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INTRODUCTION TO "THE SILENT WORLD OF DOCTOR AND PATIENT"

ALEXANDER MORGAN CAPRON*

I never cease being amazed how early reticence and evasion appear in physicians-to-be. In the first session of the "Medicine I Ethics Conference" taken by all third-year medical students at the University of Southern California, my two colleagues from medicine and ethics and I sometimes ask the students to tell us how they will introduce themselves to the patients for whom they will be caring during their six-week rotation through the Student Ward at LA County/USC Hospital. "As part of the medical team," say some, while more reply, "As Doctor So-and-So." A few suggest "student-physician," but others report feeling more comfortable with "medical student." The point of the class session is not to insist that they all adopt a particular term. Rather, we hope that they will recognize what might seem a minor matter as something of considerable importance: their first contact with a patient in which the foundation for the relationship is set, and an early test of their commitment to candor in that relationship.

Why, we ask the students who introduce themselves as "Doctor" or try to give that impression, is that term appropriate? Because they are going to touch the patients, to probe them physically and verbally, these students reply. Patients would accept such intimacies only from a physician. How do they know that, I wonder? Is this decision a reflection of how they will behave during the coming years as practitioners? Will they act like scientists and test their assumptions about patients' reactions, or will they enshrine their own reactions and fears,

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along with the "received wisdom" of their peers and predecessors, as truths that do not need to be examined? ("Never tell patients they have cancer—they don't want to know and they'll give up hope and kill themselves if you do!"¹)

Moreover, I inquire, what—besides a misrepresentation of their stage of education—are the students telling patients when they use the term "Doctor"? That they want a certain level of deference? That being "Doctor" will explain why they employ strange, Latinate words that the patients find difficult to understand? What different sort of message would be given if the term "student-physician" were used? Would that signify that the person bearing such a title is asking the patient for permission to learn by practicing (in the ordinary meaning of that word) with the patient? Such an implicit request clearly makes some students uncomfortable. Why? Because a patient might say "No, thank you, I want someone else"? Or even because it would alter the usual balance of power and authority and make the patient the *teacher* of the medical student, or, at the very least, make the two collaborators?

Of course, my questions tend to be especially pointed for this first group of students. But I also am fascinated to hear the rationales given by those who want to *avoid* any use of the word "physician" in explaining themselves to patients, and who instead adhere rigorously to the term "medical student." Why are they so modest? Their comments suggest that they view themselves as *mere* students who don't yet know much about illness and treatment, and who are insignificant foot soldiers just carrying out the orders of *real* doctors. Does this allow them to avoid some sense of responsibility, including having to answer patients' questions or having to explain what they are doing and why? Do these students imagine that when they obtain their medical degrees they will "have all the answers"—*and* will feel comfortable giving these answers to patients?

I ask them whether the uncertainty they say explains their modest self-description is just a manifestation of their novice status, or will this uncertainty remain as long as they practice medicine? If so, are they trying to come to terms with it by saying "student" (as we are all perpetual students of the world if we are lucky)? Or perhaps they are trying to deny the ignorance they feel, to make it seem almost laugh-

1. In the 1960s, studies found exactly such fears among physicians, based not on logic and rational decision but on "opinion, belief, and conviction, heavily weighted with emotional justification." Oken, *What to Tell Cancer Patients—A Study of Medical Attitudes*, 175 J. A.M.A. 1120, 1125 (1961). See generally B. GLASER & A. STRAUSS, *AWARENESS OF DYING* (1965).

ble, just as they employ gallows humor among themselves to defuse the tension that accompanies their first, fumbling attempts at technical procedures that they know they will master in time.

Perhaps I should not feel a moment's surprise at what I hear from these students. The particular mode of self-introduction to patients that each student adopts is not merely one for which he or she can give some rationale but is one that, when questioned, many admit is comfortable precisely because it fulfills the need to avoid those particular types of interactions (or feared confrontations) with patients that each student finds individually distressing. I should not be surprised by my students' answers because *The Silent World of Doctor and Patient*² makes so abundantly clear that these inclinations lie at the very heart of the traditional practice of medicine, as well as the other professions.

This issue of the *Western New England Law Review* is devoted to that remarkable book. In effect, this journal is a *festschrift* for the book's author, Jay Katz, M.D., the John A. Garver Professor of Law and Psychoanalysis at Yale Law School. Professor Katz has written on many other topics,³ and has even explored the topic of physician-patient relations and informed consent in earlier books and articles.⁴ But *The Silent World* is the summary of his thinking on this subject, and to celebrate it is thus to celebrate him. Not that all the contributors to this journal think of themselves as doing that, of course. Yet even when viewed by a critic, the book bears the mark of greatness: it provokes hard thinking on a difficult issue and forces those who disagree to reexamine their views and defend them in a new fashion.

