The Due Process of Dying

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This essay criticizes the way law has involved itself in medical decisionmaking at the end of life. The argument is that the positivism of the law in this area, and particularly the law's affinity for concepts of rights and autonomy, makes for a poor fit with the underlying structures of medical decisionmaking. These are not scientific structures but rather moral and philosophical ones; and the reason the rules of law conflict with the process of medical decisionmaking is less that medicine has an opposing set of black-letter rules of its own than because healing, which is at the heart of medicine, proceeds through a web of shared responsibilities and through subtle submissions and acceptances of power outside the recognition of law. Additionally, medicine has one commitment that does run counter to the legal commitment to autonomy: the preservation of choice and of possibility.

In overriding autonomy and forcing upon patients those choices that preserve choice, doctors must become “ad hoc paternalists.” To the extent that this prospect is distressing or frightening, the essay offers comfort, though it may be comfort of a peculiar sort: the wielders of paternalistic powers are themselves subject to uncertainty, and always answerable to those who challenge their assertions of responsibility, or challenge the particular choices they have made. The paternalists do not have all the answers (though they are temporarily invested with the responsibility for confronting the questions), and they may always be held accountable for the answers they produce. Tracing the course of doctors and patients as they made decisions in the face of uncertainty and inevitable death, this essay advises lawyers and judges to eschew the certainty of positive law. Rather, judges should acknowledge and accede to the unfamiliar structure of the healing arts, using judicial power creatively, and only to work out the terms of reconciliation between doctors and patients.

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I have been thinking a lot about medical decisionmaking at the end of life. During the summer, I returned from my study of law to attend sick patients in a medical intensive care unit (ICU) and to teach medical students how to care for the seriously ill. I told my students that I had brought back at least one pearl from the law: "After the event even a fool is wise."2 Through the summer the wisdom of this teaching unfolded. Back at law school, I have been reading about the legal vision of medical decisionmaking, trying to make sense of the underlying values and their derivative principles and rules. My inquiry concerns how my patients and I shall make our way with this law.

The birth and growth over the last thirty-five years of the law of medical decisionmaking at the end of life has been animated by the "emerging imperative of patient autonomy"3 and its frustration.4 Beginning with the decision in California of Salgo v. Leland Stanford Jr. University Board of Trustees,5 law's vision has focused on the right of each patient's medical self-determination, first in developing the doctrine of informed consent and more recently in carving out patients' rights to refuse medical treatment6 and to die at a time and in a way of their own choosing.7 This heavy dose of rights consciousness might foster a belief that the problem of the fundamental contradiction that patients both

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2. Overseas Tankship (U.K.), Ltd. v. Morts Dock & Eng’g Co., Ltd. (The Wagon Mound (No.1)), 1961 App. Cas. 388, 424 (P.C.) (appeal taken from N.S.W.) (establishing "reasonably foreseeable" test for tort liability). Viscount Simonds continued: "But it is not the hindsight of a fool; it is the foresight of the reasonable man which alone can determine responsibility." Id.


4. See J. Katz, The Silent World of Doctor and Patient passim (1984) (leading tract on informed consent doctrine); see also Medical Technology, supra note 3, at 1658-61 ("broad judicial proclamations have failed to guarantee all patients the right to medical self-determination").


6. See generally Medical Technology, supra note 3, at 1661-76 (discussing the legal foundations of the right to refuse medical treatment).

7. The American Hospital Association estimates that choices are made to withdraw or not to start death-delaying technology in 70 percent of the 6000 deaths that occur in the United States on an average day. N.Y. Times, Dec. 15, 1990, at A10, col. 4 (nat’l ed.).
need and abhor doctors\textsuperscript{8} can be solved—a belief that dominion over dying, if not yet over death, is within our grasp.\textsuperscript{9} Perhaps it is only a mirage.

Several of my patients' stories provide a setting for trying to understand what the law has to say about how doctors and patients make decisions. The plan of this essay is to consider medical decisionmaking at the end of life repeatedly, each time from a different aspect, building each new consideration upon the preceding. The method is to focus each time on a factor in this decisionmaking, use a judicial decision to introduce law's vision, and then discuss how choices are and should be made. First, I consider the right to die as an occasion to introduce medicine's moral compass and to question the value of the legal concept of autonomy. Second, I consider consent as an occasion to introduce the uncertainty of decisionmaking and to question the value of the legal concept of informed consent. Third, I consider decision as an occasion to introduce the responsibility of decisionmaking and to question the value of the legal concept of surrogate decisionmaking. Fourth, I consider consequence as an occasion to introduce the duty to care and to question the value of the legal emphasis on procedure over substance. Finally, what happened to my patients serves as an occasion for suggesting how the legal system should view medical decisionmaking. I invite consideration of the law's vision as a problem, not a solution, and propose an alternative paradigm of patient-doctor relationships, medicine's moral compass. Readers are invited to draw their own conclusions.

\textsuperscript{8} R. BURT, TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS passim (1979) (discussing patients' estrangement from and need for reconciliation with others, and problems in drawing bright lines in the doctor-patient relationship); see also C. GILLIGAN, IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT 45-48 (1982) (explaining Freud's thoughts on human mutual hostility and primary sense of connection).

The "Fundamental Contradiction" looms over critical legal studies. See, e.g., Kennedy, The Structure of Blackstone's Commentaries, 28 BUFFALO L. REV. 205, 211-13 (1979) (discussing the fundamental contradiction between the desire to unite with others yet remain separate from them); see also M. KELMAN, A GUIDE TO CRITICAL LEGAL STUDIES 16-17, 62-63, 79-80, 234-39, 289-90 (1987) (identifying the "Fundamental Contradiction" as a recurrent theme in critical legal studies). Critical legal scholars "try to retrace, hoping to see where we first got lost." Id. at 295. My essay heads in the other direction, seeking how we will find our way.

\textsuperscript{9} Because the choice of whether to die still eludes human grasp, people can exert power only by positing how to die. An alternative explanation for the foray of positive law into medicine is that exploding advances in medical technology compel law to reexamine traditional methods of health care decisionmaking. See Medical Technology, supra note 3, at 1522-24 ("individualized, ad hoc character of traditional medical decisionmaking is ill-suited to address the broader ethical issues implicated in modern medicine"). The underlying goal is "to ensure that the technologies serve rather than dictate social needs." Id. at 1528.
Mrs. A was found near death on her bathroom floor by neighbors unhappy that papers were spilling from her mailbox and blowing onto their property.

Although known to have been a hearty woman, she weighed only sixty-seven pounds when she was brought to the hospital. She made no response to painful stimuli and had no obtainable blood pressure. Because her abdomen was rigid and board-like, and she had been found soiled with her own bloody feces, she was taken to the operating room for exploratory surgery in the hope that some correctable catastrophe had led to her agonal state. Nothing was found beyond some mild abnormality in the appearance of her liver, which was that of a heavy drinker. After the operation she was brought to the ICU. Her breathing had been supported during the operation by a mechanical ventilator, from which she could not subsequently be weaned because of her profound weakness and inanition. The odds that Mrs. A would survive seemed very slim, but there was nothing immediately wrong with her that made death inevitable rather than merely likely.

The hospital priest ministered extreme unction and called her local church. He learned that she had not been seen for some months beginning shortly after her husband’s death, when she had appeared at confession with a plan to kill herself. The priest had been sympathetic to her story of life’s tribulations—a drunken husband and a drinking problem of her own, beatings, poverty, despair in this life and hope for a better one in union with her God. The priest emphasized that she must not take her life lest salvation be denied, but in answer to her questions he allowed that there was no duty to sustain life by eating or drinking. As best anyone could tell, Mrs. A set out from that day to starve herself to death.

Her sister, whom she talked with on the phone irregularly but whom she had not seen in over thirty years, shortly arrived from Ireland and came to the ICU with the parish priest. They were distraught that Mrs. A was being kept alive, supported by machines, and demanded that all medical therapy be stopped. The sister was most outraged that Mrs. A’s agony was being prolonged—even though Mrs. A was the black sheep of the family, who had brought a constant stream of worry, embarrassment, shame and disgrace to their name, she deserved a dignified and peaceful death. The ventilator must be unplugged and Mrs. A placed in God’s hands. The priest and the unit nurses concurred with the sister’s demands, but Mrs. A’s doctors were uncertain and divided.

I refused to stop meddling in Mrs. A’s life.

For medicine, this is an easy case. Patients are not abandoned to
their despair. Doctors do not stand idly by when called upon to care for people who have failed in attempts to kill themselves. Such attempts are usually for reasons other than a settled desire to die.\textsuperscript{10} The task is to deliver these patients to an option to reappraise their possibility of living. The ground for interference is not so much the sanctity of life as it is the finality of death. A person can only be condemned to live for a finite time—but death is forever.\textsuperscript{11} Because doctors are always learning, not all of them thought that hers was an easy case. The fresh circumstances of each patient provide the uncertain setting for medical decisionmaking at the end of life.

The obligation to save patients from acts of self-destruction is a duty of physicians quite unlike most legal duties. It is not "law" in the positive sense. A medical law governing whether to treat Mrs. A cannot be looked up in statutes, in judicial opinions, nor in legal treatises. No authority can or even need be cited.\textsuperscript{12} And the obligation cannot be based on the myth that doctors are mysteriously bound by a sacred oath to forsaken gods.\textsuperscript{13}

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\bibitem{10} See, e.g., D. \textit{Lamb}, \textit{Down the Slippery Slope: Arguing in Applied Ethics} 48 (1988) (discussing extreme difficulty in determining extent to which desire for death is autonomous). For example, requests for death may be protests against inadequate care, \textit{id.} at 96, or desperate pleas for someone to care at all.
\bibitem{11} "[A] person can only be condemned to live for a finite time. Only Gods and magicians have the power to condemn someone to immortality; any fool can condemn someone to death, and that is a state which is infinite." \textit{Id.} at 48.
\bibitem{12} For one contemporary clinician's thoughts on the ethical landscape in the ICU, see Luce, \textit{Ethical Principles in Critical Care}, 263 J.A.M.A. 696 (1990).
\bibitem{13} I swear by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them his art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.
Medical jurisprudence is quite distinct from legal jurisprudence. Doctors speak about medicine's "moral compass." This is the boundary of medicine, the possible way for doctors to follow together with their patients in what lies ahead. The moral compass of medicine calls on doctors, invites them on their way. The way is to set their patients free to be who they are, to allow them what is their own—the possibilities that lie ahead. The moral compass of medicine is not an obligation degenerated into conformity to a public orthodoxy. There is no black-letter medical law. The moral compass of medicine determines direction in sharing of words and thoughts, in the living together of health professionals and their patients.

Mrs. A had certainly thought she wanted to die, and the wishes of others to relieve their perceptions of her suffering initially seemed creditable. But Mrs. A had no obviously irreversible health problem, and her thinking was being judged by others in terms of their own prejudices about the worth of her life and their own desires not to suffer any longer on her account. It might have been a different problem if death had been imminent and inevitable. Then it would have been a question of when, not whether. But in Mrs. A's circumstances, the only appropriate medical decision was to keep open the possibility of the whether. This patient could not be abandoned to her despair because that would have closed off what lay ahead.

At first, the decision to treat Mrs. A appears also to be an easy legal decision. Taking one's own life transgresses the usual understanding of moral law, and suicide was a crime at common law; assisting suicide remains unlawful in most jurisdictions. But the concept of suicide has

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14. See, e.g., Model Penal Code § 210.5 (1980); Cal. Penal Code § 401 (West 1988); see also Bonds, The Hippocratic Oath: A Basis for Modern Ethical Standards, 264 J.A.M.A. 2311 (1990) ("governing fundamentals of honoring the patient and acting with honest judgement remain cornerstones of the Oath and, ultimately, of good medical practice as well"). The moral compass of medicine is heard in this oath, but the oath itself is not the moral compass.


Prosecutions for assisting suicide are quite rare. Smith, supra, at 291 & n.119; see also Cruzan
THE DUE PROCESS OF DYING

Due process of dying comes under increasing strain in its clash with the concept of autonomy. Courts, for example, have danced around the issue of what constitutes assisting suicide by attempting to distinguish means that involve "assertive, proximate, direct conduct such as furnishing a gun, poison, knife, or other instrumentality or usable means by which another could physically and immediately inflict some death producing injury upon himself" from "the mere presence of a doctor during the exercise of his patient's constitutional rights."\(^{15}\) This exercise has been said to embrace "a desire to terminate one's life[, which] is probably the ultimate exercise of one's right to privacy."\(^{16}\) The distinction is not persuasive, however, to those who adhere to the common-law definition of a suicide as one who "deliberately puts an end to his own existence."\(^{17}\) Under this view, "[s]tarving oneself to death is no different from putting a gun to one's temple."\(^{18}\)

The clash between autonomy and suicide was a problem faced in *Bouvia v. Superior Court*.\(^{19}\) Like Mrs. A, Elizabeth Bouvia thought she wanted to end her life by starving herself to death. She was a twenty-eight-year-old woman who petitioned the court for a writ of mandamus requiring that she not be fed against her wishes. Despite suffering from severe cerebral palsy since birth, she had earned a college degree. But her life had unraveled. Her husband left her. She suffered a miscarriage. Her parents turned her out of their home when they were no longer willing...
ing to provide the care she needed in her dependency on others. A search for a place for her to live was unsuccessful. As one judge viewed it, "[f]ate has dealt this young woman a terrible hand. Can anyone blame her if she wants to fold her cards and say 'I am out'?"

The writ issued granting Elizabeth Bouvia's request to starve herself to death. Her motive was held irrelevant because no one's approval was necessary for her to exercise her right to refuse medical treatment. This right was viewed as "basic and fundamental," "a part of the right of privacy protected by both the state and federal constitutions." One California Court of Appeal judge would have gone even further, suggesting that the patient's right to die, the right to control one's own destiny, should "include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible." The underlying sentiment was that "[i]f there is ever a time when we ought to be able to get the 'government off our backs' it is when we face death—either by choice or otherwise."

But after triumphing in the protracted legal struggle to vindicate her right to starve herself to death, Elizabeth Bouvia changed her mind. In a rare interview two years after her court decision, she maintained her conviction that "'people should have the right . . . to decide if they want to suffer or not.'" The irony, of course, is that as the result of her court victory the threat to her ability to voice that conviction was that the decision would be executed. If she were dead, there would not be any choice to be made at all. Her court really missed the point. Elizabeth Bouvia did not want to die, she just wanted to be wanted. If her court's decision had been executed, it would have been an injustice. In the end, Elizabeth Bouvia did not want to be put out of her suffering—she just did not want to be abandoned to it.

