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# SELF-DETERMINATION AND MORAL RESPONSIBILITY

ARTHUR J. DYCK\*

For centuries now, philosophical and religious ethics, particularly religious ethics, has reflected on the moral responsibilities of physicians, patients, and of the patients' families. Ethics is the body of systematic thought which informs the perspective of this essay.

Among the practitioners who draw upon ethics are the clergy. It should come as no surprise, then, that the clergy frequently become involved with patients who are confronted by serious health problems. When these patients do not know or appreciate the full extent of their illnesses, they wonder about the seriousness of their condition and whether they will live or die. They speculate, for better or worse, about what is in store for them in the future. The clergy is called upon to provide comfort and, at times, advice about which particular course of action a patient should pursue; patients, however, often bring to these dialogues insufficient information about their medical condition and possible choices. When the physician has not talked in candor with the patient, the result is almost inevitably uncertainty and confusion about what lies ahead.

Now there is some assistance for physicians and patients who confront the issues of serious illness and how to work together to resolve the many issues that may arise with respect to treatment choices. Professor Jay Katz, in his recent book *The Silent World of Doctor and Patient*,<sup>1</sup> makes a substantial case for the importance of opening up meaningful conversations between physicians and their patients. What Katz hopes to accomplish is to educate physicians to recognize their own limitations, to improve their ability to increase patient autonomy, to err on the side of accepting patients as self-determining, and to honor their choices after thorough conversation. The goal of this conversation is to provide an informed basis for decisionmaking,

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1. J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984).

thereby enhancing the freedom of patients to be self-determining. Katz cites some very moving examples of the mutual relief and comfort experienced by physicians and patients when they face together the awesome truth, in given instances, that a patient's impending death cannot be prevented (pp. 219-24). He argues convincingly that dissipating the fog of superficial small talk that may envelop patients who fear the worst can alleviate much anxiety and guilt and can facilitate what possibilities may exist for strengthening the bonds of human fellowship.

Katz demonstrates that genuine conversations between physicians and patients are necessary to reveal to both parties the limits of medical knowledge and of self awareness. Katz argues further that professional education should foster greater awareness of these mutual vulnerabilities and of physicians' obligations to stimulate inner reflection in themselves and their patients. *Con scire*—to know together—is the root verb of “conscious” and “conscience,” and it is through conversation that mutual understanding is achieved.

Katz carefully distinguishes autonomy from self-determination. Autonomy refers to the capacity of individuals to exercise their right of self-determination (p. 105). In turn, the right of self-determination refers to the right of individuals to make their own decisions without interference (p. 105). Self-determination has choice as its external component; its internal component is reflection. Conversation increases autonomy by increasing the conscious, rational elements which enter into decisionmaking. Physicians are obligated to converse with patients in order to stimulate the reflection necessary to meet the patient's need for more autonomy and to honor the right to self-determination. Although this is paternalistic in Katz's view (p. 110), it is an obligation for both physician and patient, grounded in mutuality.

Katz is well aware that patients may sometimes be reticent or even resistant to converse. Some patients see the physician's insistence on conversation under these circumstances as an invasion of their right to privacy. In a conflict between the values of autonomy and privacy, Katz maintains that privacy should be invaded when to do so enhances the patient's psychological autonomy: “Insisting on conversation and reflection expresses a concern for patients' needs. The ultimate acceptance of their choices expresses a respect for their rights” (p. 141). Katz criticizes current judicial decisions regarding informed consent because they do not recognize sufficiently that the failure of physicians to converse in ways that strengthen patients' autonomy constitutes harm to that patient (pp. 80-82).

As Katz describes instances of beneficial conversations between

physicians and patients, and tragic failures to converse, I find that I certainly want to be in the care of the kind of physician Katz is asking physicians to be. I wish to have a solid basis on which to make medical decisions and I value the respect for my capacities by those who can help provide that basis. However, were I to be ill, a physician would not be the only one with whom I would cherish conversation and by whom I would expect to be valued. I have a wife and children. I have a brother and sister. I have a minister. I can rely on their love and concern, and were I to be confined to a hospital bed, I would have the care and assistance of nurses. What does Katz expect of my physician and of me in the way of conversations with others who care about my well-being? Are there obligations to converse with some or all of these people?