Professor Katz's book, which is dedicated to improving communication between physicians and patients, tells a story of misperceptions and failed communications between the medical profession and the larger society. In particular, it finds the manifestations of society's views in the apparently sweeping but actually very timid judicial opinions on "informed consent." For example, even when they most boldly declare the obligation of physicians to enter into candid discussions and mutual decisionmaking with patients, judges, in Professor

2. J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984) [hereinafter KATZ].

3. See, e.g., his three pioneering casebooks, J. GOLDSTEIN & J. KATZ, *THE FAMILY AND THE LAW* (1965); J. KATZ, J. GOLDSTEIN & A. DERSHOWITZ, *PSYCHOANALYSIS, PSYCHIATRY AND LAW* (1967); J. KATZ, *EXPERIMENTATION WITH HUMAN BEINGS* (1972).

4. See, e.g., J. KATZ & A. CAPRON, *CATASTROPHIC DISEASES: WHO DECIDES WHAT?* 79-115 (1974); Katz, *Disclosure and Consent: In Search of Their Roots*, in *GENETICS AND THE LAW* II 121 (A. Milunsky & G. Annas eds. 1980); Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137 (1977).

Katz's view, so misunderstand the training and traditions of the medical profession that their rulings are self-defeating.⁵ Professor Katz would probably concur with Lord Scarman's observation that "*Canterbury* propositions reflect a legal truth which too much judicial reliance on medical judgment tends to obscure."⁶

What is so valuable about *The Silent World of Doctor and Patient*, however, is that it goes far beyond merely cataloguing and criticizing the judicial opinions. Instead, Professor Katz sets out to understand the difficulties that stand in the way of communication and mutual decisionmaking in the physician-patient relationship; he then presents a strong moral and practical argument in favor of overcoming this silence and the lack of true trust that it breeds. As a psychoanalyst, he draws on a wide range of sources to establish that the phenomenon at issue is not unique to physician-patient interactions but reflects human beings' resistance "to get to know themselves and each other better through conversation" (p. xiv). Professor Katz also operates as an historian and sociologist in this volume; nor is he hesitant to draw on literature, such as Solzhenitsyn's *Cancer Ward*.⁷ In the end, however, Professor Katz's role is that of a medical moralist calling upon his fellow physicians to overcome their fears of revealing their doubts and uncertainties, and to set aside their misguided notions of benevolence. By respecting patients' capacity for self-determination, physicians will find their relationships with patients more genuinely human, more emotionally satisfying, and more ethically justifiable.⁸

5. See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972). In *Canterbury*, Judge Robinson held that physicians need only disclose what would be material to the average, reasonable patient because this is a standard that physicians are equipped to apply, on account of their medical training and experience. *Id.* at 786-87. Not only does this "reasonable patient" standard vitiate any notion, for which *Canterbury* supposedly stands, that the law protects the individual and subjective wishes of people about their own medical care, but it also rests on the misconception that medical training provides physicians with an empirical basis for knowing what the average person wants to know about his or her treatment. The court's deference to medical standards here is particularly ironic, as Professor Katz argues, KATZ, *supra* note 2, at 77-78, because Judge Robinson had earlier held that the information to be disclosed to patients could not be left to medical standards because it is doubtful that there is any true custom, any "professional consensus on communication of option and risk information to patients. . . ." *Canterbury*, 464 F.2d at 783.

6. *Sidaway v. Board of Governors of Bethlem Royal Hosp.*, [1985] 2 W.L.R. 480, 494.

7. A. I. SOLZHENITSYN, *CANCER WARD* (1969).

8. The ethical justification of the position taken by Katz is explored further in R. FADEN & T. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* (1986), which develops the philosophical aspects of the subject with great care. In particular, Professors Faden and Beauchamp develop two senses of informed consent; the first, "autonomous authorization," corresponds closely to what Professor Katz sees as the outcome of the communicative process he recommends, while Sense₂ informed consent corresponds

Professor Katz so persuasively builds the case that silence has been a cornerstone of medical practice since ancient times that he may seem unlikely to convince those to whom his argument is most centrally addressed. Yet perhaps there is some reason for hope.

First, biomedical advances in recent years not only equip physicians with formidable tools for attacking disease and disability, they also provide physicians with an enormous amount of reliable information; unlike their predecessors in earlier centuries, practitioners today have something besides puzzlement, ignorance, and misconceptions to share with their patients. Of course, the greater powers of medicine also create a greater range of alternative treatments—and ultimately greater scope for divergence between the wishes or interests of patient and physician.

Second, despite Professor Katz's justifiable scorn for the judges' unwillingness to craft legal rules that would give real effect to the grand principles they proclaim, physicians seem to have listened to—and been affected by—the judicial opinions as well as other writings of physicians and bioethicists that defend and elaborate upon the principles. However uncomfortable they may be with the obligation, and however much they may misunderstand and sometimes ridicule the legal requirement, physicians believe themselves to be under a moral and legal obligation to obtain their patients' informed consent to treatment.⁹ Granted that for many of them this obligation is seen in fairly mechanical terms—such that these physicians equate “informed consent” with the “consent form.” It is not unusual to hear a physician ask whether someone has “consented the patient,” which probably accurately conveys the speaker's view that consent is something that is *done to* a patient rather than a *process* in which both physician and patient take part.