20. Id. at 1146, 225 Cal. Rptr. at 307 (Compton, J., concurring). Just how bad a hand was dealt is disputed. See Longmore, Elizabeth Bouvia, Assisted Suicide and Social Prejudice, 3 Issues L. & Med. 141, 152-59, 161-63 (1987) (appellate court's version of Elizabeth Bouvia's life history and physical condition was distorted and factually inaccurate and Bouvia's own lawyers distorted the nature of her disability). Rather than a question of the "right to die," Bouvia might be said to concern the duty to put the unfit out of their misery.

21. Bouvia, 179 Cal. App. 3d at 1146, 225 Cal. Rptr. at 307. No appeal was taken from this decision.

22. Id. at 1145, 225 Cal. Rptr. at 306.

23. Id. at 1137, 225 Cal. Rptr. at 301.


25. Id. at 1148, 225 Cal. Rptr. at 308. The legislature rejected this view. See supra note 14.

26. L.A. Times, May 23, 1988, § 1, at 14, col. 2. She had been living for nearly two years, and expected to spend the rest of her life, in a MediCal-paid ($292,000 per year) private hospital room. Id. For a summary of events in Elizabeth Bouvia's life between 1986 and 1987, see Bouvia v. County of Los Angeles, 195 Cal. App. 3d 1075, 241 Cal. Rptr. 239 (1987) (Elizabeth Bouvia's successful private attorney general action for award of attorney's fees incurred in her legal battles).

27. "'If I tried to starve myself, I would be publicly shunned,' Bouvia said. 'So what I am
not to death but to others, a plea for their attention, love, and concern.

Suicide is a legal term of art, ultimately a convenience in judgment as to the quality of another’s life. Suicide is thought of as the taking of a life deemed not worth living only by the person whose life is lost. Self-killing is not thought of as suicide when there is more general agreement that a life is not worth living. In any particular case it is uncertain on what grounds categorization should turn. Focused on the means, taking one’s own life is acceptable if one does not eat, but unacceptable if one shoots oneself or slits one’s wrists. In thinking this way, it is permissible to suffer a slow and agonizing death—only quick dispatch is forbidden. Focused on the ends, taking one’s own life is acceptable if one is different from others, but unacceptable if one is not. In thinking this way, it is permissible to extinguish the unconventional—only taking the life of conventional people is forbidden. The issue moreover is not simply whether people may kill themselves. It is also whether doctors ought to do the killing. How any of these judgments can and should be made is shrouded in mystery.

The law looks to values of individuality and autonomy for its grounds. Law’s vision is the right of each to choose his or her own destiny, free from the interference of others—including free from the officious intermeddling of doctors. The argument for autonomy is familiar. Patients must be free to make their own choices about what will be trying to do right now is just keep the peace.” L.A. Times, May 23, 1988, § 1, at 14, col. 2. If her judgment had been executed, Elizabeth Bouvia would not only have been shunned. She would never have been heard from again.

28. “In Elizabeth Bouvia’s view, the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration. She, as the patient, lying helplessly in bed, unable to care for herself, may consider her existence meaningless. She cannot be faulted for so concluding.” Bouvia, 179 Cal. App. 3d at 1142-43, 225 Cal. Rptr. at 304. The state interest in suicide has been characterized as “prevention of irrational self-destruction.” Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 743 n.11, 370 N.E.2d 417, 426 n.11 (1977). Sanctioned self-destruction is thus characterized as “rational.” Id.; see also Bartling v. Superior Court, 163 Cal. App. 3d 186, 196, 209 Cal. Rptr. 220, 225-26 (1984) (citing Saikewicz with approval and drawing a further, but questionable, distinction between “natural” and “unnatural” means of death). Such distinctions may be suspect as sophistic groundwork for social Darwinism. See, e.g., Longmore, supra note 20, at 164-68 (the “right to die” can become the duty to die).

29. This is Elizabeth Bouvia’s unresolved complaint. “‘Starving myself would take too long,’ she said. ‘I wish there was a quicker way.’” L.A. Times, May 23, 1988, § 1, at 14, col. 2; see also I. KENNEDY, supra note 15, at 307-08 (discussing doctors’ preference for a slow, sedated, neglected death over a clean kill).

30. See, e.g., R. BURT, supra note 8, at 169-73 (“obliteration of unconventional people in the name of individual liberty”); Longmore, supra note 20, passim (socially devalued and disadvantaged people suffer social death, rendering their physical death less problematic).

31. See generally Singer & Singler, Euthanasia—A Critique, 322 NEW ENG. J. MED. 1881, 1883, passim (1990) (urging doctors to refuse to participate if euthanasia is legalized, and professional organizations to censure members who perform euthanasia).

32. See, e.g., J. KATZ, supra note 4, at 104-29 (discussing patients’ right to self-determination and assumptions about their capacity for reflection and choice); Shultz, From Informed Consent to
done with their own bodies because their interest is that most directly affected. Thus, refusing unwanted medical treatment is a basic, fundamental, and general liberty. Patients have the right to make their own choice even if such choice is viewed by others as mistaken—even if such choice is to refuse lifesaving hydration and nutrition. The difference from the moral compass of medicine can be subtle, a matter of emphasis. The law looks for interference with possibility, not for possibility itself.

Patient Choice: A New Protected Interest, 95 YALE L.J. 219, 220 (advocating that patients' preferences generally should be controlling), 223-29 (discussing existing legal protection of patient autonomy), 274 ("it is, after all, the fact that she will have to live with the consequences of the medical choice upon which the patient's claim to authority preeminent rests") (1985).


[The sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him or visiting him with any evil in case he do otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of anyone for which he is amenable to society is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

J.S. MILL, ON LIBERTY 13 (1956). But see R. Burt, supra note 8, at 97-100 (criticizing Mill's static view of the "freely consenting adult" and arguing instead for a realistic appreciation of an individual's oscillation between dominance and submission in social relations).

Although not so often quoted, Mill qualified his doctrine, which was "meant to apply only to human beings in the maturity of their faculties." J.S. MILL, supra, at 13. Thus,

Despotism is a legitimate mode of government in dealing with barbarians, provided the end be their improvement, and the means justified by actually effecting that end. Liberty, as a principle, has no application to any state of things anterior to the time when mankind have become capable of being improved by free and equal discussion.

Id. at 14. As with barbarians, sometimes there is no possibility of speaking with or understanding patients. With no possibility of sharing a world, there is no possibility of law, and autonomy has no meaning. See also J. Katz, supra note 4, at 125 (discussing the need to determine whether and when to interfere with patients' choices). Even when communication is possible, blind acceptance of a patient's choice is disrespectful because, on reflection, there may be a different choice more appropriate to the patient's own wishes and expectations. The underlying reasons must always be sought for and explored—and then judged.

33. E.g., Cruzan v. Director, Mo. Dept' of Health, 110 S. Ct. 2841, 2851 (1990) ("general liberty interest in refusing medical treatment"); id. at 2865 (Brennan, J., dissenting) ("freedom from unwanted medical attention is unquestionably among those principles 'so rooted in the traditions and conscience of our people as to be ranked as fundamental' " (quoting Snyder v. Massachusetts, 291 U.S. 97, 105 (1934))).

34. Id. at 2852 ("for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition").
The argument for autonomy gets fleshed out in its opposition to paternalism, the desire to compel people to do what one decides is best for them. To the contrary, autonomy is the struggle to break free from others, to maintain that separation, and to resist objectification. The ready triumph is to deny any need for others, rejecting concern. A hidden downside to this struggle for freedom from others is the freedom for the others’ indifference. Freedom even for hostility. At its limits, autonomy collapses into abandonment. Patients are on their own—but only because their autonomy must be respected.

Medical self-determination requires that power be finally allocated. By denying that both patient and doctor are at once powerful and powerless in their relationship, this static and final assignment ignores power’s inevitable uncertainty and reciprocity. Autonomy cannot simply be assumed to be more fitting to the patient than physician dominance.

35. See generally Kennedy, Distributive and Paternalist Motives in Contract and Tort Law, with Special Reference to Compulsory Terms and Unequal Bargaining Power, 41 Md. L. Rev. 563, 588-90, 624-49 (1982) (discussing paternalism in detail). Kennedy argues that “principled anti-paternalism is a shallow view.” Id. at 645. The basic problem is that there is no simple solution to “the more general issue of when one ought and when one ought not to influence other people’s lives;” and normal principled approaches cannot solve that problem. Id.

36. Each side has something to fear in this struggle for power: “the fear of degradation if one were to accept the outcome . . . as representing one’s true worth, and the fear of losing to those below if the rhetoric of equality were to pass beyond form to substantive proposals for leveling.” Kennedy, supra note 35, at 622 (emphasis in original). It can never be clear that either party is entirely ready to assume these risks, which are not extinguished in victory, when parties merely change places with one another.

37. Cf. J. Katz, supra note 4, at 207-25 (explaining patients’ feelings of abandonment when their doctors fail to involve them in making decisions).


39. The law can conceive of only two possible states: either patients make choices exclusively or they are utterly choiceless. The reality of doctor-patient relationships is that there is mutual and reciprocal self-assertion that requires continuous negotiation between self-depictions. Patients provide doctors with their reason for existing as healers. Doctors provide patients with their possibility for what lies ahead. Each is defined by the other in their ongoing relationship. See generally R. Burt, supra note 8, at 41-42, 92-123, 159-62 (pervasiveness of imagery of impotence/ omnipotence and the complementarity of choiceless/choice-making roles).

No victory of patient power over doctors can ever be great enough for patients to gain true independence from doctors unless that victory guarantees health. Patients can win power over doctors only by never being ill and thereby never needing doctors’ services. Cf. Kennedy, supra note 35, at 584-86. Discussing the distribution of power, Kennedy argues that altruism does not equal egalitarianism: Even a long string of such victories will be to no avail if each successive accretion of wealth is inadequate to make the subordinate group truly independent, or if the long-run terms of trade are against it, or if it fails to find a way to profit from striking innovations, or if . . . there are no guarantees of success in the struggles of civil society.

Id. at 585-86.

40. This argument against any final and irrevocable allocation of power rejects the assumption that in all circumstances at every time autonomy is what is only most fitting for the patient. But see, e.g., Shultz, supra note 32, at 278 (“a doctor’s authority derives only from the patient and should extend no further than the patient decrees”).
Both take for granted that equality is a static condition in relationships, rather than the sum of alternating inequalities—of power and powerlessness.\footnote{This argument against any final and irrevocable allocation of power also rejects the view that, because there is a possibility that doctors can overwhelm and impose choices that are false for patients, legal institutions must protect patients by making them impervious to doctors. R. Burt, supra note 8, at 97-100.} Autonomy degenerates into repression of the other. When one must prevail, the other must necessarily be subjugated, or even obliterated.\footnote{Courts almost invariably determine that life support is not in the patient's best interests. See, e.g., Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2887-88 & n.21 (1990) (Stevens, J., dissenting) (laying out "unbroken stream of cases" authorizing cessation of treatment if patient is in vegetative state). Cruzan is, of course, an exception. See id. at 2845 (holding that Nancy Cruzan's parents lacked authority to have life-sustaining treatment withdrawn).}

The "imperative" of patient autonomy is itself, of course, paternalistic. Patients will be autonomous because it has been decided that autonomy is best for them.\footnote{The objection is to the whole relationship—it is an objection to feudalism, a way of life, or to slavery, a way of life. It makes no difference that if we apply to their actions the same tests of voluntariness we apply to our own, some people may sometimes want to be peons. We won't let them be. Kennedy, supra note 35, at 628 (emphasis in original); see also Schlag, Normative and Nowhere to Go, 43 Stan. L. Rev. 167, 178 (1990) (normative legal thought "cannot wait to tell you (or somebody else) what to do" (emphasis in original)), 185-86 (fantasy of autonomy).} The doctor is not alone in threatening an exercise of power. The state claims a stronger right to decide for people, even as it cloaks its decisions in vindicating their rights. Paternalism is at once taboo and ubiquitous, the invisible brooding omnipresence in the law. The judge decides what is best for litigants, guided by the authority of precedents or statutes or equity slogans. The law is \textit{parens patriae}. Patients might wonder what they can hope to gain when judicial orders "substitute bureaucratic authority for professional authority."\footnote{Parent of the country.} From the patient's point of view, there is only paternalism, with the legal system engaging medicine in a struggle over which ought to fill the role of father.

\begin{itemize}
\item \footnote{Parent of the country.} Black's Law Dictionary 1114 (6th ed. 1990).
\item \footnote{J. Katz, supra note 4, at 228.}
\end{itemize}
The autonomy-based right to medical self-determination, even as an "imperative," is not absolute. Ardent proponents of patient autonomy recognize a need to decide whether the value of patient self-determination is more important than patient well-being and the interests of the state, and sometimes to overrule patients' choices. Thus, patients may even have to be threatened with unwanted tests, mechanical ventilation, and resuscitation if satisfactory explanations for their decisions are not forthcoming. Autonomy then degenerates into abandonment, and into arbitrary judgment and coercion.

What is left is a hopelessly blurry vision of medical self-determination. If Elizabeth Bouvia can prevent doctors from feeding her because to do so would violate her most basic human right to control her own body, then it would seem to follow that Mrs. A should not have been fed. On the other hand, the reason for not feeding Elizabeth Bouvia could have been that her presence was discomforting. That reason to sanction her death might be grounded in revulsion by her rather than in respect for her. If doctors were not revolted by Mrs. A, they should have done what they could to save her. Elizabeth Bouvia ceased to exist when no one cared any longer for her. That is what her complaint to the court was really about. Not feeding her would just have been a formality. Every attempt to die may hide a wish to be included with other people, to

47. E.g., Medical Technology, supra note 3, at 1663, 1666-69 (state maintains powers to mandate bodily intrusions to secure evidence and protect public health, and has interests in preservation of life, prevention of suicide, protection of innocent third parties, and maintenance of ethical integrity of medical profession); see also, e.g., Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2851-54 (1990) (discussing state interest in sustaining life); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 738-45, 370 N.E.2d 417, 424-27 (1977) (surveying and discussing leading cases identifying range of state interests potentially applicable to cases of medical intervention).