Katz might consider these questions somewhat unfair, or at least not questions to ask of his book. After all, every work has a limited scope, and the focus in his book is on the obligations of physicians to cultivate relationships with their patients which foster their autonomy and which respect their right to self-determination. Whatever else physicians are obligated to do, they should not neglect the conversations with patients which provide the best basis attainable for decision-making. Katz could contend that just such a focus has the salutary effect of holding physicians strictly responsible for meeting the needs of patients for autonomy, as well as helping to actualize their patients' right to make choices of great import for their physical well-being and self-respect. These are surely points well taken. I will not quarrel with them, but neither will I accept them as adequate replies to the questions I have raised and will raise below. Why is that?

To begin with, physicians do converse with families. Indeed, in the history of medicine, there has been a fairly continuous tradition of giving family members a true picture of the patient's condition while continuing to hold out hope for recovery in conversing with the patient, even when recovery is not expected. At times, physicians have even withheld the truth from patients at the request of family members. These practices really require some discussion, but are absent from Katz's book. Even so, we can reasonably infer from what Katz says about conversations with patients that he is not likely to favor any agreements with family members that would diminish the autonomy and self-determination of patients. The family, which can often exert a powerful influence upon the degree of autonomy and self-determination of its members, can facilitate or hinder the attainment of goals Katz seeks for physicians and their patients. Families, then, will be

part of of the conversations between physicians and patients; if not explicitly, then in hidden and unpredictable ways.

But families are to be reckoned with for still other reasons. Katz acknowledges that the policy of accepting the decisions patients make has to be limited in at least two instances: first, when patients may be incompetent; and second, when patients may be making the wrong choices (pp. 157-63).

With regard to incompetent patients, Katz never takes up directly the paradigm instance in which families, particularly parents, are the usual conversation partners of physicians: when the patients are children. Katz does discuss one case of a fifteen year old patient but does not mention the family at all (pp. 161-62). As to whether fifteen year olds are to be regarded as competent, Katz is also not explicit. From what he does say, one can only assume that Katz is not questioning this fifteen year old's competence, but only her refusal of a life saving operation. Katz's counsel, which was accepted and which ended with the patient's consent and a successful operation, never goes beyond persuading the patient's pediatrician to continue the conversation with her with the help of a psychiatric social worker (p. 162). Katz's explicit word on incompetence is found in this brief sentence: "Short of substantial evidence of incompetence, choices deserve to be honored" (p. 113).

Katz thus tells us nothing about the difficulties of judging incompetence in a whole range of cases, notably children, the mentally impaired, and patients in a seriously weakened or disabled state. Since the focus of Katz's work is on conversation, it is surely necessary to determine with whom conversation will take place, not only to make treatment decisions per se, but also to assess the competence of the patient. If physicians do turn to family members, do their decisions deserve the same respect and weight that Katz reserves for competent patients?

But patients who are considered competent may choose wrongly. Katz says that he

would consider disobeying a patient's choice when two conditions have been met: one, the consequences of non-intervention pose grave risks to a patient's immediate physical condition and, two, 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 (pp. 157-58).

With regard to the first condition, Katz makes it clear that he contemplates interference only when illnesses may be treated in ways that

prevent death or predictable serious, irreversible physical injuries, and only when death or injury would be expected to occur within a relatively short time. But he views this condition as necessary for intervention, not decisive. This interference in patients' choices must also meet the test of an impaired process of thinking about choices (p. 158). This impaired process is not incompetence, and Katz believes that its occurrence should be rare whenever conversations have conscientiously and sufficiently preceded decisionmaking.

Even if interference in competent patients' choices is, or could be, a rare event, the judgment as to when that is to happen is one that Katz apparently is willing to lodge in the physician. What about the judgments of husbands and wives regarding the choices of their spouses, and the processes of thinking about these choices? What if a husband or wife conscientiously believes that life saving treatment should be undertaken when their spouse thinks otherwise, and the physician judges that the criteria for interference have not been met? Indeed, Katz does not tell us how well informed families are supposed to be and what weight is to be given to their concern and choices with respect to the care of another family member? What about nurses? Should physicians consult them in judging when interference in patients' choices is or is not the appropriate action to take?

For Katz to reply that he is concentrating on the physician-patient relationship and the nature of their conversations is not enough. After all, it is precisely the traditional belief of physicians—that people who are not medically trained and who are ill are not competent to make choices—which occasions Katz's book. Katz has documented the tendency of physicians to assume that a patient's process of thinking about choices while ill is impaired in many important respects. One could well argue that such instances are not as rare as Katz suggests. Distinguishing incompetence from an impaired deliberating process is not always easy, and what I have in mind here may be a part of what Professor Katz regards as outright incompetence. A patient who is very weak may still be sending out signals of acceptance or refusal, which some may regard as "conversation" and others may not.