Nonetheless, as far as this may fall from any true notion of consent, it indicates at least a recognition that someone other than physicians has a stake in medical decisions and that society expects physicians to bring patients into the decisionmaking process. This idea may hardly seem startling, but as anyone who has been teaching medical students for several decades can testify, it represents an amazing evolution in their professed beliefs on the subject of patient con-

to the rules for consent established by the law, which often departs from Sense₁. See *id.* at 277-87.

9. See, e.g., 1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 70-111 (1982) (reporting results of national study of physicians' attitudes toward informed consent).

sent. Therefore, the question becomes: what model of the physician-patient relationship will the profession adopt? If we are fortunate, it will be Jay Katz's.

As the readers of this symposium will discover, Professor Katz's theory is rich and provocative. Yet his central tenet can be stated fairly simply: it is that, for both ethical and practical reasons, the physician-patient relationship must be a mutual one involving both parties as active and respected participants. This is possible only through bilateral conversation in which both persons explore their expectations as well as their fears, and their knowledge as well as their uncertainties. Ultimately, patients will have the final say about their treatment, but patients' decisions can only be "informed" if physicians take seriously the need for conversation and not merely ritual "disclosures." Although the book focuses more on the need for reform of physicians' attitudes and behavior—rather than supplying a "how to" guide for patients—in Professor Katz's model, obligations do not rest solely with physicians. Rather, he grounds respect for self-determination not merely on the external component of *choice* but also on an internal component, *reflection*, which is part of the mutual obligation of both parties.

Professor Katz is very aware of the forces, both personal and professional, that make his vision of informed consent seem utopian. Indeed, he sees the pattern as age-old, a conclusion he backs up with sources from the dawn of medicine to the present day (pp. 1-47).¹⁰ Nevertheless, Professor Katz attempts to persuade physicians that if they tear down the wall of silence that separates them from their patients they will not only better respect their patients' rights but will derive greater rewards from the enriched human relationship. The authors in this collection explore and take issue with this thesis and its application in a variety of settings.

I. PATERNALISM: NECESSARY EVIL, OR JUST NECESSARY?

Given the tocsin sounded by Professor Katz, it is fitting that the

10. Katz characterizes as ineffectual exceptions to this rule the writings of various physicians and scholars over many centuries who argued for greater disclosure by physicians and respect for the wishes of patients; other commentators have taken the view that these sources indicate a divided tradition in medicine, with some authorities favoring the sort of relationship that Katz envisions. See, e.g., Pernick, *The Patient's Role in Medical Decisionmaking: A Social History of Informed Consent in Medical Therapy*, in 3 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *MAKING HEALTH CARE DECISIONS* 1 (1982) (truth-telling and consent-seeking have long been part of an indigenous tradition in medicine, based on their beneficial effects on health).

first essay in this collection takes sharp issue with both his diagnosis and his prescription.¹¹ Thomas P. Duffy, a professor of medicine at Professor Katz's own institution, faults *The Silent World of Doctor and Patient* for its too heavy concentration on the actions of surgeons, ignoring the path that leads the patient to the "villain-surgeon,"¹² a path on which Doctor Duffy identifies the family physician as the patient's guide. Doctor Duffy acknowledges that "lapses [exist] in the system,"¹³ but he laments that Professor Katz's emphasis on autonomy will further isolate patients, leaving them more vulnerable. Because illness already renders patients vulnerable, they are better served by a profession dedicated to paternalism than to autonomy.

Thus, the heart of the disagreement between Duffy and Katz is that the former believes that patients will do best to rely on "a trustworthy Diogenes"¹⁴ to lead them through the health care maze. Duffy takes trust to be the norm—actual and ideal—of the physician-patient relationship while Katz believes that trust must rest on truth and mutual assent and not on patients' obedience and compliance. Duffy agrees that conversation is important, but he doubts that physicians can usually achieve the degree of knowledge of patients' inner workings that might emerge from years of psychoanalysis. Outside the latter setting (in which Professor Katz practices), Doctor Duffy suggests, medicine possesses sufficient scientific certainty to render Katz's insistence on the disclosure of uncertainty neither realistic nor necessary.

Turning Professor Katz's description of the fate of an illustrative patient he calls Iphigenia Jones to his own purposes, Doctor Duffy argues that not all patients are sacrificial victims, nor should physicians—triumphant now in their return from a biomedical Troy—be subject to Agamemnon's fate, namely, death at the hands of the law as the avenger of wronged patienthood. Doctor Duffy laments what he sees as the result: an increasingly adversarial relationship between physician and patient. Although he admits that some of this may have been brought on by the failure of physicians in some instances to control "the reign of technology,"¹⁵ he thinks patients will derive greater protection from "beneficence and altruism"¹⁶ than from "thoroughgo-

11. Duffy, *Agamemnon's Fate and the Medical Profession*, 9 W. NEW ENG. L. REV. 21 (1987).

12. *Id.* at 23.

13. *Id.*

14. *Id.*

15. *Id.* at 25.