The process of deciding whether the individual's interests or the state's interests are more important is ordinarily called "balancing" by courts. "[B]ut the scale analogy is not really appropriate, since the interests on both sides are incommensurate. It is more like judging whether a particular line is longer than a particular rock is heavy." Bendix Autolite Corp. v. Midwesco Enter., 486 U.S. 888, 897 (1988) (Scalia, J., concurring). Because this balancing metaphor is not very helpful in understanding how judges decide which interest should prevail, it is not used in this essay. But cf. BENEFICENCE, supra note 32, passim (arguing for doctors' calculus of benefits and burdens to arrive at a right and good healing action for each patient); Medical Technology, supra note 3, at 1643 (arguing that new medical technology mandates need to balance speculative benefits of treatment against burdens of further treatment, and that critical factor has become who is to perform this balancing).

48. E.g., J. KATZ, supra note 4, at 156-63. Patient choice should not be honored when "the consequences on non-intervention pose grave risks to a patient's immediate physical condition and . . . the process of thinking about choices is so seriously impaired that neither physician nor patient seem to know what one or both wish to convey to the other." Id. at 157-58 (emphasis in original).

49. Id. at 159.

50. See, e.g., Ikuta, supra note 14, at 48-60 (legal framework inadequate for guiding timing-of-death decisionmaking in practice).
become one again with them, not to be cut off from others by death. Law's vision pleads indifference to the intent of interference or its result.

When one looks to the law, one gets double vision. Respect may be evidenced by obliteration or nurturing. Decision may be grounded in concern or revulsion. The obligation of autonomy may look suspiciously like a duty to abandon. Seemingly every rationale may be discovered in the law. In its flexibility and indeterminacy, one goes searching for support for whatever decision one makes. And lurking there simultaneously is the ammunition for proving any decision wrong. Autonomy can mean too much and, therefore, end up meaning nothing. Or it can acquire a false meaning. Freedom that is one's own cannot be any freedom from . . . One's own is a freedom to . . .

II

CONSENT

Mr. B had already been in the ICU for six weeks when I began to care for him. The decision to be made immediately was whether to accede to his request to unplug the mechanical ventilator that kept him alive. A thirty-seven-year-old writer of some local repute, he suffered from profound weakness of the muscles of breathing, which was believed to be the result of a complication of infection with the AIDS virus. Such a complication had never been previously described. There was no certainty about what course his disease might take, what chance there might be for recovery in the short haul, how long a time might pass before some cause other than inability to breathe would lead to his death. He had been offered mechanical ventilation for as long as he desired. Efforts had been made to sort out this new manifestation of AIDS. His health-care team had been frustrated by their ignorance and tormented by his complaints of pain (from deep ulcers on his back caused by lying immobile in bed) and loneliness (his friends abandoned him as his illness wore on). When Mr. B had told his doctors that he wanted the ventilator shut off, they had been, frankly, relieved.

Mr. B told me, as best he could by feebly mouthing words and making signs since he was unable to speak with the ventilator tubing in his throat, what he had told others. He wanted the ventilator unplugged. He was tired. He hurt. I agreed to think about it and talk with him again.

51. The principle of autonomy is too vague, contradictory when applied, and cannot tell people how to decide. See, e.g., M. Kelman, supra note 8, at 281 (no discernible content to concept of autonomy). The problem moreover is that there is no principle instructing how to apply the autonomy principle even were its content understood. The indeterminacy of legal rules is a generalized problem in the law. Cf. Kennedy, supra note 35, at 580-83 (rules do not tell judges what to do one way or another in deciding cases under principle of freedom of contract). It is futile to try to understand legal regimes as products of reason rather than as what they are—the products of economic or social or political power.
The other doctors, nurses, therapists, and members of the team that were responsible for his care were unhappy at the delay. Let’s get on with this—others are waiting.

I spoke with his mother and sisters, who visited him whenever they could. Reluctantly they were agreeing with his decision, which he had also communicated to them. Before I returned to speak with Mr. B about the unplugging, I noticed in passing by his room that he was engaged in a vigorous and animated discussion. Only no one was there with him. A sister admitted that, yes, he had hallucinated for many years, beginning long before he had AIDS.

The next morning, Mr. B and I spoke again. Yes, he wanted the mechanical ventilator unplugged. Only the possibility of hallucinations made me ask why. The ventilator’s noise caused him great distress, he could not rest or sleep. He wanted to leave the hospital, see his beloved niece, play with his little dog. That would not be possible. Why not? He would die within five minutes of being unhooked from the ventilator. This struck him as a complete surprise. He seemed never to have been aware of what everyone else knew for certain: only this machine stood between him and death.

We tried, unsuccessfully for the most part, to quiet the ventilator. Mr. B plunged into cooperation with a plan to try to strengthen his breathing muscles—a plan formulated after a repeat muscle biopsy showed signs of improvement. The goal was to get him at least to a point where he could breathe long enough on his own to take a spin in a wheelchair and maybe even to go outside and see his dog.

Every couple of days he repeated requests to stop some therapy necessary for his survival, and repeated surprise when the consequences were reiterated. Psychiatrists saw him on multiple occasions and were unanimous that his hallucinations in no way interfered with his decisionmaking capacity and that he was fully competent. There never was any clinical improvement, which progressively frustrated everyone. Mr. B sank inexorably into despair, consumed finally by the possibility that he might come unhooked from the ventilator, that there might be a mechanical failure, or that someone would sneak into his room while he slept and turn the machine off. He oscillated between the inconveniences of living and the finality of death. All this added to the general frustration because, in truth, there was nothing that could be done for him except to let him know that we would stand by him until the end. Reassurance really did not help very much. Even having a nurse sit by his bed and hold his hand all night was not enough support for him to feel he could safely sleep.

Complying with what patients want, their choices, depends on their consent. But certain consequences of an act may not always be apparent to the agent concerned. The case of Mr. B seems just too easy. Obvi-
ously, someone who does not know that he will die if his doctors accede to his request to unplug the mechanical ventilator keeping him alive has not made any rational consent to dying when he asks for such an unplugging. But it is not obvious that such a choice is irrational either.

The case of Mr. B appears easy only accidentally and equivocally. If reticence in the face of death had been observed, no one would have opposed his choice to cease being ventilated. If his wish to be removed from life support had been granted, he would have gotten what he wanted and would not have been around to have any regrets about the price he paid for quiet. Everyone else would have paid Mr. B their last respects by doing as he bid, and happily avoided the agony of helplessly standing by. What makes this case hard is the uncertainty over which of Mr. B's decisions should have been honored. A choice had to be made between his autonomous wish to struggle on and his autonomous wish to give up. Which choice should be respected?

Autonomy dictates that decisions be respected—and that mistakes be freely made. The questioning of Mr. B's decision necessarily entailed questioning his autonomy: it is not any decision that should be respected, but rather decisions judged to be rational, those based on adequate information. This judgment cannot be guided by a presumption in favor of respecting the patient's decision when the patient is vacillating between contradictory decisions. If decision must be arbitrary, it would seem that the better choice would be guided by a presumption to preserve the possibility of autonomy by preserving choice.

The right of medical self-determination and the imperative of patient autonomy appeared in the law less than thirty-five years ago with the birth of the notion of informed consent. Contrary to efforts to

52. Which "deserves" respect ultimately entails a judgment of "the state of [the patient's] autonomy." J. KATZ, supra note 4, at 160. The imperative of patient autonomy evaporates in the face of such a judgment.

53. Id. (arguing for such a presumption).

54. Doctors brought the concept of informed consent to the law. The doctrine was announced in Salgo v. Leland Stanford Jr. Univ. Bd of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957): A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undergo surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.
locate a hoary origin of this doctrine in battery, it is a contemporary creature of medical malpractice law grounded in negligence. The intent is to give meaning to the grand rhetoric of self-determination by securing primacy in medical decisionmaking in the patient. This requires an "informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each."
The doctrine of informed consent was, however, stillborn in hesitancy and ambiguity. Even courts articulating it with the greatest force hesitated to fully effectuate the broad powers they posited in patients. The adequacy of disclosure was in fact left largely to the discretion of doctors, who were allowed to make their own law by determining the standard of care. The retreat from patient self-determination, from disclosure and consent, began even as the boldest claims were made. To prevent doctors, and courts, from being buried by an avalanche of lawsuits by patients "with the 20/20 vision of hindsight," the doctrine of informed consent was hedged in by certain constraints. There had to be a causal relationship between the failure to inform and patient injury. Courts also adopted an "objective test" focusing not on a particular patient's need for information, but rather on what "a prudent person in the patient's position [would] have decided if adequately informed of all significant perils." Finally, despite being troubled by doctors making their own law, courts were reluctant to require more than minimal disclosure of "risk of death or bodily harm, and problems of recuperation" as would be revealed by "a skilled practitioner of good standing . . .

59. E.g., J. Katz, supra note 4, at 82-84 (informed consent doctrine did not bring greater patient self-determination because courts did not implement the doctrine with commitment); Shultz, supra note 32, at 241-48 (discussing duty to disclose).


61. J. Katz, supra note 4, at 80-82 (both judges and legislators had second thoughts when confronted with the task of determining which facts would be necessary for an informed consent, with the consequences of "foolish" patient decisions, and with the dangers inherent in interfering significantly in medical practice).

62. Cobbs v. Grant, 8 Cal. 3d 229, 245, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972); see also Canterbury, 464 F.2d at 790-91 (subjective standard "places the physician in jeopardy of the patient's hindsight and bitterness").

63. Cobbs, 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515. But see Twerski & Cohen, supra note 60, at 626-48 (arguing that the causal relationship between information and decisionmaking is not practically justiciable because of inherent complexities).

64. Cobbs, 8 Cal. 3d at 245, 502 P.2d at 11-12, 104 Cal. Rptr. at 515-16 (quoting Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972)). But see Shultz, supra note 32, at 287-91 (arguing for a "subjective test" focusing on what this particular patient would have decided if provided with the requisite information). Only a tiny minority of decisions have adopted such a standard. Twerski & Cohen, supra note 60, at 614 n.28.

For a critique of both objective and subjective tests, and the view that they are not as distinct as they might seem in that both accept physicians' presumption in favor of continued treatment, see Rhoden, Litigating Life and Death, 102 HARV. L. REV. 375 (1988).

65. See supra note 58.
under similar circumstances." Consent, therefore, remained, for the most part, determined practically by doctors' standards.

On balance, the current doctrine of informed consent requires only that doctors provide information to their patients that would lead a reasonable patient to decide against the doctor's recommendation. This significantly narrows the field of consent because, unless the doctor's recommendation is unreasonable (in which case the patient's complaint is malpractice, not lack of consent), the complaining patient would have to be unreasonable to reject it. The result is that

the law of informed consent is substantially mythic and fairy tale-like as far as advancing patients' rights to self-decisionmaking is concerned. It conveys in its dicta about such rights a fairy tale-like optimism about human capacities for "intelligent" choice and for being respectful of other persons' choices; yet in its implementation of dicta, it conveys a mythic pessimism of human capacities to be choice-makers. The resulting tensions have had a significant impact on the law of informed consent which only has made a bow toward a commitment to patients' self-determination, perhaps in an attempt to resolve these tensions by a belief that it is "less important that this commitment be total than that we believe it to be there."

While such a limited doctrine avoids the inescapable fact that there are no principled limits to a truly effective doctrine of informed consent, it

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66. Cobbs, 8 Cal. 3d at 244-45, 502 P.2d at 11, 104 Cal. Rptr. at 515.
67. To fit into the existing malpractice legal paradigm, the failure to inform gets transposed into a question of the doctor's diagnostic accuracy. Shultz, supra note 32, at 238-41.
68. See Twerski & Cohen, supra note 60, at 615. The doctrine of informed consent appears, therefore, only to be relevant in a limited number of cases in which an inherent risk of the doctor's recommendation was not fully disclosed, the undisclosed risk occurred, and the patient was harmed by that very risk. Id. at 617.
69. Katz, Informed Consent—A Fairy Tale? Law's Vision, 39 U. PRR. L. REV. 137, 174 (1977) (footnotes omitted). Katz confirmed this earlier, pessimistic assessment of law's informed consent vision in J. Katz, supra note 4, at 83. Doctors are said to suspect the doctrine of informed consent to be an albatross rather than a fairy tale, and patients to suspect its purpose is to protect doctors from lawsuits rather than patients from doctors. Shultz, supra note 32, at 254 n.141; cf. Kennedy, supra note 35, at 620-24 (ideological significance of the contract doctrine of unequal bargaining power). The basic function of doctrine is to apologize for the inability to eliminate inequality, to "transpose[ ] the deadly fights of social groups to a plane where the issue is merely formal." Id. at 621. Doctrine addresses only the procedural aspects of relationships, distracting attention from what is really at stake: "the overruling of preferences on the basis of a particular substantive moral vision of how people should deal with risk in their lives." Id. at 623. The problem is not what this moral vision is, but rather "the hopelessness of trying to avoid intuitive, immediate judgments, based on intersubjective group identity as well as on aloneness, about the acceptability of any given social arrangement." Id. at 624.
70. Contra Shultz, supra note 32, at 284-91 (arguing that effective doctrine of informed consent would "not be as unlimited as it might seem"). The argument is not very compelling unless there is inherent meaning to key words such as "material," doctors' and patients' certainties and uncertainties can be objectified, there is understanding about how "breach of [duty to inform] ought to be judged not by the standards of expert behavior but by the standards appropriate to protection of patient autonomy," id. at 286, and "all information that [the doctor] knows or should know that
does little to advance the goal of autonomy it pretends to serve.

The failure of informed consent actually to vindicate patient autonomy in medical decisionmaking has led commentators to call for reassessment of the doctrine. Some have argued for a solution grounded in insistence that doctors and patients must talk more (and better) with one another. Others have argued for a bolder step, making autonomy an independent legally protected interest. These latter commentators regard "existing legal protection for medical patients' autonomy [to be] more limited than has been recognized and more deficient than should be tolerated." They imagine a solution that would allow patients to sue for the lack of informed consent, regardless of the result of that lack.

