital to safeguarding patients' constitutionally protected liberty interests.[58]

The Patient as Whole Person

From *Roe v. Wade*[59] until *Thornburgh v. American College of Obstetricians*,[60] Justice Blackmun's Supreme Court abortion opinions stressed the value of the professional autonomy of physicians. By leaving the state "free to place increasing restrictions on abortion as the period of pregnancy lengthens," *Roe* sought to "vindicat[e] 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."[61] Some have thus criticized *Roe's* interest-balancing analysis for protecting the individual right of the doctor and not the patient.[62] The Justice responded in *Thornburgh* by making clear that the Constitution protected the pregnant woman's private sphere of liberty. "Few decisions, " he wrote, "are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman's decision . . . whether to end her pregnancy."[63] Blackmun's subsequent opinions,

58. *See* Zinermon v. Burch, 494 U.S. 113, 131 (1990) (holding that an individual who was not competent to give informed consent, and was consequently involuntarily committed to a mental institution for five months, has a justiciable claim).

59. 410 U.S. 171 (1973) (holding that a woman's right, in consultation with her physician, to choose an abortion is absolute in the first trimester of pregnancy, qualified by the state's interest in protecting the fetus in the second trimester, and subject to state prohibition in the third).

60. *See supra* note 52 and accompanying text.

61. *Roe*, 410 U.S. at 165-66. *See also id.* at 166 ("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.").

62. *See, e.g.*, Laurence H. Tribe, *The Abortion Funding Conundrum: Inalienable Rights, Affirmative Duties, and the Dilemma of Dependence*, 99 HARV. L. REV. 330, 335 (1985) ("[T]he Supreme Court in *Roe v. Wade* spoke as though it were protecting the 'privacy' rights of both the woman and her physician, and indeed at times as though the physician's rights were somehow primary . . . ."); Andrea Asaro, *The Judicial Portrayal of the Physician in Abortion and Sterilization Decisions: The Use and Abuse of Medical Discretion*, 6 HARV. WOMEN'S L.J. 51, 59 (1983) ("Blackmun's abortion opinions are as much vindications of the right of the physician to practice medicine as they are feminist 'pro-choice' victories—if not more so.").

63. *Thornburgh*, 476 U.S. at 772.

including his dissent in *Webster v. Reproductive Health Services*,[64] have also stressed that it is the right of the patient, regardless of age[65] or marital status,[66] to make intimate personal decisions without state coercion. The "quintessentially intimate, personal, and life-directing,"[67] decision to have an abortion, the Justice wrote, is within that "'certain private sphere of individual liberty' that the Constitution reserves from the intrusive reach of government."[68]

Though Justice Blackmun's later abortion decisions abandoned the emphasis on the physician's professional discretion and focused instead on the woman's privacy and autonomy, the rationale of his initial 1970s and 1980s approach warrants some comment. In *Colautti v. Franklin*,[69] Blackmun examined the constitutional significance of the physician's professional autonomy and stressed the "importance of affording the physician adequate discretion in the exercise of his medical judgment."[70] He noted that whether the procedure was medically appropriate would depend on a doctor's clinical judgment in light of all factors relevant to the well-being of the pregnant woman: physical, emotional, and psychological states, her family situation, and her age.[71]

Colautti's assertion that a patient's emotional and psychological health and her relationship with her family were factors in determining her medical well-being was remarkable, particularly as the decision was written in 1979. The 1970s, after all, marked the peak of the biomedical, cell and organ-centered model of patient care.[72] With increasingly accurate methods for diagnosing and curing disease, the physician's quest to control illness often failed to take the patient into account. Beneficial as these technologies can be, illness runs a capricious course. As the NIH and medical education continued to emphasize the science of medicine and the use of technological interventions to cure illness, physicians lost sight of the results of curing infectious

64. 492 U.S. 490, 537 (1989) (Blackmun, J., dissenting).

65. *See* Ohio v. Akron Ctr. for Reprod. Health, 497 U.S. 502, 524-26 (1990) (Blackmun, J., dissenting).

66. Writing for the Court in *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52 (1976), Blackmun struck down various Missouri statutory provisions restricting an individual woman's access to abortion, specifically those requiring spousal consent or parental consent for a minor. *See id.* at 67-75.

67. *Webster*, 492 U.S. at 538 (Blackmun, J., concurring).

68. *Id.* at 548.