16. *Id.* at 26.

ing self-determination.”¹⁷ The reader may then wish to ask: with changes in the incentives in the system of delivering and paying for health care—especially with expenditure-controls that aim to limit “unnecessary” treatment—which prescription is more likely to protect patients’ interests and well-being? Indeed, is it possible to protect both interests and “best interests,” or for that matter, in favoring what Duffy labels “civil rights,” must one necessarily risk well-being?

The next two essays in this volume further explore the tension between paternalism and autonomy.¹⁸ Law professor Charles Baron examines what Professor Katz himself terms “the need for an exception to unconditional respect for patient choice” (p. 162). In the face of grave consequences from non-treatment *and* of a serious impairment in a patient’s thinking process, Professor Katz finds it justifiable to disregard a patient’s refusal of treatment. He apparently regards unwillingness to give reasons for one’s position as the epitome of such impairment; it is ethically relevant because this unwillingness to engage in conversation prevents physicians from knowing “whether they have explained themselves satisfactorily to their patients” (pp. 162-63) and leaves them “uncertain whether [the patients are] confused as well” (p. 160).

As Professor Baron notes, one cannot be fully confident of Professor Katz’s argumentation because he clothes his justifications in a series of case studies that illustrate the path he believes physicians should follow: namely, a frank statement of frustration with the patient’s failure to explain her or his choice, an assurance that the physician wishes to be guided by the patient’s choice, and a willingness to expend whatever time is necessary in conversation.

Professor Baron fears that this conclusion could replace medical paternalism (*i.e.*, providing the treatment the doctor thinks is right despite the patient’s refusal) with “psychiatric paternalism” (*i.e.*, insistence on the patient’s *obligation* to converse with the physician, backed by the threat that the failure to provide *any* explanation of the choice will lead to its being overridden). This result would be avoided, however, if Professor Katz’s exemplary conversations with the silent patients acknowledged the physician’s own needs for conversation to avoid later feelings of guilt over having failed to fulfill ethical obliga-

17. *Id.*

18. Baron, *On Knowing One’s Chains and Decking Them with Flowers: Limits on Patient Autonomy in “The Silent World of Doctor and Patient,”* 9 W. NEW ENG. L. REV. 31 (1987); Caplan, *Can We Talk? A Review of Jay Katz, The Silent World of Doctor and Patient,* 9 W. NEW ENG. L. REV. 43 (1987).

tions to help the patient.¹⁹ Professor Baron thus sees greater dedication to Professor Katz's own goal of mutuality in decisionmaking as the natural corrective for what otherwise might be merely paternalism in a new guise.

A less accepting view of Katz's thesis emerges from the next essay, by Arthur Caplan, Assistant Director of the Hastings Center, who believes that the mutual obligation to converse actually "puts the mantle of authority squarely back on the physician's shoulders"²⁰ because many patients are reluctant to participate in the informed consent process and, yet in Katz's model, would be forced by physicians to do so. Shades of paternalism indeed!

Caplan worries that other forces in the health care system may make true communication even more difficult in the coming years. He does not totally despair, however, but recommends changes in medical education and even admissions standards, to improve physicians' skills. He suggests, too, that communication may be enhanced by the participation of other, less intimidating figures such as nurses and social workers in place of physicians. This raises an interesting question for those who share Jay Katz's desire to enhance patient autonomy: should it be purchased at the price of undermining the idealized relationship between physician and patient that Katz envisions?

The adequacy of that ideal is questioned by the final paper in this first group.²¹ Professor Arthur Dyck, the Harvard theologian, agrees that conversation leading to mutual understanding is important but argues that self-determination not only requires that a patient be treated in a morally responsible way but that the patient *be* morally responsible. Morally responsible choices are made within a context that is broader than the physician-patient relationship.²²

In effect, Professor Dyck is taking up one of the themes raised by

19. As Professor Katz also notes, the provision of reasons by the patient can also help to overcome the anger, identified in R. BURT, *TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS* (1979), that can arise when a one party in a relationship (in this case, the physician) experiences the other as all powerful, which may then lead to abandonment of the patient as the expression of an unconscious wish to hurt.

20. Caplan, *supra* note 18, at 50.

21. Dyck, *Self-Determination and Moral Responsibility*, 9 W. NEW ENG. L. REV. 53 (1987).

22. As Professor Dyck recognizes, Professor Katz did not fall into the trap of confusing "autonomous decisions" with isolated decisions; rather, he simply concentrated on the need for changes in the physician-patient relationship and seldom took account of other relationships. The reader should be aware that in Professor Katz's usage "autonomy" is a psychological concept that refers to people's capacity—about which lawyers and judges as well as physicians have many conscious and unconscious doubts—to exercise the right of

Doctor Duffy. He points in particular to the relationship of patients to their families, and of physicians to these families as well, as a source both of support for the patient and of information about the patient. As he notes, there is a long tradition in medicine of disclosing information to next-of-kin while dissembling to the patient in order to maintain hope. Although Professor Katz would not approve of such subterfuge, family and friends have just as important a moral role as physicians both in promoting autonomous decisionmaking and in protecting well-being, according to Professor Dyck.