Three problems face this call for change. First, judges conceive of informed consent as protecting an interest in not being injured by unreasonable conduct—the same interest that is already protected by malpractice and other tort law. The argument that new protection is needed has not been persuasive to courts. Second, doctors and patients are not

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71. Patient autonomy "has been vindicated only as a by-product of protection for two other interests—bodily security as protected by rules against unconsented contact, and bodily well-being as protected by rules governing professional competence." Shultz, supra note 32, at 219.

72. See R. Burt, supra note 8, passim; J. Katz, supra note 4, passim.

73. See Shultz, supra note 32, passim; Twerski & Cohen, supra note 60, passim (arguing that attention must be focused on valuing the process of decisionmaking, not its result). As Professor Shultz imagines an improved doctrine of informed consent, patients would make choices, "including choices that differ from what the doctor deems 'reasonable.'" Shultz, supra note 32, at 247. This appears straightforward, but actually the only way it might be known that patients had in fact made their own choices would be if they disagreed with their doctors. And even if patients disagreed with their doctors, they could always later claim that they were not properly informed when they made their choice. A cause of action would always lie open. For a discussion of the impossibility of principled limits to a truly effective doctrine of informed consent, see supra note 70.

74. Shultz, supra note 32, at 298.

75. It might be argued that "informed consent is nothing but a second, easier bite at the same apple of malpractice recovery." Id. at 236 (but that is said not to be the case "because the interests at stake are different"). Of course, this is precisely the view that commentators argue against. See generally J. Katz, supra note 4, at 48-84 (stating that ideally the doctrine of informed consent should extend patients' rights to self-determination); Shultz, supra note 32, at 298 (arguing that informed consent does not protect patient autonomy and that patient autonomy is "more deficient than should be tolerated"); Twerski & Cohen, supra note 60 (urging courts to value a patient's decision rights, which a doctor destroys by withholding information).

76. There has been no judicial stampede to effectuate the dicta of informed consent doctrine by answering commentators' calls to recognize that injury is the invasion of autonomy.

Professor Shultz's argument for an independent interest in medical choice has been cited in the published decisions of seven courts, none of which mentioned, let alone embraced, her argument for an independent cause of action for lack of informed consent. See Townsend v. Turk, 218 Cal. App.
fungible. Doctors have esoteric knowledge and expertise that patients do not, and the need is that they apply it for the good of their particular patients, not that they simply transmit it for their patients' use. Doctors are not only teachers, but healers as well. Third, if informed consent were conceived of as protecting the patient's interest to make a choice about medical care, the courts would have to set a price for the patient's dignity. It is much easier, of course, to put a price on a bad result.

Professors Twerski and Cohen have been cited by the lone dissenter in one published opinion. See Roybal v. Bell, 778 P.2d 108, 116-17 (Wyo. 1989) (Urbigkit, J., dissenting) (citing Twerski and Cohen to illustrate argument that the doctrine of informed consent creates a legal fiction because a patient, by signing a consent form, is not necessarily adequately informed).

Difficulties of interests and values are identified in Twerski & Cohen, supra note 60, at 620-21. They argue that the valuing of process and options, required if lack of informed consent is to be a meaningful tort, is somewhat difficult but not insurmountable. Id. at 648-65.

Setting a price for bad results may be easier than for dignity, but both are intrinsically arbitrary. The damage to the victim is not part of the crime. Moreover, there are no natural or real prices. Kennedy, supra note 35, at 578-79 (no possibilities "can lay claim to the special virtue of naturalness"). Kennedy argues:

Values (prices) depend on supply and demand, which depend in turn on the contingent variables of taste and technology, and on the competitive structure of markets. They also depend on the choice of a particular set of alternatives among many possible legal regimes. No outcome is natural in the sense of being somehow prior to the legal rules in force.
A different problem, however, precedes interests and prices. It is the uncertainty that hangs over doctors and patients—the uncertainty of medicine and the uncertainty of relationships, the problem of what to do when no understanding is possible in a setting of ambiguity and confusion. This was a problem faced in Bartling v. Superior Court. Like Mr. B, William Bartling wished to end his life by ordering his doctors to disconnect the mechanical ventilator that sustained his breathing. He was a seventy-year-old man who entered the hospital for treatment of depression. His routine admission chest x-ray disclosed a tumor, which was biopsied by inserting a needle into his lung. Unfortunately, this caused his lung to collapse. He might have died right then, but tubes were inserted through his chest wall and down his throat, and his breathing was supported by a mechanical ventilator to buy time for his lung to heal and reexpand. Only his lung did not heal or expand. He could not be weaned from the ventilator, and, to prevent his dying if he were to remove himself from the machine accidentally or deliberately, he was tied down to his bed. His demands to be disconnected from the ventilator and to be free to die coincided with his frantic wishes to be reconnected to the ventilator when he became accidentally detached, his wishes to live, and his wishes that he did not want the ventilator disconnected.

The court was not greatly troubled by William Bartling’s vacillation: “[t]he fact that Mr. Bartling periodically wavered from [preferring death rather than life sustained by mechanical means] because of severe depression or for any other reason does not justify the conclusion of . . . his treating physicians that his capacity to make such a decision was impaired to the point of legal incompetency.” Which of his contradic-

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Id. at 578 (emphasis in original). When rights are reduced to cash value, whatever the price might be, patients will end up paying twice: once when the costs of damage awards are passed back to them by their doctors, and once again in making their agonistic way with their doctors. Only the lawyers are guaranteed not to lose out.

80. See generally J. Katz, supra note 4, at 165-206 (emphasizing difficulties doctors face in dealing with uncertainties of medicine and with their own uncertainty, but neglecting dilemma patients face before the same uncertainties).

81. When the patient is confused, the patient’s doctors will be confused. Cf. R. Burt, supra note 8, at 22-45 (discussing the problem of Mrs. Lake, an elderly woman who could not remember her address when asked by a policewoman, showing that relationships are mutually coercive enterprises, that self is determined only in meeting and interacting with others, and that questions of capacity and possibilities of confusion inhere in the reciprocity of self-assertion).


83. Id. at 193, 209 Cal. Rptr. at 223-24. The court’s choice of “wavering” to characterize William Bartling’s decisionmaking betrays its inchoate understanding that he had, in fact, made no decision. His capacity was quite clear—he was irresolute between choices. One lesson that can be drawn from this case is that people had best avoid articulating their consideration of the possibility of death unless they are prepared that it will be seized upon and effectuated. See supra note 42.

“The problem with the notion of capacity in a setting like this one is not that it’s positively
tory wishes to honor was made easier by the fact that William Bartling was already dead when the court made its decision that, for him, death was rational. The rightness of the decision might have been less obvious if the judges had stood at his bed and disconnected the ventilator themselves.

There simply is no principled way to make a judgment as to the rationality or irrationality of people's decisions at any particular time and thereby choose for them, least of all when faced with their doubts. Any choice under such circumstances is intrinsically arbitrary, and its caprice is only thinly veiled by the destruction of the person for whom the choice is made. In that destruction, autonomy is perversely, and inexplicably, said to be vindicated. The vexation of uncertainty is removed by an exercise of power. The victim, destroyed, cannot complain. The decisionmaker is anesthetized by the powerlessness of having made the only rational choice. The process of making decisions is simplified by the static assignment of power to the patient and the resulting compulsion to obey the patient's will. The responsibility for the decision rests on its victim.

This is the stuff of myth and fairy tale. But the myth does not lie in the doctrine of informed consent. The myth is the normative commitment to static, separate, and impermeable selves—the normative commitment that one must not care. It is a powerful and pervasive myth that allows one at once to make the other's decision and to deny that one had anything to do with it. If Mr. B had been given any real choice between dying to silence the ventilator and living on for the next two months in the grip of such dread that he could never be at peace, what would he have chosen? No one can be certain that hindsight provides any wisdom. In going on, at least the possibility of making choices was not closed off. The matter of his informed consent was only an illusion because actually no one could have informed him about his death in any meaningful sense.

III
DECISION

I also met Mr. C on the first day I returned to the ICU. Death
seemed near. Only thirty-four years old, he had suffered from the ravages of diabetes mellitus since childhood. His kidneys having failed some years ago, he had hung on to life by performing chronic ambulatory peritoneal hemodialysis. At home each night he would hook up the bottles and the tubing that delivered a wash of his abdominal cavity, draining away the toxic waste products that relentlessly built up in his bloodstream. He was angry and bitter at his lot, but worked to survive.

But then his father had entered the room without wearing a surgical mask and coughed while Mr. C was setting up his dialysis. A few days later, Mr. C arrived at the hospital with his diabetes out of control and complaining of abdominal pain. He blamed his troubles on his father’s uncovered cough. His diabetes was treated, and his blood was cleansed by a mechanical kidney machine, but the pain persisted. He was taken to the operating room to explore his abdomen, but no surgically correctable problem was found. Bacterial cultures of fluid in Mr. C’s abdominal cavity and blood from that time later grew staphylococcal bacteria, which would not be suspected to have been there as a result of anyone’s cough.

After the operation, his blood pressure collapsed. To save him from certain death, high doses of intravenous medications had to be given to sustain enough blood pressure so that his brain would not, it was hoped, suffer irreversible injury from want of oxygen. The medication supporting blood pressure was slowly withdrawn over the next weeks as the infection responded to antimicrobial therapy that had been started at the time of surgery. Dry gangrene of the hands and feet was the unavoidable consequence of what had been necessary to avoid death from bacterial shock.

One month ended, and the next began. I met Mr. C after being advised by his kidney doctors that his situation was hopeless, and that the ventilator should be disconnected and all therapy discontinued. My problem was that I could not be certain that further therapy would be of no benefit to the patient. In the face of uncertainty and disagreement, and a very sick and wholly unresponsive patient, the hospital ethics committee asked to meet with all the patient’s physicians, nurses, respiratory therapists, and social workers to facilitate formulation of a plan under the circumstances. A physician and a nurse skilled in psycho-social issues in critically ill patients represented the ethics committee.

My position was based on my worry that it was not possible to determine the potential quantity or quality of life Mr. C might have. The appropriate choice was to discontinue the narcotics and sedatives he was being given to ensure that he not suffer from the horrible discomforts and indignities that necessarily accompanied the heroic effort to save his life. If he were to awaken, if he could breathe without the aid of a machine, then Mr. C himself could be asked what sort of plan he thought was appropriate.
I was not persuaded by the arguments of the kidney doctors. They had known Mr. C for years as a bitter and angry man who was not wholly cooperative with his therapy or grateful for the possibility that he could go on living. In the past, he had once been maintained for a time on a kidney machine, coming to the hospital several times a week to be hooked up so that he would not slowly die from kidney failure. He had been hateful and unruly, and had readily agreed that he preferred to manage his disease by himself, at home. He had even said that he would rather die than ever be treated on a kidney machine again. The kidney doctors believed now that it would no longer be possible for him to manage his disease at home, and that it would be very disruptive to have to accommodate him with their many patients maintained by periods on the hospital’s kidney machines. In addition, they believed that even were it possible, it would be futile because Mr. C had no chance of making a meaningful recovery—he would be totally helpless absent his dead hands and feet. They, and nurses and social workers, had also spoken with Mr. C’s father, who was of the opinion that his son’s life had been a living hell for everyone, and that he should not be tormented further.

The ethics committee representatives explained at the outset that the final decision was solely in the hands of the attending physician. My sense was that for Mr. C a living hell might be preferable to no living at all. As a result, the meeting was only a formality. Everyone having expressed an opinion, therapy was continued with a regular schedule on a kidney machine. The narcotics and sedatives were stopped, and Mr. C gradually improved to the point where he no longer required mechanical ventilatory support. After he regained some strength and began to have lucid intervals when he knew who he was and where he was, what had happened to him and why was repeatedly explained to him. Mostly, he just lay in his bed staring at his black, withered hands. He never asked about them or commented on them to anyone, and was only silent when it was explained that soon they and his toes would need to be amputated.

Respect for patient autonomy dictates that conscious, competent patients make their own decisions, even if the decision is to let others make decisions for them or to forgo therapy that is absolutely necessary for survival. The leftover questions concern the meaning of conscious, the meaning of competent, and the judgment of the decisions made. The answers are indeterminate. Even if patients have expressed or suggested wishes or desires prior to their incapacity and their competence or

86. See supra note 81. See generally Appelbaum & Grisso, Assessing Patients’ Capacities to Consent to Treatment, 319 NEW ENG. J. MED. 1635 passim (1988) (reviewing concepts of competence and approaches to help doctors make necessary assessments about patients’ decisionmaking capacity); Comment, Capacity, supra note 42, passim (proposing “capacity for interpersonal relationships” standard).
capacity to have done so is not disputed, there is no clear way to apply such abstract wishes or desires to specific medical decisions required in particular settings of acute illness and threat of death. The law wants to freeze time in certainty of decision. What the patient loses is the liberty of a change of mind in a change of circumstances. What is lost when what patients were, or are, becomes more important than what they can be, is precisely the possibilities that lie ahead—that which is their own.

Patient autonomy, however difficult and indeterminate in the conscious patient, is wholly incomprehensible as a principle for decisionmaking for incompetent or unconscious patients. This was a problem faced in Superintendent of Belchertown State School v. Saikewicz. Like Mr. C, Joseph Saikewicz was unable to choose. He was a sixty-seven-year-old man, profoundly retarded and unable to communicate, who had been institutionalized since early childhood. He was diagnosed as suffering from an invariably fatal leukemia. The question for his court was whether he should be treated. It was known that despite serious adverse side effects, high risk of failure, and limited promise of success of treatment, the majority of persons suffering from this particular leukemia who were able to make an informed choice chose to be treated. Joseph Saikewicz could not understand the nature of his illness or its prognosis, could not respond to inquiries as to whether he was experiencing pain, and could not cooperate with the treatment. He would have had to have been sedated and restrained, and he would not have understood the discomforts that would have resulted from the treatment. His only living relatives preferred not to become involved in the decision of whether to treat him. Therapy was held pending judicial choice for him.

The court arrived at a decision after Joseph Saikewicz was already dead from a complication of his leukemia. It rationalized its decision

87. Advanced directives concerning medical decisions at the end of life are beyond the scope of this essay. For a discussion of living will and "right to die" statutes, see Gelfand, Living Will Statutes: The First Decade, 1987 Wis. L. Rev. 737 (comparing and evaluating existing living will statutes); Medical Technology, supra note 3, at 1670-72 (examining state "right to die" statutes). For empirical evidence that such advance directives are not effective in practice, see Davis, Southerland, Garrett, Smith, Hielema, Egner & Patrick, A Prospective Study of Advance Directives for Life-Sustaining Care, 324 NEW ENG. J. MED. 882 (1991).