The argument for conversation with patients, however, is also an argument for conversation with others. These might include, for example, other physicians, nurses, family members, and other professionals such as ministers. Because there are judgments to make about the limits of self-determination, Katz's ideal physicians, more aware of their own vulnerabilities and limited knowledge, should perhaps be obligated to converse with others besides their patients. But is it enough,

from a moral and legal perspective, that a choice be self-determining, that it occur in a process of thinking which is properly regarded as unimpaired, and that life be sustained only long enough to assure that process?

The series of questions I have been raising point to certain inadequacies in Katz's portrayal of self-determination. Its boundaries are left ambiguous with respect to the relationship between self-determination and moral responsibility, and between self-determination and moral deliberation. I can most quickly illustrate my contention by referring to a recent case with which I am familiar.

A young woman, no longer living with her parents, was in a hospital for a relatively routine operation. She showed every sign of an uneventful recovery, but then refused to eat adequately. Given her history of being a sparse eater, she soon showed symptoms of malnourishment which alarmed her professional caregivers. No one on the hospital staff was successful in getting her to eat properly. Her father, however, who had been through previous similar episodes, was able to persuade her to eat sufficiently. The young woman's health returned.

Assume that the attending physician in this case had made every effort to converse with this young woman. Assume further that the physician had enlisted other professional help. Katz is not clear whether he would force this woman to be fed, or whether or when he would accept her refusal to eat as her personal right and a choice to be honored. In short, do physicians have a strict moral obligation to work to save a life that can be saved even when the patient opposes the intervention necessary for that purpose? Katz does not explicitly endorse such an obligation, nor does he explicitly obligate patients to seek to have life sustained in instances of this kind, where what is required to sustain life is not an extremely painful, burdensome, or life threatening intervention.

What is the role of the father who thinks his daughter is unable to make this decision on her own? He believes his input is needed. While it is not clear that Katz views parents as essential partners in the necessary conversations between this patient and her physician, there is much to suggest that Professor Katz would welcome any aid in restoring this patient to health. Nothing in his decisionmaking model, however, depicts a network of relations which is required to achieve an unimpaired process of thinking about choices. The success or failure of parental attempts at assistance is not really the issue here: the issue is rather whether any physician should neglect to honor the

moral responsibilities family members have for one another. Such neglect may be interpreted as a violation of their rights to self-determination as it bears on the fate of their family members and on the process of making choices. Suppose this young woman to be the fifteen year old Katz discussed. Would the wish on the part of either or both parents that she be fed be decisive for Katz? What about a wish by either or both that she not be fed?

As the reader surely is aware, my concern with what Katz leaves ambiguous includes, but goes beyond, a desire for intellectual clarity. There are moral responsibilities and deliberative processes with respect to them which Katz has not made a predictable, self-conscious part of his decisionmaking model. First, all human beings who are sufficiently "autonomous" to be "self-determining," in Katz's sense of these terms, share a moral responsibility to make reasonable efforts to sustain their own life and that of others. Second, there is a moral responsibility shared by all human beings, but tied to familial and friendship relations in a special way—a responsibility to enhance autonomy and self-determination and to encourage morally responsible expressions of that autonomy.

While parents generally are perceived as moral educators of their children, Aristotle contemplated moral improvement as an aspect of friendship. Physicians, then, are not alone in being morally responsible for strengthening the autonomy patients need to be morally responsible, nor in seeking to be certain that patients' rights to make well informed choices are honored. Moral responsibility may sometimes, however, demand that physicians and family members oppose a choice even though the process of making the choice does not seem impaired. I offered as an example of this a case in which a young patient chose starvation while feeding that patient was essentially all that was needed to restore and maintain her health.

I have had both kinds of experiences as a family member. I felt morally constrained to fight my father's apparent choice to be allowed to die; thirty years later I felt morally constrained to respect my father's autonomy and allow him to die. In the first instance, my father had a massive and painful infection following a gall bladder operation. The physician, with undoubtedly compassionate motives, asked the family whether treatment with antibiotics should cease. We all opposed the cessation of treatment. My father was a strong man in otherwise good health. So I pleaded and argued with him as he, in great pain, expressed a desire to die. This was not easy for me to do, but fortunately his pain soon passed and his good health returned quickly. Loved ones wish one another to exist; that is a very impor-



tant part of what love means. If mistakes must be made, those who wish the life of another will err on the side of life sustenance.