Finally, Professor Dyck examines the ways in which the law has responded when a patient is incapable of participating in the informed consent process. He would place limits, as created by the courts and legislature, on the choices that family and others could make about incompetent patients in order to ensure that choices not be made that accelerate death or add to discomfort.

II. THE LAW AT WORK IN SPECIFIC SETTINGS

In his essay, Arthur Caplan worries that physicians will feel unfairly criticized by Professor Katz's account of their attitudes and behavior. What really happens in various medical settings vis-à-vis physician-patient communication? How well does it measure up to the law's expectations of disclosure and assent, or to Professor Katz's call for mutual decisionmaking?

A pessimistic answer emerges from a description of obstetrical care by a law professor with first-hand clinical experience.²³ Like Arthur Caplan, Professor Nancy Rhoden sees many of the limitations in autonomy arising from patients themselves: most pregnant women find rejecting medical recommendations virtually unthinkable. Consequently, obstetricians do not give these women choices, which reinforces their passivity.

Professor Rhoden observed two paradigmatic approaches to obstetrical decisions. Developing the theme of uncertainty that is so central to Professor Katz's work, Professor Rhoden describes the first as a "maximin strategy,"²⁴ in which uncertainty drives physicians to take aggressive steps against the worst possible outcome, regardless of the probability of that outcome and of the drawbacks inherent in the pre-

self-determination, that is, the right to make their own decisions without interference. *Id.* at 54.

23. Rhoden, *Informed Consent in Obstetrics: Some Special Problems*, 9 W. NEW ENG. L. REV. 67 (1987).

24. *Id.* at 68 (citing Brody & Thompson, *The Maximin Strategy in Obstetrics*, 12 J. FAM. PRAC. 977 (1981)).

ventative measures themselves. Although the maximin strategy is a legitimate response to uncertainty, neither the uncertainty nor the choice of the strategy (and its manifestation in forms of obstetrical treatment) is usually made clear to patients.

When a bad outcome for a fetus seems to be materializing, Professor Rhoden found obstetricians turning to a second strategy, which she terms “the only hope”²⁵ approach to decisions: aggressive treatment to give the baby its last chance, even when the chances of success are extremely low. The decision to deliver a premature baby by Cesarean section illustrates her point, since the operation gives surviving babies a better chance but also produces a large number of babies who would have died during vaginal delivery but who survive with serious deficits or who die after weeks or months of intensive care.

Elaborating further on the concerns raised in *The Silent World of Doctor and Patient*, Rhoden finds in the obstetrical setting a great likelihood for the divergence between physicians’ views and those of their patients. For example, physicians “scoff” at women’s concerns about the process of birth, and yet for many women process and outcome are intertwined. Such conflicts increasingly involve other parties, as judges are called upon to overrule women’s choices that physicians believe will endanger the fetus,²⁶ and as legislators and regulators restrict the range of choices that can be made about the withdrawal of treatment from imperiled newborns.²⁷ Unfortunately, the result of such rulings—as Professor Katz would predict—is not only to prevent candid and mutually respectful communication but even to drive women away from the health care system, just as a person needing psychiatric care may avoid seeking it out of fear of being involuntarily committed to a mental hospital.

A second setting in which to test Professor Katz’s thesis is provided by George Annas, health law professor at Boston University’s schools of medicine and public health.²⁸ In the context of an experimental procedure, such as implantation of an artificial heart, Professor Annas argues that more than informed consent is needed: “an *independent judgment* must be made that the proposed therapy . . . is a reasonable experiment from both a scientific and public policy per-

25. *Id.* at 72-76.

26. *See, e.g.,* Jefferson v. Griffin Spaulding County Hosp. Auth., 247 Ga. 86, 274 S.E.2d 457 (1981).

27. Child Abuse Prevention and Treatment Act Amendments of 1984, 42 U.S.C. §§ 5101-07 (Supp. II 1984); 45 C.F.R. § 1340 (1985).

28. Annas, *Death and the Magic Machine: Informed Consent to the Artificial Heart*, 9 W. NEW ENG. L. REV. 89 (1987).

spective.”²⁹ Of course, Annas’ argument is not really with Katz but with the surgeons who, in his view, have used their patients’ consent not as a shield that protects the patient but as a sword to sweep aside the objections of critics of the experiment.

The example chosen by Annas does, however, raise questions about an issue that *The Silent World of Doctor and Patient* resolves only partially; namely, are there not circumstances in which the risk of exploitation of patients is so great that they should be protected from their own self-determination? Professor Annas is particularly worried that present procedures—from those of the Food and Drug Administration down to those of Institutional Review Boards at the institutions where research is conducted—inadequately protect terminally ill patients, who are regarded (and may regard themselves) as having “nothing to lose,” a notion that Annas finds dramatically contradicted by the actual experience of Barney Clark and his fellow recipients of the Jarvik-7 heart.

Another setting that involves decisions about critically ill patients is examined in Professor Sandra Johnson’s article on legislation in support of “living wills.”³⁰ Although supported as a means of protecting patients’ choices about the extent to which they wish the moment of death delayed by medical interventions, these statutes have the same unfortunate effect as the judicial decisions on informed consent discussed by Professor Katz. According to Professor Johnson, the laws assume sequential rather than mutual control of decisions by physicians and patients; thus they reinforce the long-standing tradition of silence in the relationship.