69. 439 U.S. 379 (1979).

70. *Id.* at 387.

71. *See id.* at 387-88 (quoting Doe v. Bolton, 410 U.S. 179, 192 (1973) (Blackmun, J.).

72. *See* CALLAHAN, *supra* note 2, at 27-29.

diseases. Thus, we are burdened by chronic diseases and disabilities and smart, scientific medicine has not developed a plan for caring for the chronically sick and elderly. Not only has our science failed to improve the health of the public, but it has also concentrated medical attention on patients' diseases and obscured the meaning of illness in their individual lives. In his opinion in *Colautti*, Justice Blackmun saw beyond this limited biomedical understanding of illness.

Only recently have medical schools and residency training programs in the United States begun to move away from the biomedical model, and to migrate, through an emphasis on primary care, to a more complete view of the patient. Spurred by reports that our country is producing too many specialists and too few primary care physicians and by increased attention to cost containment and cost effectiveness, medical schools and residency programs have begun training more physicians to practice primary care. Primary care practitioners "stress preventive medicine and concern for mental and emotional problems as well as physical ones."[73] "Teachers of primary care . . . assert that their practice requires a biopsychosocial model . . . rather than the more traditional biomedical [one] . . . ."[74] In other words, they instruct physicians to assess well-being from the multifactored perspective that Justice Blackmun set out in the mid-1970s.

Research from the University of Western Ontario has demonstrated that the kind of patient-centered care Justice Blackmun envisioned actually produces better health outcomes.[75] For instance, one study found that the accuracy of a physician's diagnosis and the sophistication of the ensuing treatment did not reliably predict whether the patient felt better.[76] Rather, a better predictor was the "patient's own perception that the physician had listened carefully to the explanation of the problem and had agreed with [him or her] about the nature of the problem . . . ."[77]

73. HOWARD BRODY, THE HEALER'S POWER 57 (1992).

74. *Id.*

75. *See id.* at 58.

76. *See id.* at 59.

77. *Id.* at 58-59 (summarizing the theoretical, therapeutic, and pedagogical approaches to research on primary care at the University of Western Ontario and citing J.H. Levenstein et al., *The Patient-Centered Clinical Method. Part 1. A Model for the Doctor-Patient Interaction in Family Medicine*, 3 FAMILY PRACTICE 24 (1986)).

Formation of Justice Blackmun's Views about Patient-Centered Care

I have suggested above that the Justice's respect for the confidentiality of patient's medical information, his generous assessment of the roles of allied health professionals, his nuanced approach to informed consent, and his holistic view of patients all demonstrate an unusually progressive and sensitive understanding of the doctor-patient relationship. Though it is impossible to be certain about how he came to lead American medical philosophy, I cannot resist the urge to speculate. The Justice himself might have attributed his understanding of medical practice to the happy decade he spent as general counsel to the Mayo Clinics and Association.[78] It is also possible that the Justice's appreciation for the patient as a whole person reflects his appreciation for the plight of vulnerable individuals outside the social safety net.[79] Finally, the fact that many of the cases he faced concerned the care of pregnant women probably gave him insight into both the multidisciplinary nature of clinical practice and the need to treat the patient as a complete person; indeed, because pregnancy is generally not a dangerous condition, the harms of an unwanted pregnancy might be considered social rather than medical. By insisting that damage to emotional and psychological well-being was nonetheless a medical problem, the Justice came to see medicine as a therapeutic relationship between individuals rather than as a pure scientific endeavor.

It might also help to understand that Justice Blackmun was fascinated by Hippocrates, whom he described as the "great Greek, . . . the Father of Medicine, the 'wisest and the greatest practitioner of his art,' and the 'most important and most complete medical personality of antiquity,' who dominated the medical schools of his time, and who typified the sum of the medical knowledge of the past."[80] It is, of course, not uncommon to trace medical ethics to Hippocrates, as his disciples left a large body of both scientific literature and a small collection of moral maxims. Though the former is now forgotten, the

78. Justice Blackmun was the first resident counsel to the Mayos from 1950 to 1959, years that he calls "the happiest . . . of my professional experience," *Blackmun Remarks*, 15 L. MED. & HEALTH CARE 175-88 (1987), a "decade of close and intimate association . . . with people of medicine, with the medical mind and medical ways, and with medical education and research . . . ." Harry A. Blackmun, *Remarks at the Commencement Exercises of Mayo Medical School*, 55 MAYO CLINIC PROC. 573, 573 (1980).