88. People can revise their goals, their values, and their definitions of personal well-being when faced with new realities. Or, they may simply change their minds. Seizing on any arbitrary moment for final definition of people denies their ongoing identity. See supra notes 26-27 and accompanying text; see also Medical Technology, supra note 3, at 1650 (uncertainties involved in effectuating expressions of patients' prior choices).

89. 373 Mass. 728, 370 N.E.2d 417 (1977). The patient stories and case law in this essay could all be thought of in terms of comprehensibility of the principle of autonomy.

90. The cause of his death was precisely one of the conditions identified as a toxic side effect of treatment, one that caused unacceptable pain and discomfort. Saikewicz, 373 Mass. at 734, 370
not to treat him on a legal theory of "substituted judgment,"91 which was "subjective" in that its "goal [was] to determine with as much accuracy as possible the wants and needs of the individual involved."92 To this end,

the decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.93

Although courts and commentators have ridiculed the Supreme Judicial Court of Massachusetts for this formulation,94 it perfectly articulated the essence of substituted judgment doctrine. The decision made is the decision the patient would make were the patient someone else. The surrogate decisionmaker, whether a court, a doctor, family, or anyone else, can only make a decision that is not the patient's own. But once made,

N.E.2d at 421. The court, however, characterized his death as "without pain or discomfort." Id. at 735, 370 N.E.2d at 422.

91. Id. at 751-52, 370 N.E.2d at 431. See generally Medical Technology, supra note 3, at 1646-57 (substituted judgment standards).

92. Saikewicz, 373 Mass. at 750, 370 N.E.2d at 430. In brushing past the fact that people who can choose almost always choose treatment, the court defended the right of incompetent people to have a different choice imposed on them, explaining that

[t]he "best interests" of an incompetent person are not necessarily served by imposing on such persons results not mandated as to competent persons similarly situated. It does not advance the interest of the State or the ward to treat the ward as a person of lesser status or dignity than others. To protect the incompetent person within its power, the State must recognize the dignity and worth of such a person and afford to that person the same panoply of rights and choices it recognizes in competent persons. If a competent person faced with death may choose to decline treatment which not only will not cure the person but which substantially may increase suffering in exchange for a possible yet brief prolongation of life, then it cannot be said that it is always in the "best interests" of the ward to require submission to such treatment. Nor do statistical factors indicating that a majority of competent persons similarly situated choose treatment resolve the issue. The significant decisions of life are more complex than statistical determinations. Individual choice is determined not by the vote of the majority but by the complexities of the singular situation viewed from the unique perspective of the person called on to make the decision. To presume that the incompetent person must always be subjected to what many rational and intelligent persons may decline is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality.

Id. at 746-47, 370 N.E.2d at 428. The court argues at elaborate length to justify imposing a choice that most rational and intelligent persons would regard as foolish. Evidently, they were persuaded, but it is still difficult to understand why people would want to have a foolish choice made for them even if it were symbolic of their autonomy.

93. Id. at 752-53, 370 N.E.2d at 431.

94. See, e.g., In re Jobes, 108 N.J. 394, 424, 529 A.2d 434, 450 (1987); R. BURT, supra note 8, at 149-50, 152-53 (criticizing Saikewicz court for insisting that treatment decisions could only be reached through an imagined construction of Saikewicz's wishes); L. TRIBE, AMERICAN CONSTITUTIONAL LAW § 15-11, at 1369 (1988) (describing Saikewicz as "reaching[ing] almost Alice in Wonderland proportions"); Rhoden, supra note 64, at 385-86 (arguing that because the Saikewicz court was following judicial inclination to equate competents with incompetents, it had to "postulate a miraculously lucid Mr. Saikewicz looking down upon himself and his plight"); Medical Technology, supra note 3, at 1648-49 (despite criticism, Massachusetts courts continue to apply Saikewicz standard in cases involving patients who were never competent).
the surrogate's choice becomes the patient's own decision, which must be executed in "regard for human dignity and self-determination." 95

Questions about patient competence, and about the locus of decisionmaking power for patients whose competence is questioned, ignore the crucial issue of the patient's own interest in the outcome of the decision that is about to be made. The theory is that a struggle for power breaks out among family, friends, and health providers, and, if this struggle is indecisive, with the government as parens patriae becoming involved as well. Each party lays claim to interests coincident with the patient's, but to grant any of these claims is to impose a choice upon the patient that is false in that it is not the patient's own. Nevertheless, a decision is made, and power is acquired in the patient's utter helplessness and impotence—the "patient's" decision must be obeyed.

The various doctrines of surrogate decisionmaking attempt to end the power struggle and to justify taking the patient's choice from him and granting it to another. The fiction advanced is that the decision is what the patient would decide. 96 Only the reality is that the patient is obliterated when the choice is made by another. It is the only solution law can see when the patient cannot decide. The assumption is that some decision must be made. Not only what but also whether to decide is a matter in which the patient has no possibility of choice. And then the decision made for the patient magically becomes the decision made by the patient. The patient's dignity is respected by obedience to that choice. The patient is responsible. But what is really going on is normative disavowal of personal responsibility. 97 It is a tidy matter to rest responsibility on the victim. Everyone else is powerless, impotent before the patient's autonomy. Hidden away may be secret relief in getting rid of one who could exercise such power.

Norms of paternalism oppose this abdication of personal responsibility. 98 Such norms are disfavored because they are not products of the free will of the beneficiaries. Tyranny is legitimately feared if paternalism is an issue of power, and the problem is that there is no obvious stopping place once some people start telling other people what they

95. Saikewicz, 373 Mass. at 739, 370 N.E.2d at 424.
96. For empirical evidence that identity of patient and surrogate choice is in fact fiction, see Seckler, Meier, Mulvihill & Paris, Substituted Judgment: How Accurate Are Proxy Predictions?, 115 ANNALS INTERNAL MED. 92 (1991) (neither family members nor physicians were able to adequately predict currently competent, chronically ill elderly patients' wishes in hypothetical cardiopulmonary resuscitation scenarios).
97. Moreover, it is a disavowal of morality. "The essence of moral decision is the exercise of choice and the willingness to accept responsibility for that choice." C. Gilligan, supra note 8, at 67.
98. See Kennedy, supra note 35, at 638-49 (arguing for ad hoc paternalism); see also M. Kelman, supra note 8, at 137-41 (discussing critical legal studies critique of paternalism).
ought to do. But paternalism might be an issue of false consciousness\textsuperscript{99} on the part of either patients, who make mistakes about what is best for themselves, or doctors, who are trying to do what is best for their patients. Paternalism might be desirable if it were based not on the incompetence of patients to decide for themselves, but rather on the differences between doctors and patients, their needs for each other, and care. Then the problem would be its scope, which would be limited by capacity to know the consciousness of the other.\textsuperscript{100}

There are two variants of paternalism.\textsuperscript{101} Strong paternalism claims an intuitive access to the consciousness of others so as to participate in their suffering directly.\textsuperscript{102} In the version of strong paternalism doctors have historically embraced, access to the consciousness of others comes from the esoteric knowledge of the medical profession, which qualifies doctors to know their patients, and to share an identity of interests. Whatever the source of this privileged access, the hypothetical identity which is its result has been thoroughly debunked.\textsuperscript{103} Strangers, and even friends, cannot be so intimate as to coincide with the other. And if they could, the other would be obliterated by no longer existing separately. In fact, no exercise of power would even be necessary because the other would have the identical interests and make the identical choices that the stranger or friend would be tempted to impose.

Weak paternalism, unlike strong paternalism, claims no special access to the consciousness of others because knowing them is not necessary at all\textsuperscript{104}—weak paternalism rests on a belief in the paternalist’s moral superiority. Weak paternalists decide what is best based on their own notions of how others ought to act. But weak paternalism is disqualified from serious consideration because there can be no principled basis for or limit to arbitrary domination when there can be no claim of knowledge of the one who will be dominated.

What is left when autonomy is a fiction and paternalism a tyranny is a responsibility to care and to take the risks care engenders. This is the soul of medicine’s legitimate task. “People are idiots.”\textsuperscript{105} They need to

\textsuperscript{99.} Cf. Kennedy, supra note 35, at 626-31 (contract law imposes compulsory terms in the belief that buyers suffer from false consciousness preventing them from supplying the terms themselves).

\textsuperscript{100.} Id. at 624.

\textsuperscript{101.} Id. at 638-42 (subsection entitled The Phenomenology of Paternalism).

\textsuperscript{102.} Id. at 638.

\textsuperscript{103.} See, e.g., R. Burt, supra note 8, at 92-123 (problems of objectivity and subjectivity in patient-doctor relationship); J. Katz, supra note 4, at 1-29 (historical foundation of identity of interests concept).

\textsuperscript{104.} “Weak is to strong paternalism as the legally compelled altruism of tort law is to the true altruism that causes us to put on the brakes rather than run down a pedestrian guilty of contributory negligence.” Kennedy, supra note 35, at 641.

\textsuperscript{105.} Id. at 633.
be protected against themselves, and others, because people do not always know or choose the possibility they ought to prefer. The underlying theory is human fallibility and finitude. This theory is an insult to human dignity only if the contrary assumptions—that people are infallible and immortal—are correct. The conviction that a modest theory of humanity is correct is the very foundation of both law and medicine. It is what judgment and care are all about.

Doctors should be "ad hoc paternalists." Perhaps paternalism will always be in some sense suspect, because whether it purports to be grounded in esoteric knowledge, or whether it alleges moral superiority as its foundation, people distrust its origins. But this need not be fatal if people can reconcile themselves to the means through which paternalism operates. And here "ad hoc" paternalism is different from both strong and weak paternalism. This difference rests on the distinction between power and care—between the doctor as ventriloquist, seeming to speak as the patient, and a genuine dialogue in which doctor and patient continually redefine each other and themselves. In this dialogue, the true goal of doctors is not to tip the balance of power in their favor. Realizing that everyone is likely to make mistakes, or be sick or old or abandoned or just not cared for, there is a possibility that they might need to be protected not only from others but also from themselves. It is not a question of power—it is a question of care.

The obligation to care involves enormous risks. The most important is that the subject of care may not forgive doctors for taking things into their own hands. The patient may be angry, and the doctor will suffer

106. "[I]mage a society in which everyone agreed that in particular situations or states of mind, everyone was likely to make mistakes and needed to be protected from themselves. The category of paternalism might come up mainly with strong positive connotations of loving care for others." Id. at 588.

107. For a discussion of "ad hoc paternalism," see Kennedy, supra note 35, at 638-49 (section entitled Ad Hoc Paternalism). "[I]n fear and trembling you approach each case determined to act if that's the best thing to do, recognizing that influencing another's choice—another's life—in the wrong direction, or so as to reinforce their condition of dependence, is a crime against them." Id. at 644. But see M. Kelman, supra note 8, at 139-41 (finding Kennedy's argument for ad hoc paternalism strained and incomplete, and rejecting paternalism not grounded in intimacy).

Ad hoc paternalism suffers from inclusion of the dreaded "paternal" in its name. But since it would not be changed in substance by calling it by some other name, "maternalism" for example, there does not seem to be any compelling need to coin a new designation. The only purpose that might serve would be to deceive temporarily the most casual and inattentive autonomists. See Kennedy, supra note 35, at 589.

108. "The idea of power as domination recedes in favor of the idea of power as capacity—notably the capacity to provide care to others in the network of connection." Karst, supra note 38, at 487; see also C. Gilligan, supra note 8, at 167-68 (referring to women's fantasies of equating power with giving and care).

109. Kennedy, supra note 35, at 649. The way to reach this goal is to recognize the incapacity of patients, not to deepen it by demanding that patients be abandoned to their mistakes.
both because a seemingly valid project was frustrated and because a patient's anger hurts. Moreover, there is the shame and guilt of the injustice of bad judgment. Another important risk is that of being haled into court for public rebuke and humiliation, and having competency and capacity called into question, most sharply by doctors themselves. But there is no way out. Doctors can be criticized for bad custodial decisions, for intervening, and for not intervening. Whatever they do, they will be said to be playing God with their patients' lives. And whatever they do, they have to take responsibility for the consequences.110

That is the moral compass of medicine—the risks in allowing patients what is their own, and the responsibility to care. Its limits are the possibilities that lie ahead. There is no possibility to be smug or sanctimonious, because Mr. C might blame his doctors, and his doctors might blame themselves, for his being condemned to live even one more day. Only death can finally rule out that possibility.

IV

Resolution

I had first met Mr. D when he entered the hospital with AIDS and pneumonia. He wanted everything done that could possibly be done to save him from death for as long as possible. As death was then very near from suffocation by the infection in his lungs, he was moved to the ICU and placed on a mechanical ventilator. The infection responded to treatment, but his lungs scarred as they healed and he could not be weaned from the ventilator. I left him in the care of others before it was obvious that he could never survive outside the ICU.

I met Mr. D again more than eight months later when I returned to attend in the ICU. His course had been one of relentless complications of therapies, brushes with death, salvation through heroic efforts of his own and his health-care teams. He had no family, and his friends had dwindled in number and then disappeared as the months wore on. The ICU became his home, and his doctors, nurses, and therapists his family.

But he was a changed man. Ravaged by disease and therapies, imprisoned in his hospital bed by illness and the mechanical ventilator, he still recognized me from those days when together we had pledged to fight with all we had for his life. He alternately begged me for death and blamed me for his sorry existence. He raged on in his every lucid moment. It was one of the hardest decisions I ever had to make, and I am haunted

110. [W]hat we need when we make decisions affecting the well-being of other people is correct intuition about their needs and an attitude of respect for their autonomy. Nothing else will help. And even intuition and respect may do no good at all. There isn't any guarantee that you'll get it right, but when it's wrong you're still responsible.

Id. at 646.
by it to this day as though it happened yesterday. Only it was more than a decade ago.