But we cannot indefinitely love one another into existence and sustain that existence. After another thirty years of good health at the age of eighty-four, my father was stricken by cancer and spent the last month of his life in a hospital. He underwent diagnostic testing upon admission but refused further medical tests despite the doctor's order for them. Because the attending physician would not disclose his diagnosis to my father or our family, we did not have a knowledgeable basis on which to oppose these tests. Only when I found a physician in which we could all trust did we learn of the diagnosis already on my father's hospital chart. Once informed of the diagnosis of terminal cancer, we viewed as futile the surgery and further tests recommended by the physician first in charge. It required a concerted stand by our newly retained physician and our whole family—my brother, sister and I—to have the tests halted and the surgery cancelled.

During this interval, the first physician was seeking consent to the medical procedures not from my father, but from the family. As far as we were concerned, our *father* was the appropriate one to decide these matters and, despite his growing weakness, he was making it clear to us that he wanted no more intervention. He gradually declined over the next two weeks. He took food by mouth until three days before he died, but then refused. Agreeing that death was imminent, our new physician and the family declined to forcefully administer nourishment in those last three days. Our father died peacefully and, as far as we could tell, not painfully.

I wish to emphasize that I do not regard failing to provide nourishment as morally responsible if it will be the proximate cause of death or a source of discomfort. In my view, withholding or withdrawing nourishment can be justified only when death is imminent and no discomfort to the patient will result. To justify painful interventions requires reasonable certainty of a compensating benefit, as in the case of life saving surgery that is not in itself unduly risky, or administering antibiotics to someone in pain in the reasonable hope that thereby health will be restored and the cause of pain eradicated.

Being morally responsible, then, is not necessarily achieved by being self-determining. Some expressions of self-determination are immoral. Thus, Katz expects self-determining physicians and patients to engage in honest communication, striving conscientiously to deceive neither themselves nor one another. Deception robs the person being deceived of some degree of autonomy and hence of the very capacity

to be self-determining. For example, patients who are successfully convinced that their illness is not fatal, when in fact it is, do not have the necessary basis for making the most reasonable choices with respect to their treatment and how they will spend their remaining time.

Truth-telling and sustaining life are indeed basic moral values. They are requisite for all of the cooperative activities that characterize human communities and make them possible, and for self-determination as well. That communities and individuals need truth-telling and protection of life is recognized and evidenced by laws against certain breaches in faithful communication<sup>2</sup> as well as life threatening and homicidal acts.<sup>3</sup> At the same time, legislatures and courts protect a wide range of freedoms and increasingly, in medical decisions, what has come to be identified as a right of privacy.<sup>4</sup> It is precisely at this point that serious conflicts arise between satisfying the community's obligation to life on the one hand, and to self-determination on the other. Three differing views of this conflict are presented in the decision of the New Jersey Supreme Court in *In re Conroy*,<sup>5</sup> decided January 17, 1985.

The Conroy case concerns an incompetent, bedridden, eighty-four year old nursing home patient with irreversible physical and mental impairments and a limited life expectancy.<sup>6</sup> The issue for decision was a request by her guardian nephew to remove from this patient the nasogastric feeding tube which served as her primary conduit for nutrients and was necessary to prevent her death from malnutrition.<sup>7</sup>

The trial court which first heard the case decided that the removal of the feeding tube should be permitted.<sup>8</sup> Finding that Ms.

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2. See, e.g., FED. R. CIV. P. 26(b)(1) (excluding privileged information from the discovery process); FED. R. EVID. 501 (shielding statements made within protected relationships against compulsory disclosure on witness stand); READINGS IN LAW AND PSYCHIATRY 161-65 (R. Allen, E. Ferster & J. Rubin eds. 1968) (listing of various state statutes protecting confidential communications made within the doctor-patient relationship); AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS § 9 (1957) (articulating physician's duty to maintain confidentiality unless disclosure becomes "necessary in order to protect the welfare of the individual or of the community").

3. See, e.g., MODEL PENAL CODE §§ 210.1, 210.5, 211.1, 211.2 (Official Draft 1962) (Criminal Homicide, Causing or Aiding Suicide, Assault and Recklessly Endangering Another Person, respectively).

4. See, e.g., DEL. CODE ANN. tit. 16, § 2501 (1984); FLA. STAT. § 4 (1984); NEV. REV. STAT. ANN. § 449 (Michie 1977) (natural death acts); see also *Roe v. Wade*, 410 U.S. 113 (1973); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976).

5. 98 N.J. 321, 486 A.2d 1209.