Applying Professor Katz’s observations, Professor Johnson raises a host of objections to the so-called living-will statutes. She is concerned both by their *failure* to reach important categories of decisions, such as treatment termination for patients who were never competent to express a choice, and by their *success* in reaching many other categories, into which the views of the majority about the extent of care may be injected, even when these views differ from those of individual patients. Further, the laws’ assumption of an identity of interests between physician and patient seems a doubtful foundation for “protecting individual control over medical treatment decisionmaking,”³¹ in Johnson’s view.

29. *Id.* at 90 (emphasis in original).

30. Johnson, *Sequential Domination, Autonomy and Living Wills*, 9 W. NEW ENG. L. REV. 113 (1987).

31. *Id.* at 128.

If Professor Johnson is correct that even when a living will appears to preserve individual control it may actually disserve the individual, because it represents an easier path—and one more likely to result in the refusal of treatment—than the route of real conversation that Katz recommends, then the increasing emphasis on patients executing “advance directives” such as living wills and durable powers of attorney³² would be something to lament. Yet, just as the existence of informed consent requirements can be the spur for a true process of discussion and decision, so the filling out of a directive can be the spur for genuine conversation about a patient’s goals and fears among patient, physician, family, and anyone else who will be called upon to act as a surrogate decisionmaker should the patient become incompetent. Such a process could, of course, have valuable benefits for the quality of decisionmaking even while the patient is still competent. Yet, as Jay Katz would certainly agree, such a fortunate result is by no means guaranteed by the existence of living-will and durable power of attorney statutes, nor even by the use of the documents to which such statutes give legal sanction.

Professor Johnson believes that lawyers are well situated to encourage good use of advance directives; rather than relying on forms, they can draw up individual documents tailored to the client’s circumstances and can urge the client to talk to physician and family about the subject. In his contribution to this volume, Professor Mark Spiegel shifts the spotlight to lawyers themselves as the objects—rather than the creators—of the requirement of informed consent.³³ Extending the general analysis of this issue that he undertook in a pioneering article nearly a decade ago,³⁴ Professor Spiegel asks whether the doctrine of informed consent is needed in the law if, as some contend, “large corporate clients exercise control over their lawyers rather than vice versa.”³⁵

Besides criticizing the weakness of the data on which proponents of the corporate-control thesis rest their case, Professor Spiegel challenges the underlying proposition that attorneys for corporations lack autonomy in their relationships with their clients. Drawing on Katz’s

32. See, e.g., N. CANTOR, *LEGAL FRONTIERS OF DEATH AND DYING* 48, 122-23 (1987); PRESIDENT’S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT* 136-53 (1983).

33. Spiegel, *Lawyers and Professional Autonomy: Reflections on Corporate Lawyering and the Doctrine of Informed Consent*, 9 W. NEW ENG. L. REV. 139 (1987).

34. Spiegel, *Lawyering and Client Decisionmaking: Informed Consent and the Legal Profession*, 128 U. PA. L. REV. 41 (1979).

35. Spiegel, *supra* note 33, at 140.

analysis—particularly his emphasis on the need to recognize the potential for divergence between professional and client on means even when they agree on a common goal—Spiegel argues that “means can either determine ends or be ends in and of themselves.”³⁶ Particularly significant is the ability of a lawyer—through what Spiegel terms intermediate forms of influence—to turn the issue of “what is right?” into “what can be done, technically?”³⁷ Spiegel admits that the greater reliance on in-house counsel may reduce the need for informed consent because the corporation thereby becomes an informed consumer of legal services. Yet that would seem simply to shift the focus of inquiry: to the extent that in-house counsel are still professionals, what standards of disclosure and consent should govern the decisionmaking process in which they and their client/employers engage?

Assuming that informed consent has a role in the lawyer-client relationship,³⁸ what special problems arise when this doctrine—developed as a means of social control over the actions of physicians—is applied to lawyers? Professor Spiegel is troubled by the notion that informed consent would have the effect of linking lawyers more closely to the actions of their clients, which actions often can have adverse effects on third parties (unlike most medical treatment decisions, in Spiegel’s view).

The harm envisioned by Spiegel could arise if lawyers feel impelled to honor their clients’ autonomy by implementing the clients’ wishes even when doing so violates other ethical precepts. Yet if informed consent is interpreted as Professor Katz urges, it could lead to greater conversation between lawyer and client that could clarify the client’s true intent, which may be less objectionable than the lawyer assumed.

The problems caused by extending informed consent to lawyering would be exacerbated if the requirement of honoring clients’ wishes is understood to relieve lawyers of moral responsibility for the choices made. The irony here is that this argument against informed consent is the converse of that raised by physicians. The latter claim that in-

36. *Id.* at 143.

37. Spiegel suggests the need for study of this intermediate form of influence on decisions. *Id.* at 144 n.24. Such an examination could be broadened to include not merely the comparable phenomenon in medicine but the ways that “cans” are translated into “musts” in society generally. See D. CALLAHAN, *THE TYRANNY OF SURVIVAL* 253-69 (1973).