People ought to be allowed that which is their own—their death. Of course, no one can take it away from them, but people's deaths may be hastened or postponed. Whether either should be the case is not an open-ended question. Doctors cannot perform miracles. Sometimes treatment is impossible or futile, and there is no choice presented to doctors or patients.111 When there is no treatment that can restore a conscious and sapient life in which choices may be made, people can only be made more comfortable. When there can be no recovery, there is simply no use for doctors and patients struggling only to sustain biological life.112

Accepting that there is no longer any treatment that can restore a person's possibility to choose was a problem faced in *Cruzan v. Director, Missouri Department of Health.*113 Like Mr. D, Nancy Cruzan had no

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111. Generally, three separate reasons to cease life support are recognized: the patient wants to stop, society wants to stop, or the life support is futile. Futility is the sphere of doctors' decisionmaking. *See generally* Schneiderman, Jeeck & Jonsen, *Medical Futility: Its Meaning and Ethical Implications,* 112 ANNALS INTERNAL MED. 949 (1990) (arguing that "futility is a professional judgment that takes precedence over patient autonomy and permits physicians to withhold or withdraw care deemed to be inappropriate without subjecting such a decision to patient approval," *id.* at 953). The medical futility principle may be at least partially quantifiable. For example, a doctor might conclude that a treatment is futile if it has proved useless in the last 100 cases. *Id.* at 950-52 (distinguishing benefit that appreciably improves person as a whole from effect limited to some part of the patient's body). Qualitative judgments are not eliminated. *Id.* at 952-53; *see also,* e.g., Council on Ethical and Judicial Affairs, American Medical Association, *Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders,* 265 J.A.M.A. 1868, 1870 (1991) (discussing futility as a basis for withholding cardiopulmonary resuscitation); Ruark, Raffin & The Stanford University Medical Center Committee on Ethics, *Initiating and Withdrawing Life Support: Principles and Practice in Adult Medicine,* 318 NEW ENG. J. MED. 25 (1988) (practical advice on appropriate response to case law); Schneiderman & Spragg, *Ethical Decisions in Discontinuing Mechanical Ventilation,* 318 NEW ENG. J. MED. 984 (1988) (practical advice on unplugging mechanical ventilators). Empirical evidence as to how decisions to withhold and withdraw life support from critically ill patients actually are made is presented in Smedira, Evans, Grais, Cohen, Lo, Cooke, Schecter, Fink, Epstein-Jaffe, May & Luce, *Withholding and Withdrawal of Life Support from the Critically Ill,* 322 NEW ENG. J. MED. 309, 309-15 (1990) (physicians and families usually agree to limit care).


113. 110 S. Ct. 2841 (1990). The dispute was between Nancy Cruzan's parents and Missouri, not between Nancy Cruzan and her doctors. One view was that it actually involved Missouri's desire to define life. *See id.* at 2886-89 (Stevens, J., dissenting). An analogous suspicion may be raised about the decision of Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986), in which Elizabeth Bouvia might have been used as a means to advance the end of the "right to die." *See Longmore, supra* note 20, at 156-59, 161-62. The patient stories and case law in this
possibility to do anything other than survive biologically.114 She had lost control of her car in 1983, landing face down in a ditch where she was found without detectable respiratory or cardiac function. Her brain was severely and irreversibly injured by lack of oxygen, but she survived in a persistent vegetative state from which there was no possibility of regaining her cognitive faculties.115 Her parents petitioned the courts to order withdrawal of their daughter's artificial feeding and hydration equipment because there was no chance she could recover.

The Court, in affirming the decision of the Supreme Court of Missouri that Nancy Cruzan's parents lacked authority to effectuate their request to withdraw life support,116 considered the question presented to be a narrow one of whether the United States Constitution prohibits Missouri from choosing the rule of law that it had chosen.117 Despite rights and values dicta in the court's opinion,118 the two concurring opinions,119 and the two dissenting opinions,120 Nancy Cruzan was not allowed her death.121 Procedural concerns—federalism—guided the decision, perhaps because the substance was too difficult to reach.122

The substance of medical decisionmaking at the end of life by doctors and their patients cannot be avoided on procedural grounds. The essay could all be thought of in terms of the possibility to choose and in terms of people as means or ends.

114. Unlike Nancy Cruzan, Mr. D was able to communicate his wishes directly and the judicial process had not been brought to bear on his plight. In part for these reasons, the decision for him was the opposite of that for Nancy Cruzan.

115. Cruzan, 110 S. Ct. at 2879 & n.2 (Stevens, J., dissenting) (succinctly describing Nancy Cruzan's medical condition, a persistent vegetative state).


117. See Cruzan, 110 S. Ct. at 2851. The decision rests on federalism concerns. Because "no national consensus has yet emerged on the best solution for this difficult and sensitive problem [of the right to refuse medical treatment], . . . the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the 'laboratory' of the States . . . ." Id. at 2859 (O'Connor, J., concurring).


119. Id. at 2856-59 (O'Connor, J., concurring), 2859-63 (Scalia, J., concurring).

120. Id. at 2863-78 (Brennan, J., dissenting), 2878-92 (Stevens, J., dissenting).

121. Id. at 2856 (concluding, in affirming the judgment of the Supreme Court of Missouri, that "the State may choose to defer only to those wishes [for which there is clear and convincing evidence], rather than confide the decision to close family members"). Contra Rhoden, supra note 64, passim (arguing for a presumptive right of families to exercise discretion over treatment decisions).

122. A State that seeks to demonstrate its commitment to life may do so by aiding those who are actively struggling for life and health. In this endeavor, unfortunately, no State can lack for opportunities: there can be no need to make an example of tragic cases like that of Nancy Cruzan.

Cruzan, 110 S. Ct. at 2892 (Stevens, J., dissenting).

On remand, friends of Nancy Cruzan offered new testimony on her prior wishes, and her doctor gave new information about her deteriorating physical condition. The county probate judge authorized Nancy Cruzan's parents to cause the removal of her nutrition and hydration. Missouri had withdrawn from the case. N.Y. Times, Dec. 15, 1990, at A10, col. 1 (nat'l ed.).
process that is due is one of working through possibilities until futility signals that the task has ended and that all that is left due is dying.\textsuperscript{123} The task itself is particular to particular patients in their relationships with their particular doctors. When no treatment is left that can restore a patient's ability to choose, the patient's doctor has no reason to go on treating. There is nothing left to be done but to let patients be who they are, to allow them what is their own—their death.

This is the nature of the medical enterprise: ad hoc paternalism in the face of profound uncertainty. Patients meet their doctors on their way, and by sharing their maladies invite doctors to restore or maintain their possibilities. Doctors can only accept this invitation insofar as they communicate with their patients and take personal responsibility for sharing the way. Because this way is so uncertain, doctors and patients must set out along it together. And their way together is not endless. Doctors can only accept their patients' invitations to go along this way insofar as death does not interfere.

The temptation can be to succumb to the belief that medicine is just one of the sciences, that the enterprise of healing can be objectified and perfected. Given modern knowledge, how patients ought to be treated should be determined rationally by what is scientifically known about the disease from which they suffer. The disease ought to make the choice as to the therapy required. Medical decisionmaking would be greatly simplified if it could thus be totally objectified and judged. There would not even be any need for doctors because patients could use science to heal themselves.\textsuperscript{124} Aside from any concern that there is probably no reasonable basis for a belief that scientific knowledge of human disease will soon, if ever, be thoroughly reliable for self-healing, such a promise would only address one aspect of the uncertainty of judgment. The "right" treatment might be plain, but patients and their doctors would be made slaves to the commands of science. There would be no occasion to choose, no need for responsibilities between doctors and patients, and patients would be left to face scientific possibilities without the companionship of healers who care. Many complaints about contemporary medical practice stem from the emergence and growth of this vision. The false promise of scientific, objectified health care has invited bureaucratization and subsequent loss of personal responsibility and care by doctors.\textsuperscript{125} As the

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\item \textsuperscript{123} See supra notes 111-12 and accompanying text.
\item \textsuperscript{124} Doctors generally believe that, in treating themselves, they have a fool for a patient. An analogous belief is held by lawyers. Cynics could claim economic bases for these beliefs rather than others' good.
\item \textsuperscript{125} For two different critiques of the ethos of scientific medicine, see R. BURT, supra note 8, at 92-123 (the "scientific endeavor" is composed of "intertwined destructive and constructive aspects"; "[t]he exhilarating sense of self-mastery that comes from extending the reach of rational control
medical-industrial complex gains the upper hand in the "health care industry," patients and doctors become victims of excessive faith in human reason, in posited values, in policies. An appeal to the certain judgment of science is a prayer to a false god.

The principle of autonomy fuels the alienation of doctors and patients. When this nice value gets applied to the messy and uncertain circumstances of sick and dying people, the interest that is primarily promoted is patients’ pride, not their dignity.\textsuperscript{126} The circumstances of medical decisionmaking at the end of life require some guiding principle other than everybody for themselves, because in these circumstances each person is inextricably bound to others.\textsuperscript{127} Rights, with their requirement that people be separate and competing individuals, are not a proper framework for resolving the conflicting responsibilities of people connected in the activity of care.\textsuperscript{128} The necessity and compulsion of the norm of autonomy are not always appropriate in a reality composed of relationships rather than of people standing alone.\textsuperscript{129}

Helping is not a favor one does someone else. There simply is no right to refuse to care when one is in a position to help.\textsuperscript{130} "[A] doctor's readily, almost indistinguishably, becomes transformed into the impulse to destroy everything that seems beyond control," \textit{id.} at 112); \textit{J. KATZ, supra} note 4, at 40-46, 180-82 ("[m]odern medicine remains caught between science and intuition," \textit{id.} at 46).

\textsuperscript{126} The focus on abstract autonomy "encourages name-calling and defensive self-righteousness" and "divert[s] inquiry away from the concrete harms caused to real people" in real situations. \textit{KARST, supra} note 38, at 488.

\textsuperscript{127} The idea of a morality of responsibility is argued by \textit{C. GILLIGAN, supra} note 8, passim (contrasting men's "ladder" morality of rights with women's "web" morality of responsibility). \textit{Cf. Karst, supra} note 38, passim (speculating on the consequences of applying the morality of responsibility to constitutional law).

The view from the ladder tends to produce a morality of rights, an abstract hierarchy of rules to govern the competition of highly individuated individuals. To see the world from the web, however, is to see individuals in connection with each other, and to see morality as a question of responsibilities to particular people in particular contexts. \textit{Id.} at 462. For a further discussion of these different approaches to self-definition, see \textit{id.} at 483-84 (contrastng identity in separation with identity in connection).

\textsuperscript{128} \textit{Cf. C. GILLIGAN, supra} note 8, at 19 ("morality as concerned with the activity of care centers moral development around the understanding of responsibility and relationships . . . [whereas] the conception of morality as fairness ties moral development to the understanding of rights and rules").

Every argument made as to why patients need to be protected by law from their doctors could be made as well as to why clients need to be protected from their lawyers and parties from their judges. \textit{See generally} Simon, \textit{Visions of Practice in Legal Thought}, 36 \textit{STAN. L. REV.} 469 passim (1984) (contrasting lawyers' traditional professional notions of client and system with vision derived from critical legal writing); \textit{Simon, The Ideology of Advocacy: Procedural Justice and Professional Ethics}, 1978 \textit{Wis. L. REV.} 29 (1978) (imagining "non-professional" advocacy). How the legal system might be imagined getting a dose of its own medicine is beyond the scope of this essay.

\textsuperscript{129} \textit{Cf. C. GILLIGAN, supra} note 8, at 26-29 (describing a study in which a boy sees a moral problem as "a math problem with humans," while a girl—whose perspective the study discredits but Gilligan affirms—sees "a world comprised of relationships, rather than of people standing alone").

\textsuperscript{130} "[T]here can be no 'rule' against paternalism." \textit{Kennedy, supra} note 35, at 647. Such a
first duty is to ask forgiveness”—forgiveness for the temporary inequality of power with patients and for the uncertainty of knowledge and ability to heal. There is no duty to engage in a struggle of wills. The goal for medicine is to use its powers to remove the disparity of power by restoring patients to the possibilities that lie ahead.

The decision to disconnect Mr. D from life support involved responsibilities, not merely rights. The problem was to untangle the reluctance to choose from the reality of having no choice at all. There was no treatment that could free Mr. D from total preoccupation with sustaining biological life in the intensive care unit. Responsibility had to be taken for facing death. The possible wrong inhering in this decision, that the patient would not be allowed his death, need not be avoided by appealing to autonomy, where the results of such appeal would be uncertain. This wrong is recognized better by an appeal to the care that directs the relationship of doctors and their patients.

The haunting is that someone was hurt in that his life could not go on and everyone else was left without him. There was a failure to heal in the face of uncertainty, a frustration before the unknown. A decade ago, science made no pretense of mastery over Mr. D’s circumstances. Whether there might have been other and better choices that could have been made by both Mr. D and his doctors can never be known. The only certainty was an irrevocable decision grounded in the dialogue between fairness and care.

A

Mrs. A’s sister returned to Ireland when she was unable to secure permission to sell Mrs. A’s house. The priest never returned to the hospital after he and I had a vigorous argument about theology and morals. More than nine months later, Mrs. A was finally able to breathe on her own.
Slowly and painfully, she regained her weight, which had fallen to as little as forty-five pounds.

Mrs. A was not one of my patients last summer. We knew each other for many years. She always fended off my questions about her wishes past and present for life with a stern embarrassment. Her legs were crippled from her ordeal in the ICU, and she went to a nursing home in a wheelchair to live out her days. There, she was known for her ready wit and good humor, her delight in Christmas decorations, and her uncanny ability to cadge cigarettes from visitors.

"Whether this is the only way or even the right one at all, can be decided only after one has gone along it." It is a paradox of human finitude. The right path can be known only after one has gone along it, and one can never know paths not taken. The way gone along is not subject to change by approval or disapproval at a later time, and it cannot be validated or invalidated by casting wisdom back over it. It is the "right" way in that it was the one gone along. The way not taken never has any existence to be judged at all. No one can take back the past. People are what they might have been based on what they have been, not based on what they might have been or what they wish they had been. Decisions seemingly proved "right" (or "wrong") by the passing of time are not in need of any proof at all. At the moment of choice, the future gapes dark and empty. It is nothing until it is filled by making a way into it, groping toward possibilities.

This paradox might appear fatalistic, reason enough to acquiesce in the death wishes of people like Mrs. A and Elizabeth Bouvia. If they were dead, nothing could be changed for them by making judgments. No one can take back death. But what can be changed are ways yet to be chosen. Acting to close off the way ahead is not the right way at all—nothing can be decided after one has gone along it. To escape from the paradox, those faced with decision must focus their vision on the possibilities that lie ahead. Healing is an event, not a thing. It is only known in its happening.

