

THE JOURNAL OF LAW, MEDICINE & ETHICS

Volume 49:4 • Winter 2021

A Journal of the American Society of Law, Medicine & Ethics • www.aslme.org



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Rethinking the Principle of Justice for Marginalized Populations During COVID-19
Henry Ashworth, Derek Soled, and Michelle Morse

ISSN: 1073-1105

 CAMBRIDGE
UNIVERSITY PRESS

The Journal of Law, Medicine & Ethics (JLME): Material published in *The Journal of Law, Medicine & Ethics* (JLME) contributes to the educational mission of the American Society of Law, Medicine & Ethics (ASLME), covering public health, health disparities, patient safety and quality of care, and biomedical science and research, and more.

The Journal of Law, Medicine & Ethics is published by Cambridge University Press on behalf of the American Society of Law, Medicine & Ethics.

ISSN: 1073-1105

E-ISSN: 1748-720X

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Printed in the USA by The Sheridan Group

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Letters to the Editors: Comments on articles in the Journal should be addressed to the Editor at the editorial office or emailed to thutchinson@aslme.org

Submission Guidelines: For submission guidelines, please contact the editorial office at thutchinson@aslme.org or go to cambridge.org/jlme/submit

Supplements: Initial inquiries should be directed to the Editor at the editorial office or emailed to thutchinson@aslme.org

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C O N T E N T S

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Symposium Articles

**First
Amendment
Values in
Health Care**

Guest Edited by
Sonia M. Suter

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*Letter from
the Editor*

*Cover image courtesy of
the Metropolitan Museum
of Art, New York, Public
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**514
Reproductive Technologies and
Free Speech**

Sonia M. Suter

The Supreme Court and lower courts have not articulated a clear or consistent framework for First Amendment analysis of speech restrictions in health care and with respect to abortion. After offering a coherent doctrine for analysis of speech restrictions in the doctor-patient relationship, this piece demonstrates how potential legislation restricting patient access to information from reproductive testing intended to limit “undesirable” reproductive choices would violate the First Amendment.

**531
Assuming Access to Professional
Advice**

Claudia E. Haupt

Access to reliable health advice can make the difference between life and death. But good advice is hard to come by. Within the confines of the professional-client or doctor-patient relationship, the First Amendment operates in a way that protects good and sanctions bad advice. Outside of this relationship, however, the traditional protections of the First Amendment prohibit content- and viewpoint discrimination. Good and bad advice are treated as equal. A core assumption of First Amendment theory is the autonomy of speakers and listeners. Another assumption, as this Article demonstrates in the health context, is the availability of access to professional advice. This assumption, however, is erroneous because access to health advice in fact is unevenly distributed.

This Article argues that assuming access to professional advice creates indefensible inequality. Lack of access to expert advice puts some listeners at much higher risk than others. Current First Amendment doctrine is largely unproblematic for those who can afford expert advice and makes expert advice much costlier where health provider access is needed to obtain good advice. Those who lack access must place a higher degree of trust in widely-available information because they have no more reliable alternative. In other words, First Amendment doctrine places a higher burden on those who can least afford expert advice and who are most dependent on experts in public discourse.

**542
Disestablishing Hospitals**

Elizabeth Sepper and James D. Nelson

We argue that concentration of power in religious hospitals threatens disestablishment values. When hospitals deny care for religious reasons, they dominate patients’ bodies and convictions. Health law should — and to some extent already does — constrain such religious domination.

**552
Vaccines Mandates and Religion:
Where are We Headed with the Current
Supreme Court?**

Dorit R. Reiss

This article argues that the Supreme Court should not require a religious exemption from vaccine mandates. For children, who cannot yet make autonomous religious decision, religious exemptions would allow parents to make a choice that puts the child at risk and makes the shared environment of the school unsafe — risking other people’s children. For adults, there are still good reasons not to require a religious exemption, since vaccines mandates are adopted for public health reasons, not to target religion, are an area where free riding is a real risk, no religion actually prohibits vaccinating under a mandate, and policing religious exemptions is very difficult.

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From the Shadows: The Public Health
Implications of the Supreme Court’s
COVID-Free Exercise Cases**

Wendy E. Parmet

This article analyzes the Supreme Court’s “shadow docket” Free Exercise cases relating to COVID-19. The paper highlights the decline of deference, the impact of exemptions, and the implications of the new doctrine for vaccine and other public health laws.

Independent Articles

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The Dizziness of Freedom: Understanding and Responding to Vaccine Anxieties

David I. Benbow

The rise in vaccine hesitancy in high-income countries has led some to recommend that certain vaccinations be made compulsory in states where they are currently voluntary. In contrast, I contend that legal coercion is generally inappropriate to address the complex social and psychological phenomenon of vaccine anxieties. I note that historical experience of mandatory vaccination in the United Kingdom (UK) indicates that coercion may exacerbate such anxieties. I utilize a psycho-social dialectic methodology that the Frankfurt School philosopher, Theodor Adorno, employed within his research into anti-Semitism, to examine the social conditions which have influenced vaccine anxieties. I identify many of the same psychological tricks that Adorno detected within anti-Semitic discourse within anti-vaccination discourse. I contend that education is a preferable policy response than compulsion, but note that education concerning the facts about vaccines may backfire by entrenching vaccine anxieties. I argue that educating people about the psychological reasons why they may invest in anti-vaccination discourse may alleviate such anxieties.