38. As Professor Spiegel points out, even were one to conclude that corporate clients do not need the protection provided by informed consent requirements, it does not follow that it is unnecessary to apply informed consent to the legal profession because individual clients are likely to stand in relationship to their attorneys much the way individual patients do toward their physicians. Spiegel, *supra* note 33, at 145.

formed consent rules force them to involve patients in decisions and follow patients' directions even when the choices patients make will serve the *patients'* interests less well than would decisions made on their behalf by their physicians. The premise is that physicians should be trusted not only because they are more knowledgeable and dispassionate but because they are ethically required to put patients' interests above all others. Conversely, the objection to informed consent that concerns Spiegel is that the doctrine will cause lawyers to give up on their present role as moderators of their clients' harmful, selfish behavior, to the detriment of third parties or general *societal* interests.

In Professor Spiegel's view the problem is actually that lawyers too seldom assume the role of moral agents vis-à-vis their clients' actions. A dialogue of the type recommended by Professor Katz for physicians and patients would thus be a good prescription for lawyers and clients as well. It would reinforce the reality that both parties are jointly involved in decisionmaking and bear responsibility for the choices made—neither lawyers claiming to be neutral professionals nor clients relying on lawyers to preempt decisions in order to achieve an "ethical" outcome that had never been broached, much less thrashed out, with the client. Though it may not be possible simply to apply doctor-rules to the practice of law, *The Silent World of Doctor and Patient* contains ideas that reverberate for lawyers as well as for physicians.

III. JUDICIAL RESPONSES

Returning to some of the themes discussed by Professors Dyck and Johnson, the presiding judge and first assistant register of a Massachusetts probate and family court explore the relationship between Professor Katz's book and the obstacles they have seen in judicial proceedings that stand in the way of the treatment needs of incompetent patients.³⁹ Because of the Commonwealth's somewhat unusual insistence on the primacy of judicial control of treatment decisions for incompetents,⁴⁰ the court-appointed guardian ad litem and counsel for the incompetent, and then the judge her or himself, are placed in a role with the physician comparable to that of competent patients deciding about their own treatment. This insistence upon the involvement of a disinterested judge seems consistent with Professor Katz's concern

39. Dunphy & Cross, *Medical Decisionmaking for Incompetent Persons: The Massachusetts Substituted Judgment Model*, 9 W. NEW ENG. L. REV. 153 (1987).

40. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

that physicians by themselves cannot be counted on to make decisions in their patients' true interests. But from another angle, it merely shifts the locus of concern: can judges be counted on to play the role of an *engaged* patient and not to retreat from an active conversation with the physicians and other treaters?

Judge Dunphy and Mr. Cross find in trial judges a tendency to defer to the medical personnel when called upon to make a "substituted judgment" for an incapacitated patient. Worse yet, communication may be so unclear that each participant may think that another is actually taking responsibility for the decision.⁴¹ Nonetheless, they believe that guidelines established by the courts for the trial judge, guardian, and counsel can ensure that a complete picture of each case emerges from the adversarial proceedings in the courtroom.

Especially if the court proceedings are going to turn into the sort of give-and-take discussion imagined by Professor Katz, they will certainly demand a good deal of judicial time and social resources—and the Dunphy-Cross article argues for the allocation of additional personnel and funds. Concern over the wisdom of such allocation—is the result in terms of improved decisionmaking worth the extra cost?—is comparable to the doubts Katz found in physicians concerning the burdens created by informed consent requirements. The authors do not answer this question directly, but they support penalties (in licensure or malpractice settings) for physicians who attempt to evade the requirements of prior judicial review.

At the opposite extreme from enforced medical deference to the legal system lies the British approach to physician-patient relations, as portrayed in Professor Frances Miller's contribution to this symposium.⁴² In her view, the deference to medical decisionmaking in English law rests on two factors. First are the deeply ingrained class (and meritocratic) distinctions which produce the judiciary's solicitude for its sister profession of medicine. Second, the organization of medical care—in which general practitioners are expected to act as gatekeepers for the National Health System—would be made much more difficult if the gatekeepers had to inform their patients fully about possible options for treatment and then attempt to implement their patients' choices.

This is not to say, however, that British practitioners are under

41. Dunphy and Cross quote the transcript in the *Saikewicz* case itself, Dunphy & Cross, *supra* note 39, at 159-60, which Professor Robert Burt used to illustrate just such confusion. See R. BURT, *supra* note 9, at 155-57.

42. Miller, *Informed Consent for the Man on the Clapham Omnibus: An English Cure for "An American Disease"?*, 9 W. NEW ENG. L. REV. 169 (1987).

no obligation to disclose; merely that their duty does not encompass the patient-based standard of *The Silent World of Doctor and Patient*.⁴³ The courts not only accepted the view that informed consent rules would impose excessive burdens on physicians but also opined that they would undermine trust. This view is so diametrically opposed to Professor Katz's that the impetus for the changes he recommends will in England have to come from patients or medical leaders rather than from the law.