If Mrs. A’s sister and her priest had been more tenacious, and her doctors less lucky and skillful, it is easy to imagine that her story could have had a different ending. Lawyers might have been brought in to vindicate her rights, judges could have become involved to make her decisions for her, and she might have been shoved aside so that a power struggle could be played out between autonomy and care. She might have become, in the end, merely an object of charity to be put out of her misery. Doctors do not have to become parties to such struggles. Doctors treat patients who seemingly wish to end their lives all the time.

135. M. HEIDEGGER, supra note 1, at 487.
Treating these patients against their will need not be characterized as an assault on their autonomy. Rather, in recognizing that people's wills can be set on choices that are irretrievably false for them, treatment is necessary precisely to preserve any possibility of autonomy at all. The principle of autonomy loses all coherence when it is applied for self-destruction.

Of course, making decisions with and for patients entails risks that patients might feel that the choices made were false regardless of who made them or that, in the alterative, their deaths will deprive them of any further choices. Every decision is irreversible in that it closes off other ways that might have been gone along.136 These risks are unavoidable if doctors are to take their responsibilities to go along the way with their patients.

B

When I left to return to law school, Mr. B was fading rapidly, wasted by the inevitability of his approaching death. I heard later that, after consultation of his doctors with the hospital's ethics committee, he had "sort of" agreed that death could not be avoided, and had been given a dose of morphine before he was disconnected from the ventilator.

Not every decision can be imagined with certainty to have been proved right by the passing of time. Looking back on the agonies of the two-month struggle Mr. B was invited upon by not heeding his wishes to be disconnected from his ventilator, the path taken was not clearly wise. The path never taken would, however, have closed off the possibility of ever arriving at this doubt. A decision to press on can open the possibility of a living hell,137 but that possibility can never be more than elusively hypothetical at the time a decision must be made. A change of mind in a change of circumstances remains open.

The futility of changed circumstances can itself prove to be a slippery concept. Futility is capable of only the roughest quantification, and cannot be secured against cynical manipulation to serve ends other than preserving choice. But a judgment that some lives are not worth living guarantees arbitrary results.138 Drawing a boundary and proclaiming that those who fall on one side of it may be allowed to die may appear to

136. Even decisions not to decide, which merely seem to preserve the status quo, close off alternative decisions that could have been made.

137. This is not a risk where patients in persistent vegetative states are oblivious to the path taken, because recovery and consciousness are not possible. Only the sapient and cognitive can be tormented by the biological existence of the hopelessly damaged. See, e.g., Cruzan v. Director, Mo. Dept of Health, 110 S. Ct. 2841, 2845 & n.1 (1990); In re Quinlan, 70 N.J. 10, 23-26, 335 A.2d 647, 654-56 (allowing father of woman in persistent vegetative state to have her respirator removed), cert. denied, 429 U.S. 922 (1976).

138. See D. LAMB, supra note 10, at 12. The slippery slope phenomenon, which "begins when
be morally commendable to relieve suffering. But there are always problems that there may be alternative relief, and that such lines have the inherent danger of being exploited by evil intentions. The way to avoid the slide into indeterminacy that necessarily arises from loose concepts is to adhere to a very rigid principle with exceptions that are both few in number and acknowledged as wrong.¹³⁹ Moral hypocrisy at least recognizes principles, rather than simply rejecting them.¹⁴⁰

The people in the most immediate danger from the “right to die” are the unconventional, people who have handicaps or disabilities, or even unpopular diseases, that separate them from conventional people who can set themselves up to pass judgments over them. One argument for disconnecting Mr. B from his ventilator that arose even before he was attached to it was that AIDS rendered all treatment futile. Hidden in this argument are the assumption that patients with AIDS are already condemned to a living hell, and the judgment that the hypothetical quality of their future living recommends mercy in a quick and painless death. This assumption itself is living hell, condemnation to estrangement from others. The erroneous conclusion is that people have arrived too late to be cared for or helped. Confidence that barriers can be erected on the way down the slippery slope to provide appropriate care to those who are said to have arrived in time is precarious. The burden of proof should be on the confident advocates of such barriers to justify why the killing should begin before it progresses to swallow the people who most need care and protection.

C

When Mr. C no longer required the resources of the intensive care unit, he was transferred to a bed on the hospital wards where his care came under the authority of the kidney doctors. In his increasing lucid moments, he repeatedly and spontaneously expressed his desire to live. But his therapy was postponed beyond the time life could continue in the absence of any kidney function of his own. When Mr. C died, no heroic arguments are developed to prove that certain lives do not have any moral status,” id. at 45, is considered in detail by Lamb. Id. passim.

¹³⁹ Holding double standards where one of which is clearly formulated and essential to the activity in question is preferable to standards which are imprecise and subject to constant revision and misunderstanding. The strengths of slippery slope objections are two-fold; given an appropriate social situation they force a discussion of potential abuse of certain newly proposed moral boundaries, and draw attention to the error of analysing indeterminate concepts with methods which are only appropriate for the analysis of determinate concepts. It is important to be precise about concepts we can be precise about and to be careful to recognize concepts we cannot be precise about.

Id. at 9.

¹⁴⁰ Id. at 55-56.
resuscitative efforts were attempted. His father was relieved that his son's suffering had ended.

The decision to withdraw life support in a situation where death is an inevitable outcome of such action can be based on a claim that the patient was a nuisance to himself or others. The obligation to save the lives of nuisances would not be lessened by the fact that they might even come to see themselves as nuisances to themselves. The challenge is rather to make them less of a nuisance.141

Any claim of nuisance is suspect because it is not obvious that the "quality of life" has any meaning apart from the particular person who is living that life.142 Mr. C's father escaped further blame. He believed that the quality of his life was improved by his son's death, but that improvement in quality may have had as much to do with relief from his son as it did with relief for his son. The doctors rest on uncertain ground. Not having to face Mr. C's anger and frustration, both that which preexisted this illness and that which was feared from it, cannot be assumed to have been merely a happy corollary to his death. Any assumption that surrogates will decide in the patient's own interests cannot escape grounding in hypotheses about the quality of both the patient's and the surrogate's life and being a verdict on both.

Arguments to place discretion to decide for patients in families, doctors, or courts create as many potential offenses as they trap.143 Abuse of

141. D. LAMB, supra note 10, at 66-67 (discussing a kidney dialysis patient who, like Mr. C, was a nuisance to others, but who, unlike Mr. C, was rescued from involuntary death by public outcry when his plight became known).

142. Doctors have been encouraged to factor quality of life into their decisionmaking. See, e.g., Tomlinson & Brody, Ethics and Communication in Do-Not-Resuscitate Orders, 318 NEW ENG. J. MED. 43, 43-44 (1988) (hypothetical quality of life assessed in deciding whether to resuscitate). No principles, however, were provided for forming these hypotheses estimating the value of life.

143. For an argument that decisionmaking should be confided in families, see Rhoden, supra note 64, passim. But many patients have no families, and others have families ready, purposefully or quite accidentally, to make decisions that patients would not make. See, e.g., Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2856 (1990) ("no automatic assurance that the view of close family members will necessarily be the same as the patient's"). Mr. C's father decided exactly the opposite from what Mr. C decided. For an example of surrogate decisionmaking abused with economic motives, see La Puma & Schiedermayer, The Bookie, the Girlfriend, and the Vultures (letter), 114 ANNALS INTERNAL MED. 98 (1991) (financial conflict of interest leading to use of advance directive as a lethal weapon rather than a helpful tool).

The argument that doctors should decide cannot be credible when their own interests conflict with those of their patients. Disguising inconvenience and disgust as futility might have helped lead Mr. C's doctors to decide exactly the opposite from what Mr. C in fact decided.

For an assertion that decisionmaking is the province of courts, see Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 758-59, 370 N.E.2d 417, 434-35 (1977). Most courts deny any desire to wrench private decisions away from the parties in interest. E.g., Cruzan, 110 S. Ct. at 2855 ("we do not think the Due Process Clause requires the State to repose judgment on these matters on anyone but the patient herself"); Bartling v. Superior Court, 163 Cal. App. 3d 186, 197, 209 Cal. Rptr. 220, 226 (1984) ("no legal requirement that prior judicial approval is necessary before any decision to withdraw treatment can be made"); Barber v. Superior Court, 147
discretion in decisions that do the patient a great harm is a problem unsolved in the law. Courts have shied away from imposing criminal or civil liability on doctors for discontinuing life support, seemingly motivated by a belief that the threat of legal sanctions motivates doctors needlessly to prolong their patients' dying. How reasonable such a belief may really be is debatable, and it does not address "how [to] prevent the reasons for merciful killing from being hijacked by the merci-

Cal. App. 3d 1006, 1022, 195 Cal. Rptr. 484, 493 (1983) ("requiring judicial intervention in all cases is unnecessary and may be unwise"); In re Browning, 568 So. 2d 4, 17 (Fla. 1990) ("without prior judicial approval, a surrogate or proxy . . . may exercise the constitutional right of privacy for one who has become incompetent"); In re Quinlan, 70 N.J. 10, 50, 355 A.2d 647, 669 ("a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome"); cert. denied, 429 U.S. 922 (1976). The strongest argument against judicial review is that it would inundate trial courts with termination-of-treatment cases. E.g., In re Conservatorship of Torres, 357 N.W.2d 332, 341 n.4 (Minn. 1984) (en banc) (estimating ten patients per week removed from life support in Minnesota alone). More than 4000 end-of-life decisions need to be made each day in the United States. See supra note 7.


144. E.g., Barber v. Superior Court, 147 Cal. App. 3d 1006, 1022, 195 Cal. Rptr. 484, 493 (1983) (no criminal liability for intentional omission to continue treatment). In Barber the patient could not decide for himself to discontinue treatment. Id. at 1010, 195 Cal. Rptr. at 486.

The death at the hands of doctors of patients who can decide for themselves raises quite a different issue. A variation in which a doctor did the killing was addressed in Michigan. Jack Kevorkian, a retired pathologist and euthanasia advocate, was charged with first degree murder in the death of a woman suffering from early signs of Alzheimer's disease who volunteered to let him attach her to a suicide machine he invented. N.Y. Times, Dec. 4, 1990, at A1, col. 1 (nat'l ed.). After a preliminary hearing, the state district court judge ruled that prosecutors failed to prove that Kevorkian had planned and carried out the death of the woman, and that rather she had caused her own death. Noting that Michigan had no specific law against assisting suicide, the judge called on the legislature to address the issue. An injunction remains in effect prohibiting further use of the suicide machine. N.Y. Times, Dec. 14, 1990, at A1, col. 1 (nat'l ed.). The prosecutors dropped plans to appeal, and also called on the legislature to clarify the matter. N.Y. Times, Dec. 15, 1990, at A9, col. 5 (nat'l ed.). See Cassel & Meier, Morals and Morality in the Debate over Euthanasia and Assisted Suicide, 323 New Eng. J. Med. 750, 750-52, passim (1990) (Kevorkian case illustrates public desire for more control of circumstances of death, calls for thorough and thoughtful analysis, and should not be obscured by inflexible rules that have little relevance to people doctors serve). Alzheimer's disease could be thought of as joining the list of unpopular diseases that make people candidates to be put out of their misery.

These peculiar circumstances will provide uncertain guidance in Mr. C's situation, in which he was an unwilling participant in his own death. In any case, "a murder prosecution is a poor way to design an ethical and moral code for doctors who are faced with decisions concerning the use of costly and extraordinary 'life support' equipment." Barber, 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486.


146. E.g., In re Quinlan, 70 N.J. 10, 50, 355 A.2d 647, 669 (proposing "diffusion of professional responsibility for decision" to free doctors from self-protection concerns).
The danger is that after the first killings, the others are just business.\textsuperscript{148} The law's vision is not focused on many real problems troubling medical practice at the end of life: the insistence of patients and families on treatments that are futile;\textsuperscript{149} the false promise of immortality made by modern science; the indeterminacy that renders legal rules arbitrary and capricious when applied to clinical medicine; the ongoing complexity and uncertainty of circumstances that must be oversimplified in adversarial proceedings before remote and detached judges; the triumph of procedure over substance in the law; the failure to know how to correct doctors' moral compasses gone awry. At the same time, well-intentioned efforts to apply fundamental principles that ground law to doctor-patient relationships stumble on general lack of knowledge about if and how such norms should be applied, and how doctors and patients share their way. Vision dims in the shadow of death, and "[n]o one can jump over his own shadow."\textsuperscript{150}

\textbf{D}

The simplest prescriptions are often the best: set people free to be who they are, allow them what is their own—the possibilities that lie ahead.

Let patients be as they are. They seek doctors because they perceive their own suffering, because they wish to restore their possibilities to make their own law. They come for cure, the care in which they might be made whole. They have a responsibility to make their way with their doctors. They cannot call on doctors to be magicians. If patients do not tell their doctors how they are suffering and what they require, they cannot expect their needs will be met. No one can presuppose that doctors will know what is best for patients, what information patients will need to make their choices, or what goals are the ones that shall determine their way. Patients cannot be helped to seek their possibilities in their own way if that way is kept secret. First they must allow doctors to

\textsuperscript{147} D. LAMB, \textit{supra} note 10, at 62.

\textsuperscript{148} See, \textit{e.g.}, id. at 52-59 (discussing contagiousness of killing). \textit{But see, e.g.}, Angell, \textit{Euthanasia}, 319 NEW ENG. J. MED. 1348, 1348-50 (1988) (arguing inevitability of legalized euthanasia and advising doctors opposed to rethink their positions).

\textsuperscript{149} Patient or surrogate insistence on continuing futile treatments (the reverse of the cases discussed in this essay) is largely an unappreciated and unlitigated problem. A case of a hospital seeking to end a patient's life support over family protests made its way into the Minnesota courts. N.Y. Times, Jan. 10, 1991, at A1, col. 1 (family believed extremely religious woman would prefer even vegetative coma, medically dependent life rather than death). The court gave the patient's husband, a retired lawyer, the power to make medical decisions for her, N.Y. Times, July 2, 1991, at A12, col. 5, but the patient died of overwhelming infection and multiple organ failure a few days later, N.Y. Times, July 6, 1991, § 1, at 8, col. 1. Appellate courts have not considered this problem.