6. *Id.* at 335, 340, 486 A.2d at 1216, 1219-20.

7. *Id.* at 355, 486 A.2d at 1216.

8. *In re Conroy*, 188 N.J. Super. Ct. Ch. Div. 523, 457 A.2d 1232 (1983).

Conroy's life had become impossibly and permanently burdensome, the court reasoned that prolonging her life would be pointless and perhaps cruel.<sup>9</sup> At the same time, the court determined that removing the tube would lead to death by starvation and dehydration within a few days and this death could be a painful one.<sup>10</sup>

In my view, this court did not show sufficient regard for either the value of self-determination or of life. Whether a person's life is to be regarded as "burdensome" relative to an illness, impairment, or medical treatment is precisely a judgment that depends on that person's own perception. People have different reactions to pain, for example, and something one person finds very painful may not be reported to be so by someone else. Indeed, we remain uncertain whether one person may actually be experiencing a lesser degree of pain or assessing that pain based on a higher degree of tolerance for painful stimuli. Neither courts nor physicians nor even family members are in a position to decide when someone else's life has become too much to bear.

The trial court in *Conroy* did something even more astounding, however, when it chose to permit an act which it had determined would result in death for the patient. What has happened to the protection of the patient's right to life? I am inclined to think that, if a court can sanction an act that is the proximate cause of the death of a person innocent of any crime and posing no threat to anyone's life, those on the court responsible for that decision should be liable to a charge of unlawful homicide or subject to a suit for damages brought by the patient's loved ones.

The New Jersey Appellate Court argued, as I have, that withdrawing Ms. Conroy's nasogastric tube would be tantamount to killing her.<sup>11</sup> It would not be a case of letting her die, but would instead be active euthanasia. The appellate court regarded such a course as "ethically impermissible."<sup>12</sup> Since Ms. Conroy was not facing imminent death, depriving her of food would, under these circumstances, constitute hastening death rather than simply allowing her illness to take its natural course.

When the New Jersey Supreme Court took up the case, it relaxed the strict protection of life announced by the appellate court.<sup>13</sup> The supreme court asserted a right of privacy that included the right to

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9. *Id.* at 528, 457 A.2d at 1235.

10. *Id.* at 530, 457 A.2d at 1236.

11. *In re Conroy*, 190 N.J. Super. Ct. App. Div. 453, 472-73, 464 A.2d 303, 313-14 (1983).

12. *Id.* at 473-74, 464 A.2d at 314.

13. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

refuse nourishment, even if death was not imminent.<sup>14</sup> The supreme court did expressly limit such a right of refusal to those who were deemed to be terminally ill and expected to die within a year or less.<sup>15</sup> The supreme court did not, like the appellate court, regard this as killing such patients, despite the fact that death without proper nourishment would, for many, occur *before* they died of their illness.<sup>16</sup> Furthermore, the supreme court did not limit the withholding or withdrawing of nourishment to instances where patients requested it, but extended such permission to instances in which patients were in unavoidably severe pain, in circumstances otherwise comparable to those of Ms. Conroy.<sup>17</sup> The court thereby made a judgment for someone else regarding what kind of life is too burdensome. What constitutes a burdensome life, however, is emphatically a matter best left to self-determination.

Justice Handler of the New Jersey Supreme Court dissented in part.<sup>18</sup> Pain, he argued, can usually be controlled.<sup>19</sup> There is often disagreement among health care providers about the severity of a patient's pain, as there was in Ms. Conroy's case.<sup>20</sup> Justice Handler took the position that judicial permission to withhold a life sustaining treatment from someone incompetent to make such a choice should be limited to persons terminally ill and imminently dying.<sup>21</sup> Justice Handler, then, appropriately in my view, did not wish to involve a court of law in permitting an action or inaction which could be the proximate cause of an innocent person's death.

*In re Conroy* provides an example of how the same case may elicit significantly different responses from the three courts just examined. The appellate court was the only one of the three to insist that the court not permit an act that it perceived as one that would lead to the death of the patient.<sup>22</sup> The courts, then, do not always err on the side of life, as I would urge them to. Although the New Jersey Supreme Court claimed that it was protecting life by limiting the withdrawal or withholding of nourishment only to terminally ill patients, this claim is undercut by their allowance of the withdrawal as much as a year

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14. *Id.* at 348, 486 A.2d at 1222-23 (citing *In re Quinlan*, 70 N.J. 10, 70, 355 A.2d 647, 663 (1970)).