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Curbside Consults in Clinical Medicine: Empirical and Liability Challenges

Rachel L. Zacharias, Eric A. Feldman, Steven Joffe, and Holly Fernandez Lynch

In most U.S. jurisdictions, clinicians providing informal “curbside” consults are protected from medical malpractice liability due to the absence of a doctor-patient relationship. A recent Minnesota Supreme Court case, *Warren v. Dinter*, offers the opportunity to reassess whether the majority rule is truly serving the best interests of patients. Precluding liability for informal consults may encourage clinicians to be willing to offer them, which in turn may benefit patients through efficient and free access to specialist advice. But this approach may also lead to patient harm if informal consults are provided without due care. Given the lack of evidence that the benefits of informal consults outweigh their risks, we offer two recommendations. First, informal consultants should not currently be granted special legal protections against medical malpractice liability, but rather should be held accountable when their advice foreseeably causes patient harm. Second, empirical research into both the benefits and drawbacks of informal consults, as well as the benefits and drawbacks of different approaches to liability, should be given high priority. The evidence generated from this research should then be used to guide policymakers in crafting the ideal legal response to informal consults going forward.

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Rethinking the Principle of Justice for Marginalized Populations During COVID-19

Henry Ashworth, Derek Soled, and Michelle Morse

In the face of limited resources during the COVID-19 pandemic response, public health experts and ethicists have sought to apply guiding principles in determining how those resources, including vaccines, should be allocated. The application of such principles, however, has further marginalized historically oppressed communities and perpetuated White normative biases. This paper explores the core tenet of justice in medical ethics and proposes an applicative justice framework that prioritizes equity over equality in allocating resources. Critics of this proposed reform may deem it reverse discrimination or unfair to dominant group; however, it justly accounts for the existing and longstanding historical inequities embedded in the current healthcare system. An applicative justice ethical framework provides guidance for the moral imperative of restitution and offers concrete methods to combat these injustices in allocating resources such as vaccines. Through collective action and policy change, the healthcare system can be reoriented towards achieving equity now and in the future.

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Shared Decision-Making for Implantable Cardioverter-Defibrillators: Policy Goals, Metrics, and Challenges

Birju R. Rao, Faisal M. Merchant, David H. Howard, Daniel Matlock, and Neal W. Dickert

Shared decision-making has become a new focus of health policy. Though its core elements are largely agreed upon, there is little consensus regarding which outcomes to prioritize for policy-mandated shared decision-making. In 2018, the Centers for Medicare and Medicaid Services mandated a shared decision-making interaction with a decision aid (DA) prior to implantation of implantable cardioverter defibrillators (ICD) for primary prevention of sudden cardiac death. We conducted a pilot implementation study to assess the impact of providing DA prior to the shared decision-making visit compared to providing the DA at the end of the shared decision-making visit. We observed a signal of improvement in some comprehension domains in patients who received the DA earlier, but we did not observe any differences in other shared decision-making domains or patients' choices. These results raise important questions regarding how to contextualize these data and how to evaluate policy-mandated shared decision-making. Greater clarity is needed regarding the goals of policy-mandated shared decision-making, which metrics should be prioritized, and how these should be weighed against the challenges related to implementation of shared decision-making policies.

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COMMENTARY

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The Ethics of Unilateral Do-Not-Resuscitate Orders for COVID-19 Patients

Jay Ciffa

This paper examines several decision-making models that have been proposed to limit the use of CPR for COVID-19 patients. My main concern will be to assess proposals for the implementation of unilateral DNRs — i.e., orders to withhold CPR without the agreement of patients or their surrogates. I argue that patient-centered rationales for unilateral DNRs appear to extend the concept of futility beyond its usual meaning and application, while utilitarian justifications sometimes fail to delineate the circumstances under which a shift from patient-focused care to maximization of public health outcomes is warranted. This lack of clarity can sow confusion and lead to clinical judgments that don't align with well-established principles of crisis management, such as consistency, transparency, the duty of care, and fairness. Though unilateral DNRs can be justified as an element of pandemic response, their use should be carefully restricted. Rationales for withholding CPR based on futility judgments must be consistent with current practice, and rationales based on scarcity of human and material resources should only be used when crisis standards of care are in effect.

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Of Athletes, Bodies, and Rules: Making Sense of Caster Semenya

Matteo Winkler and Giovanna Gilleri

This article aims to systematically deconstruct four distinct narratives derived from the case of Caster Semenya v. IAAF (Court of Arbitration for Sport). These narratives utilized by the adjudicators to justify an exclusionary regime for athletes with differences of sex development, ignore the notions of gender and race, and demonstrate an inherently myopic view of scientific and ethical concerns.

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Letter to the Editor

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Independent articles are essays unrelated to the symposium topic, and can cover a wide variety of subjects within the larger medical and legal ethics fields. These articles are peer reviewed.

Columns are written or edited by leaders in their fields and appear in each issue of JLME.

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Lynch