A refreshing counterpoint to the paternalism of the British rulings is offered by Chief Justice John B. Doolin's opinion for the Supreme Court of Oklahoma in *Scott v. Bradford*,⁴⁴ excerpts from which provide the concluding entry in this section of the symposium. Professor Katz praised *Scott* as the "one exception" (p. 76) to the "reasonable patient" limitation placed on disclosure by courts that adopted a patient-based rather than a physician-based standard.⁴⁵

It is not hard to understand the motivation for this outcome; for it might seem harsh to judge the materiality of information by "the patient's need," since a physician "obviously cannot be required to know the inner workings of his patient's mind." [Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628, 639 (1970).] But an objective standard shares the basic fault of the "medical community" standard which these courts were abandoning. Adherence to what a group in the lay community believes to be "reasonable" may rob the patient of "the undisputed right . . . to receive information which will enable him to make a choice" [Wilkinson v. Vesey, 110 R.I. 606, 625, 295 A.2d 676, 688 (1972)] as surely as will adherence to a judgment of the medical community.

. . . Since the purpose of requiring informed consent is to allow

43. It may surprise Americans to find that Lord Diplock, in the House of Lords decision in *Sidaway v. Board of Governors of Bethlem Royal Hosp.*, [1985] 2 W.L.R. 480, actually claimed an elite position for judges (and perhaps others who have undergone the rigors of training and experience at the Bar?): their right to be fully informed about and involved in their medical care must be protected even though physicians were under no such obligation toward ordinary Englishwomen and men. *See id.* at 500. In *Blyth v. Bloomsbury Health Auth. & Another*, (May 24, 1985) (LEXIS, Enggen library, Cases file), the court took a similar view regarding a physician's obligation to give complete information about drug side-effects in response to direct inquiries from a plaintiff "with nursing qualifications who could be trusted not to act irrationally because of what she was told." *Id.*

44. *Scott v. Bradford*, 606 P.2d 554 (Okla. 1979).

45. *McPherson v. Ellis*, 305 N.C. 266, 287 S.E.2d 892 (1982), also adopted a subjective standard, but the decision was of little importance since it enunciated a rule applicable to the operation performed in 1975, while beginning in 1976, North Carolina by statute required that an objective standard be applied.

patient-subjects to participate in the course of therapy and research as informed decisionmakers, concern should focus on whether the patient-subject in question understood what the physician-investigator was proposing to do as compared with other ways of proceeding. To eliminate the "subjective" elements that relate to the particular patient-subject (which lead him, for example, not to be "reasonable" in deciding about certain kinds of interventions) is to make the informed consent doctrine an engine of depersonalization rather than personalization.⁴⁶

IV. THE WIDER PROSPECTS FOR COMMUNICATION

In the final contribution to this symposium, Martha Minow of the Harvard Law School extends Jay Katz's examination of the silence between physicians and patients into other relationships—parent-child, professional-client, stranger-stranger, and state-individual.⁴⁷ In all of these settings, she sees the possibility for challenging abuses of power through communication.

As Professor Minow recognizes, there are times—when a sexually active adolescent wants birth control devices, for example—when requiring conversation may result in immediate harm rather than greater equality and shared decisionmaking. Further, civil or criminal actions to enforce disclosure and consent rules risk destroying some very delicate relationships. But if the participants are willing to engage in communication in the fashion recommended by Professor Katz, sharing uncertainties and recognizing mutuality, Professor Minow suggests that patterns of dominance and dependency—with all their potential for misunderstanding, disappointment, and harm—can be overcome.

Some of Professor Minow's examples may seem to extend Professor Katz's thesis beyond its limits,⁴⁸ but it is actually a compliment to *The Silent World of Doctor and Patient* that all of the contributors to this volume were inspired to attempt just such intellectual stretching.

46. Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 408-09 (1974).

47. Minow, *Many Silent Worlds*, 9 W. NEW ENG. L. REV. 197 (1987).

48. Labeling the relationship between a manufacturer and a consumer a stranger-stranger relationship, Professor Minow suggests that the difficulties in communication once insulated manufacturers from liability ("absence of privity"); now a doctrine of strict liability applies to injuries caused by product defects. Playing on words, Professor Minow argues that strict liability "communicates to the producer the risk of injury to the buyer." *Id.* at 203. Doubtless strict liability encourages producers to internalize the costs of injuries into their calculations but this "communication" looks remarkably different from the dialogue that Professor Katz describes in his book.

Through his careful look at the history and norms of one particular profession, Professor Katz has provided insights that illuminate other activities and the relationships on which they are built, even when his observations about physicians and patients cannot be extended exactly to those other relationships. Similarly, his meticulous dissection of the judicial opinions on informed consent not only increases clarity in this area of the law but also shows how the law sometimes falls short of its stated aspirations, and why.

With this book, Jay Katz has begun a dialogue about the harmful effects of reticence in a relationship that is important in all our lives. The contributors to this symposium have joined this dialogue, in which the editors of the *Western New England Law Review* and I now invite you to participate.