15. *Id.* at 363-64, 486 A.2d at 1230-31.

16. *Id.* at 350-57, 486 A.2d at 1224.

17. *Id.* at 364-66, 486 A.2d at 1231-32.

18. *Id.* at 388, 486 A.2d 1244.

19. *Id.* at 394, 486 A.2d at 1247.

20. *Id.* at 394-95, 486 A.2d at 1247.

21. *Id.* at 397-98, 486 A.2d at 1249.

22. *In re Conroy*, 190 N.J. Super. Ct. App. Div. 453, 469, 464 A.2d 303, 312 (1983).

before the patient's death is expected. This position thus involves the court in an act that would be the proximate cause of the patient's death. I do not see how such a decision can be left to the courts. To counter this improper judicial interference it appears that legislation is needed to specify that prior to a patient's imminent death, food and water are to be treated like the air we breathe and not *only* as medical treatments. After all, subsequent to removing someone from a respirator, we do not also remove all air from their room to make sure the patient will not breathe again. Removing a feeding tube when it is needed to sustain life and when death is not imminent is the moral equivalent of taking someone off a respirator and then also removing any air supply from him or her. The needed legislation, applied to the concept of a living will, would limit the content of such a will with respect to these decisions about food and water.

The roles I am suggesting for courts and legislatures with regard to medical decisions are minimal, though important. One role is to try to assure that life is adequately protected; the other is to try to assure that persons who, for whatever reason, are regarded as incompetent enjoy the same protection as competent persons.

Who, then, is generally responsible for medical decisionmaking? Katz is right to emphasize the obligation to do what can be done to bolster the autonomy of patients and to respect their right to make choices. But as I have contended, physicians are not the only ones with the responsibility and desire to do this. Friends, family members, the clergy, and nurses also can contribute mightily to the freedom of patients and can point that freedom in the direction of what is best in the moral sense.

Ethicists have identified certain parameters of decisionmaking which tend to function implicitly as criteria of decisionmaking and which may be helpfully rendered explicit. These are first, factual knowledge; second, vividly imagining how everyone is affected by an action or policy; and third, impartiality.<sup>23</sup>

The special education and experience of physicians and other health professionals impose special responsibilities on them. This includes the duty of faithful communication and conscientious efforts to avoid self-deception. But friends and family members often know a great deal about a patient and this knowledge deserves attention and evaluation by both health professionals and their patients.

When physicians or patients or both imagine the effect of a medi-

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23. See, e.g., A. DYCK, ON HUMAN CARE ch. VII (1977); W. FRANKENA, ETHICS, ch. VI (1973).

cal choice, it is vital for them to be in touch with the patient's loved ones. While health professionals may sometimes find families or friends of patients too zealously opposing or urging treatment, it is important that they deal with these positions because patients may otherwise adopt extremes of action or inaction. And while health professionals need to be advocates of sustaining life and ameliorating illnesses when they can, under some circumstances, especially in the last days of a patient's life, comfort may become their central concern and may be the most responsible use of their talents.

Impartiality, in the context of medical care, means at the very least equal consideration of the rights to life and self-determination of all human beings. It also means that quality of care is maintained and applied equally to everyone as is medically indicated and responsibly chosen. No one, patient or health professional, is immune from being influenced by their likes and dislikes and their own preferences for particular modes of care. For these reasons, physicians should welcome the opportunity to explore how patients perceive their conditions and the care being recommended; they should likewise welcome the possible correction of perspective that nurses, the clergy, or next of kin may contribute. In this essay I have discussed some examples of a parent in one case,<sup>24</sup> a whole family in another,<sup>25</sup> whose determined efforts to keep awake their loved ones' will to live was necessary to obtain a recovery from illness. Indeed, I suggest that in those difficult decisions which, if followed, could mean death for the patient, a single voice insisting on the course of action most likely to sustain life should prevail. That voice may be that of physician, nurse, patient, or loved one. At the same time, to refuse life sustaining treatment should require a consensus of these same moral agents. I take for granted that someone who feels deeply that the decision being made is morally wrong and a violation of the patient's rights has recourse to the courts.

Jay Katz has done us all a favor by making a case for strengthening patient autonomy and respect for the freedom to be self-determining. I have built on these important concepts, but I have tried to indicate that achieving this is the responsibility of all health professionals and loved ones involved with a given patient. In the end, the right to self-determination is a right to be morally responsible as well as a right to be treated in a morally responsible way.

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24. *See supra* p. 58.

25. *See supra* pp. 59-60.