79. *See* Pamela S. Karlan, *Bringing Compassion into the Province of Judging: Justice Blackmun and the Outsiders*, 97 DICK. L. REV. 527 (1993).

80. Roe v. Wade, 410 U.S. 113, 130-31 (1973) (citing A. CASTIGLIONI, A HISTORY OF MEDICINE 84 (E. Krumbhaar trans. and ed., 2d ed. 1947)).

latter live on as the collective conscience of medicine. For example, Charles Fried's conditions for an ethically sound doctor-patient relationship included the Hippocratic elements of fidelity—an obligation to act as a trustworthy fiduciary—and humanity—the obligation to treat patients with sensitivity and compassion.[81] I think Justice Blackmun would have shared Hippocrates' and Fried's sense that the physician must remember the patient's vulnerability and discern when fear, depression, or other consequences of illness might rob the individual of his or her usual sense of self. The Justice who saw "another world 'out there'"[82] recognized that a medical clinic, like "an unfamiliar and mystifying court system" could be a harsh forum in which to address "intensely intimate matter[s]."[83] Justice Blackmun's views regarding the doctor-patient relationship, respect for other health care providers, and holistic patient care to this day help both to protect vulnerable patients and to promote fidelity and humanity.[84] This approach does not confuse the patient's disease with the patient. To use a metaphor which geography-buff Blackmun might have appreciated, it does not mistake the map for the territory.

Empirical Jurisprudence and Evidence-Based Medicine

Justice Blackmun's advocacy of patient-centered care only partially reflects his understanding of current issues in medical practice. We should also note that Justice Blackmun's familiarity with medical science, coupled with his mathematics training and extended exposure to the "exacting quantitative nature" of tax law,[85] made him unusually "well-versed in the scientific method."[86] Drawing upon this back-

81. *See* Brody, *supra* note 73, at 44-45.

82. Beal v. Doe, 432 U.S. 438, 463 (1977) (Blackmun, J., dissenting).

83. Ohio v. Akron Ctr. for Reprod. Health, 497 U.S. 502, 527 (1990) (Blackmun, J., dissenting).

84. I note, as well, that fidelity and humanity not only appear as essential virtues for Justice Blackmun's conception of the good physician, but they serve as lodestars for his own compassionate jurisprudence. *See, e.g.,* Karlan, *supra* note 79.

85. Justice Blackmun practiced at the Dorsey firm, the preeminent Minneapolis law partnership, where he specialized in the characteristically precise fields of taxation, civil litigation, and trusts and estates. *See* Michael Pollett, *Harry A. Blackmun*, in 5 THE JUSTICES OF THE UNITED STATES SUPREME COURT 3, 5 (L. Friedman & F. Israel eds., 1978).

86. *See* Steven R. Schlesinger & Janet Nesse, *Justice Harry Blackmun and Empirical Jurisprudence*, 29 AM. U.L. REV. 405, 406 & n.3 (1980); Paul S. Appelbaum, *The Empirical Jurisprudence of the United States Supreme Court*, 13 AM. J.L. & MED. 335, 341-45 (1987) (discussing McCleskey v. Kemp, 107 S. Ct. 1756 (1987); Barefoot v. Estelle, 463 U.S. 880 (1983)). I am indebted to Dr. Appelbaum, whose analysis of Justice Blackmun's dissents in Barefoot and McCleskey I have adopted here. *See* Appelbaum, *supra* note 86, at 340-41, 344-45.

ground, the Justice used empirical data and statistical analysis to add precision to the Court's reasoning and to "assist the court in reaching fair adjudicative results."[87]

In *Barefoot v. Estelle*,[88] the Court upheld the death penalty sentence based partially on two psychiatrists' predictions that the defendant was likely to commit violent crime again. In reaching this decision, the majority ignored the conclusions of an American Psychiatric Association amicus brief emphasizing the unreliability of long-term psychiatric predictions of dangerousness.[89] Indeed, most studies of psychiatrists' predictions of patients' future violent behavior have found that only one out of five or six such opinions turned out to be accurate.[90] The best results—obtained in an idiosyncratic study with a population of sex offenders—found accurate only one out of three predictions.[91]