\textsuperscript{150} M. HEIDEGGER, AN INTRODUCTION TO METAPHYSICS 199 (R. Manheim trans. 1959).
share that way with them in the sharing of words and thoughts, in traveling together. When patients do not or will not communicate, they cannot be surprised when their way is determined by others. Not only must they share their way, they should be able to expect that when they cannot communicate, every effort will be made to restore that possibility to them. Patients have to let themselves be patients. Their doctors must be allowed to share their suffering, and care.

Let doctors be as they are. They await patients because this is their answer to the call to be healers. Doctors must be ready to go with their patients along the way towards the possibilities that are their patients' own. They fail in their vocation when they impose choices on patients that are false for them.\textsuperscript{151} To succeed, doctors must understand and allow the otherness of their patients. The invitation extended by patients to join them on their way invites the same sharing of words and thoughts by doctors with patients as by patients with doctors in their living together. Humble acceptance is the care sought, the assumption of a responsibility to promote patients' saying their own law.\textsuperscript{152}

No one has the power to give what he does not have. Doctors did not acquire their possibility to heal from the state.\textsuperscript{153} It was never a delegated responsibility and there is no obvious reason why it should be wrenched from doctors to be fulfilled by anyone else.\textsuperscript{154} Neither does the state have any call to impose on patients choices that are not their own by forcing patients to seek their possibilities in any predetermined way.\textsuperscript{155} Erection of an elaborate procedural edifice in which doctors and

\textsuperscript{151} The goal is to know others, not to make rules for them. \textit{See, e.g.,} Kennedy, \textit{supra} note 35, at 649 (only way to reduce mistakes is for decisionmaker to investigate consciousness of others).

\textsuperscript{152} Responsibility might be suspected to be a smoke screen for a sneak attack on autonomy. One of the assumptions of this suspicion is that doctors inevitably act arbitrarily without any determinate standards and against their patients' interests. The basic question to ask is whether the law ought to embrace and protect this assumption.

\textsuperscript{153} The state, of course, has no healing power and is not an original party to the doctor-patient relationship. Moreover, it "lacks the medical expertise and administrative capacity to dictate treatment decisions on a case-by-case basis." \textit{Medical Technology, supra} note 3, at 1609 (going on to tout alternative "adequate procedural [due process] protection" and "the capacity to respond quickly," \textit{id.} at 1611).

\textsuperscript{154} The argument that government acquires a legitimate claim to authority over medicine by funding health care is not very persuasive. Patients hire their doctors on a fee for service basis, whether they pay their doctors directly or pass the money through the hands of third parties like insurance companies or the government. Patients buy rights to negotiate the terms of the service they get for their fee, not authority to dictate. They can always refuse to pay for services they do not want or "vote with their feet." The bottom line is that first-party control ought to be cheaper than third-party control. Analysis of this argument is beyond the scope of this essay. For a general economic viewpoint, see McMenamin, \textit{What Do Economists Think Patients Want?} (Commentary), \textit{HEALTH AFF.,} Winter 1990, at 112-19.

\textsuperscript{155} The realities of "value pluralism, factual indeterminacy, and increasing options," Shultz, \textit{supra} note 32, at 222, argue as strongly against government control of medical decisionmaking as against doctor control.
their patients must dwell might serve judges by giving them something they know how to judge, but it also serves to limit people's possibilities. Rules, inherently arbitrary and indeterminate in their interpretation and application, seldom, if ever, lead to the ends they were imagined to serve and can never create an ideal world. Patient autonomy cannot be secured by commands, nor vindicated in the destruction of any possibility to choose.

Legal assistance should rarely be needed by patients and their doctors. If they become involved in some dispute that they cannot resolve themselves, courts should avoid exercising power to impose choices that are not the parties' own. The adversaries must be clearly identified. The struggle is not between doctors and patients, it is against the obstacle of uncertainty of what lies ahead. Judges know less than doctors or patients about that uncertainty. Courts should decide to keep communications open, to encourage doctors and patients to make their way together. This need not, and in fact cannot, be done by announcing a rule. Doctors and patients would see their need for each other if they were kept off balance. They should never acquire the confidence that only their own will can prevail. Allowing procedure to triumph over substance robs both the sufferer and the healer of their reasons for being together. The law can only succeed by refusing to take control and forcing doctors and patients to realize that there is no single locus of power.

Courts ought not aid evasion of responsibility by doctors. It would be a mistake to think doctors should want to escape their responsibilities with their patients and to encourage their thinking that way. Courts and commentators sometimes imagine that doctors long to be

156. Cf. Williams, supra note 1, at 2130-32 ("sausage-machine analysis," a call to revolt against the tyranny of definition-machines and insist on one's right to name what one's senses well know, the limits of justice).

157. The assumption of an intrinsic power struggle between patients and their doctors, with an outcome that need be determined by law, is unwarranted. See supra note 152. Contra Shultz, supra note 32, at 269-76 (conflicts of interests and values intrinsic to doctor-patient relationship, even though "professionals are to a significant degree motivated by caring for others; we need them to continue to be," id. at 299).

158. See generally R. BURT, supra note 8, at 124-43 (arguing for assuring conversation between doctor and patient). The goal is not just to communicate but also to help, and ultimately mobilize patients to dispense with their doctors' services. See, e.g., Kennedy, supra note 35, at 649 (arguing for mobilization).

159. See R. BURT, supra note 8, at 136-37 ("code of principles that purports to answer every question of power in doctor-patient relations . . . [is a] confidence game . . . in which each actor assigns 'full responsibility' for his action to another, and no one consequently admits that he is deeply pained by the impact of his actions both on himself and on others").

160. "At the Nuremberg trials after the Second World War it was established that obedience by a soldier to command resulting in an unlawful act should be considered a crime. The excuse, 'I was only obeying orders,' was no longer considered acceptable." D. LAMB, supra note 10, at 36-40. The principle is being forgotten.
relieved and would welcome an invitation to dispose painlessly of "those unfortunate individuals to whom death beckons as a welcome respite from suffering." But the responsibility doctors have for their patients, and for the decisions they make with and for their patients, is precisely what directs the moral compass of medicine along the right way. Without these responsibilities and the risks they create, the hard cases can be disposed of by simply abandoning patients to their suffering and their deaths.162

Doctors must be held accountable for their personal involvement in healing. The impersonal norms of the legal system are not appropriate for an enterprise of care. Judges ought to insist on doctors' personal responsibility and keep doctors off balance in uncertainty about whether patients can inflict pain on them with the legal system. In every medical decision, doctors basically gamble that their patient, and if need be a court, will later find their behavior reasonable. The fundamental uncertainty of the risks is part of the insurance that decisions are carefully made. Cementing the locus of medical decisionmaking power in any party abrogates this insurance by allowing the people involved to assign responsibility for their actions to someone else.

Let judges be as they are. Patients and doctors come before them for justice. Courts ought to understand their own powers and limitations.163 There is no certain path along which doctors and patients must go to begin with. Likewise, there is no unequivocal guide for judges in fundamental legal principles or in precedents to order doctors and

161. Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1147, 225 Cal. Rptr. 297, 308 (1986) (Compton, J., concurring); see also Shultz, supra note 32, at 282 n.278 ("[d]octors may actually be relieved to reduce their responsibility for others' fate"). Besides psychic relief, it is imagined that doctors would reap legal relief by ceding their responsibilities: "the greater the degree to which the patient participates and is informed, the less likely she is to file a malpractice claim." Id. at 296. Contra Adams & Zuckerman, Variations in the Growth and Incidence of Medical Malpractice Claims, 9 J. HEALTH POL., POL'Y & L. 475, 484-85 (1984) (significantly higher annual rate of malpractice claims associated with informed consent). Because doctors create the risk of liability in their relationships with patients, they may reduce that risk by managing their relations more effectively. See, e.g., Green, Minimizing Malpractice Risks by Role Clarification: The Confusing Transition from Tort to Contract, 109 ANNALS INTERNAL MED. 234 passim (1988) (presenting models of doctor-patient relationships, and sample questionnaire and application for patient-doctor relationship).

162. A basis in existing legal theory for thinking about doctor-patient relationships in terms of responsibility could be sought in general fiduciary principles. Shultz, supra note 32, at 260-63 (analyzing disclosure under such principles), 279-81 (redefining fiduciary principles "to stress more advising and less deciding"). The problem with focusing attention on looking for bases in legal theory for doctor-patient relationships is that such relationships are their own bases, not posited by rules.

163. "This Court need not, and has no authority to, inject itself into every field of human activity where irrationality and oppression may theoretically occur, and if it tries to do so it will destroy itself." Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2863 (1990) (Scalia, J., concurring).
patients along their way. Judges need to ask themselves what it is that they really want to accomplish, and then try to figure out how to go about reaching their goals. The first question to address is whether judges want to be patients. If not, then they will need to use restraint in seizing power from patients and deciding for them lest they gut autonomy of any conceivable meaning. The second question to address is whether judges want to be doctors. If they do, they must answer the call, prepare themselves to go to the bedside and along the way with their patients. It cannot be imagined that by exercising judicial powers medicine is practiced. Finally, the third question to address is whether judges want to be judges. If so, they will be creative in realizing that there are alternative solutions to positing universal rules of procedure to solve problems between particular doctors and patients. Most promising might be a process of collaboration by which doctors and patients, and judges, continually re-create their identities by interacting with each other. Doctors and patients need judges, and law, to protect them from abuses, not to create new opportunities for abuse. The responsibility of judges is to work out the terms of reconciliation between doctors

164. Case law addressing medical decisionmaking at the end of life lacks consensus. In its review of the cases, the Supreme Court disapproved none. See Cruzan, 110 S. Ct. at passim (1990). There seem to be only two ways to harmonize the disparate decisions. One commentary observes systematic asymmetric gender-patterned reasoning within the cases: courts use different patterns of words and concepts when writing about men and women, with the result that "women are disadvantaged in having their moral agency taken less seriously than that of men." Miles & August, supra note 42, at 92 (cases in harmony in that women do not really have a "right to die," id. passim). A more obvious harmony in the cases is the near unanimity of decisions resulting in death rather than in sustaining life. See supra note 42.

165. Judges ought to communicate law to doctors more effectively than they do now. Both what the law is and how it is applied are largely mysteries to doctors, who get their information about law from newspapers and medical journals. In the retelling of the law, commentators inevitably simplify and put a gloss on it, and pass along the law that they believe should have been as much as that which is. See, e.g., Annaas, Nancy Cruzan and the Right to Die, 323 New Eng. J. Med. 670, 670-73 (1990) (explaining Cruzan, concluding that "[o]utside Missouri and New York, there is no legal obligation to provide incompetent patients with medical care that is either unwanted or not medically indicated"); Annaas, Arnold, Aroskar, Battin, Bartels, Beaulclump, Brock, Buchanan, Caplan, Colen, Cranford, Dresser, Dubler, Faden, Fost, Frader, Francis, Grodin, Hackler, Jennings, Lappe, Macklin, Mayo, Meisel, Miles, Morrein, Nelson, Parker, Pearlman, Self, Shapiro, Walters, Wear, Weir, Wilder & Youngner, Bioethicists' Statement on the U.S. Supreme Court's Cruzan Decision, 323 New Eng. J. Med. 686 (1990) (explaining that Cruzan decision "affirmed the right of competent patients to refuse life-sustaining treatment").

166. See, e.g., Lo, Rouse & Dornbrand, supra note 143, at 1229 (questioning whether judicial rulings are based on sound clinical information).

167. Alternatives to winner-takes-all decisions would promote cooperative resolution of conflicts. See, e.g., Karst, supra note 38, at 489-95, 501-02 (focusing on interdependence and integration of rights and responsibilities rather than on zones of noninterference); see also, e.g., McClung & Kamer, Legislating Ethics: Implications of New York's Do-Not-Resuscitate Law, 323 New Eng. J. Med. 270 passim (1990) (describing legislation enshrining communal approach to medical decisionmaking). Innovative proposals must be thought carefully through. A problem with communal decisionmaking is strongly held minority views: the weakest party ends up kidnapping the power to make a decision.
and patients, to restore to them their possibility to make their way together. Justice is in this way, not in the imposition of an alien law upon them.

What is finally due is the process of dying. An abyss of uncertainty confronts medical decisionmaking at the end of life. It is not a patient problem or a doctor problem or a judicial problem. It is a human problem. We are all bound inextricably together in this. Death is, after all, our destiny. No one can take a person's dying from him. We all will join in this dilemma at some time, together facing death in a complex web of relationship and care. Then, as ever, what we are will include the possibility of what we can be, and so there is always hope in a continuing renewable possibility to reconsider everything from the ground up.

Let law be as it is. Two women once asked a great judge to settle their dispute over whose baby had lived through the night. The baby survived in the saying of the law.\(^\text{168}\) If this wisdom were not forgotten, we might be able to prepare ourselves to be recalled to our most essential possibilities by thinking and experiencing the threat to the essence of healing arts in positive law.

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\(^{168}\) Then two harlots came to the king, and stood before him. The one woman said, “Oh, my lord, this woman and I dwell in the same house; and I gave birth to a child while she was in the house. Then on the third day after I was delivered, this woman also gave birth; and we were alone; there was no one else with us in the house, only we two were in the house. And this woman’s son died in the night, because she lay on it. And she arose at midnight, and took my son from beside me, while your maidservant slept, and laid it in her bosom, and laid her dead son in my bosom. When I rose in the morning to nurse my child, behold, it was dead; but when I looked at it closely in the morning, behold it was not the child that I had borne.” But the other woman said, “No, the living child is mine, and the dead child is yours.” The first said, “No, the dead child is yours, and the living child is mine.” Thus they spoke before the king.

Then the king said, “The one says, ‘This is my son that is alive, and your son is dead’; and the other says, ‘No; but your son is dead, and my son is the living one.’” And the king said, “Bring me a sword.” So a sword was brought before the king. And the king said, “Divide the living child in two, and give half to the one, and half to the other.” Then the woman whose son was alive said to the king, because her heart yearned for her son, “Oh, my lord, give her the living child, and by no means slay it.” But the other said, “It shall be neither mine nor yours; divide it.” Then the king answered and said, “Give the living child to the first woman, and by no means slay it; she is its mother.”

1 Kings 3:16-27.