Justice Blackmun's dissent cited much of this empirical literature in noting that "the unanimous conclusion of professionals in this field [is] that psychiatric predictions of long-term future violence are wrong more often than they are right . . . ."[92] It is therefore "difficult to understand how the admission of such predictions can be justified as advancing the search for truth . . . ."[93] He also noted correctly that correlative conclusions are of limited utility in predicting the outcome of an individual.[94] With these factors in mind, the Justice concluded that "[t]here is every reason to believe that inexperienced jurors will be still less capable of 'separating the wheat from the chaff', despite the Court's blithe assumption to the contrary."[95]

Justice Blackmun demonstrated a similar appreciation of statistical evidence in *McCleskey v. Kemp*.[96] In *McCleskey,* the plaintiff challenged the constitutionality of Georgia's capital sentencing process in light of two statistical studies[97] which demonstrated that race

87. Schlesinger & Nesse, *supra* note 86, at 406.

88. 463 U.S. 880 (1983).

89. *See id.* at 898-99.

90. *See* Appelbaum, *supra* note 86, at 338 (citing J. MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR (1981)).

91. *See id.*

92. Barefoot, 463 U.S. at 921 (Blackmun, J., dissenting).

93. *Id.* at 928.

94. *See id.* at 922.

95. *Id.* at 929-30.

96. 481 U.S. 279 (1987).

97. McCleskey relied on two studies performed by Professor David C. Baldus and colleagues, including a massive effort that examined sentencing practices in a sample drawn from over 2,400 Georgia murder cases from 1973 to 1980. *See* Appelbaum, *supra* note 86, at 341.

substantially affected the imposition of the death penalty. Specifically, the studies showed that defendants charged with killing Whites were 4.3 times more likely to receive the death penalty than those charged with killing African-Americans.[98] The Court, however, dismissed this data, holding that it did not demonstrate a constitutionally significant risk of racial bias.[99] The Court held that the risk could be minimized by various procedural mechanisms, including prescribed aggravating and mitigating factors and mandatory review by the Georgia Supreme Court.[100]

In his *McCleskey* dissent, Blackmun rejected the notion that the Court could simultaneously accept the validity of the statistical data and discredit its conclusions. "McCleskey," the Justice wrote, "has demonstrated a clear pattern of differential treatment according to race that is 'unexplainable on grounds other than race.'"[101] The Justice also noted the Court's failure to distinguish the use of these statistics in *McCleskey* from prior cases in which the Court had accepted statistical analyses as proof of discriminatory intent.[102] "The number of variables to be taken into account does not appear to differ, and even if the number of decision-making bodies varies, it does not do so in any way that affects the statistical analysis."[103]

Justice Blackmun and the Paradox of Medicine

How did Justice Blackmun's vision of the doctor-patient relationship and his sophisticated understanding of statistics combine to inform health policy? Statistical information tells us that, as a society, we have not achieved the overall good health that should be our goal.[104] Evidence-based medicine suggests that some interventions will be only marginally beneficial to many patients.[105] Yet we must also remember that each patient is an individual; as Justice Blackmun understood, a patient with a 10 percent chance of survival ultimately

98. *See id.* at 342.

99. *See McCleskey*, 481 U.S. at 313.

100. *See id.* at 302-03, 313.

101. *Id.* at 361 (Blackmun, J., dissenting) (citing Arlington Heights v. Metropolitan Hous. Dev. Corp., 429 U.S. 252, 266 (1977)).

102. *See id.* at 293-94 (citing Castaneda v. Partida, 430 U.S. 482 (1977), Turner v. Fouche, 396 U.S. 346 (1970), and Whitus v. Georgia, 385 U.S. 545 (1967) as examples).

103. *See* Appelbaum, *supra* note 86, at 345.

104. *See* CALLAHAN, *supra* note 2, at 59-72 (assessing the lack of overall health in terms of mortality statistics, infectious disease, chronic disease, aging, genetics, and molecular medicine).

105. Consider the painful and contentious debate over the utility of routine screening for breast cancer in women under 50.

can fall either in the 90 percent or the 10 percent category.[106] Every patient is, as Albert Jonsen describes, a "statistic of one."[107] This phenomenon creates an inevitable tension between the need to practice prudent medicine and the urge not to skimp on ensuring the best possible outcome for an individual patient.

Two leading medical economists described this tension as "the paradox of excess and deprivation."[108] Medical culture, ethics, and malpractice law demand that physicians provide patients with any medically beneficial test or treatment that the patient wants and can afford. At the same time, the number of uninsured Americans now reaches 41 million;[109] what we like to call "the best health care system in the world" continues to deny care to more people than any other industrialized nation on earth.[110]

Though Justice Blackmun appreciated the importance of each individual patient, he would also recognize that society cannot continue to pour money into what Richard Lamm, the former governor of Colorado, calls "marginal medicine."[111] In a world of limited resources, society cannot simultaneously maximize the health of the individual and the health of the group.[112] When physicians define good health care as all possibly beneficial and reimbursable treatments going to each individual, marginally beneficial medicine flourishes. As Victor Fuchs observed, "'the divergence between what is beneficial for the individual and what is beneficial to . . . society as a whole is the key element in the . . . health care debate.'"[113] Justice Blackmun would understand the physician's individual commitment to delivering health care to patients and medicine's general obligation to promote the health of populations. Yet the Justice would not forget those who live

106. In fact, the Justice made this point in *Barefoot* when he noted the limited utility of some statistical variables in an individual case. *See* Barefoot v. Estelle, 463 U.S. 880, 929-30 (1982) (Blackmun, J., dissenting).

107. JONSEN, *supra* note 9, at 115.

108. Alain Enthoven & Richard Kronick, *Universal Health Insurance Through Incentives Reform*, 265 JAMA 2532, 2532-36 (1991).

109. *See* John C. Goodman, *D'Amato Care*, WALL ST. J., Dec. 5, 1997, at A18.

110. *See* Richard D. Lamm, *Marginal Medicine*, 280 JAMA 931, 933 (1998).

111. *Id.*

112. Professor Haavi Morreim calls this dilemma "contributive justice." E. Haavi Morreim, *Moral Justice and Legal Justice in Managed Care: The Ascent of Contributive Justice*, 23 J.L. MED. & ETHICS 247, 247 (1995). If one physician makes irrational or marginal use of a common pool of money, that prevents another physician from meeting a higher need. *See id.*

113. Lamm, *supra* note 110, at 993 (quoting Victor Fuchs, *Poverty and Health* (Feb. 27, 1992) (paper presented at Cornell University Medical College Health Policy Conference, Ithaca, New York)).

outside the protection of society and its health care system: women,[114] people of color,[115] the poor,[116] children,[117] and the elderly.[118] In evaluating health policy, as in evaluating scientific evidence, he would ultimately not seek an "exhaustive search for cosmic understanding" but a "particularized resolution."[119]

In his parting words to his colleagues on the Supreme Court, Justice Blackmun expressed hope that "when history eventually places us in such perspective as we deserve, it at least will be able to say: 'They did their best and did acceptably well.'"[120] I think he would say that the best we can provide for everyone will suffice as acceptable for each individual. In his same remarks upon leaving the Court, he noted the importance of acknowledging when a task is "common, not . . . individual."[121] Medicine is about more than disease and health care—it is about health and well-being in the face of human frailty. To see only disease would contradict the Justice's emphasis on the whole patient, the complete person. Every individual cannot have all the health care he wants, or even all the health care he needs. However, medicine can direct its attention to the demands of an aging society and one in which 20% of children live in poverty.[122] I think Justice Blackmun would have said, "We can do better. We might even do acceptably well."

114. *See, e.g.*, Roe v. Wade, 410 U.S. 113 (1973).

115. *See, e.g.*, Regents of the Univ. of Cal. v. Bakke, 438 U.S. 265, 407 (1978) (Blackmun, J., concurring).

116. *See, e.g.*, Beal v. Doe, 432 U.S. 438, 462 (1977) (Blackmun, J., dissenting).

117. *See, e.g.*, DeShaney v. Winnebago County Dep't of Soc. Serv., 489 U.S. 189, 212 (1989) (Blackmun, J., dissenting).

118. *See, e.g.*, Gregory v. Ashcroft 501 U.S. 452, 486 (1991) (Blackmun, J., dissenting).

119. Daubert v. Merrel Dow Pharm., 509 U.S. 579, 597 (1993).

120. Retirement of Justice Blackmun, 512 U.S. viii, ix (1994) (response letter of Blackmun, J.).

121. *Id.*

122. Combined News Services, *Poverty Rates Drop as Incomes Rise*, NEWSDAY, Sept. 25, 1998, at A20.