SEQUENTIAL DOMINATION, AUTONOMY AND LIVING WILLS

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Jay Katz presents a rich and detailed portrait of the doctor-patient relationship that resembles Degas' *Absinthe*. In Degas' portrait, as in Katz's, the two parties find themselves in a relationship that each joined consensually although from some sense of necessity. Now engaged in the object of their mutual choice or need, however, they sit as isolated individuals, gazing away from each other, not touching, silent.

Degas leaves us to speculate as to the forces that brought his couple together at the café and those that keep them apart. The power of Katz's work in *The Silent World of Doctor and Patient* is that he not only presents the human costs of the frustrated relationship but also identifies precisely the barriers that have confined patients and doctors within so unsatisfactory a world. In so doing, Katz has revealed not only the tradition of silence of the medical professionals but also the patients' fear of conversation as dual causes of the failure of communication. These obstacles are more than historical, although their long existence contributes to their continuing strength. They are nourished by the continuing professional domination of the patient-physician relationship and by the resultant distrust of physicians by their patients (pp. 95-103). Katz presents an insightful analysis of the role of law in confirming, rather than reordering, the hierarchical domination of physicians over patients. Thus, Katz contradicts a not uncommon perception of law as libertarian in compari-
son with the paternalistic ideals of medicine. Although, as Katz notes, "Anglo-American law has, at least in theory, a long-standing tradition of preferring liberty over custody" (p. 2), when confronted with the conflict between liberty and custody in informed consent, judges "fashion[ed] a doctrine of informed consent that has secured for patients the right to better custody but not to liberty—the right to choose how to be treated" (p. 49).

Although the patients apparently won the battle between liberty and custody in the doctor-patient relationship through recognition of the requirement of informed consent, that victory is only illusory, according to Katz. Such apparent victories will continue to disguise defeat so long as the legal doctrines or procedures continue to rest upon the fallacy that patients can have autonomy over treatment decisions absent a radical reordering of the patient-physician relationship: "Challenging the long-standing tradition of silence requires nothing less than uprooting the prevailing authoritarian value and belief systems and replacing them with more egalitarian ones" (p. 28). Because the current hierarchical patient-physician relationship rests on both an overestimation of professional expertise and an underestimation of patients' capacity for autonomy, a fundamental change in the nature of this relationship requires change on both sides.

Law will continue to confirm the domination of patients by doctors unless the courts and the legislatures become aware that facially neutral legal mechanisms often enhance professional authority at the expense of personal autonomy. Absent this awareness, patients will continue to be betrayed by illusory victories in their battles for autonomy over medical decisionmaking.

The validity of Katz's thesis concerning the role of law in confirming the traditional structure of the doctor-patient relationship and its impact on patients' autonomy is borne out in its application to legislation concerning decisions about death and dying. The living-will statutes, which, aside from the guardianship, are the most common legislation on the refusal of life-sustaining treatment by adults, explic-
Itly elevate the choice of the individual to primacy in the competition for control over these medical treatment decisions. The living-will legislation thus promises patients control over their own medical treatment as well as a shield against professional domination. These may be empty promises. The living-will legislation is hampered in achieving its goal of securing autonomy for patients in a large number of cases because its structure treats as inevitable the domination of the professional over the patient and "protects" the patient from conversation, to use Katz's term, that may actually enhance the patient's autonomy.

Rather than treating patients and physicians as coparticipants in an effort to evaluate alternatives, this legislation assumes a patient-physician relationship of sequential domination, in which first the doctor and then the patient dominates and controls the decisionmaking to the exclusion of the other. Thus, it affirms rather than challenges the long-standing tradition of silence. It is important to examine the living-will legislation from this perspective because such an analysis calls into question facile exhortations to physicians and patients that they use the living will as an opportunity to communicate with one another and because it reveals the subtle, but significant, risks hidden in the structure of this very popular mechanism.


6. "One New York group has distributed millions of living wills. The columnist who writes 'Dear Abby' reports receiving tens of thousands of requests for copies each time she deals with the subject." President's Commission for the Study of Ethical
At its best, the living will protects personal choice against profes­
sional — both legal and medical — interference. The living will affirms
the central value of the individual patient as both the subject-object
and ultimate arbiter of his or her own treatment decisions. The living
will may allow to be done what ought to be done by providing the
comfort of written documentation of the patients’ desires at a time
when they can no longer speak for themselves. At its worst, however,
the living will, now available in a convenient “permanent mini-will
version . . . in [a] new credit-card size,” reduces a sometimes complex
judgment to a slogan: No machines!

The apparent simplicity of the living will conceals the real oppor­
tunities for misunderstanding and the range of discrete decisions that
often must be made. For example, a hospital recently described a situ­
ation in which a doctor brought the living wills of two young and
healthy men to be “put on file” in the emergency room so that they
would not be resuscitated should they suffer heart failure at the hospi­
tal from injuries incurred in an automobile accident or some other
event. When the hospital called these men, they were shocked at what
the doctor had done.

The widely circulated mini-will provides: “If there is no reason­
able expectation of my recovery from extreme physical or mental disa­
ability . . . I direct that I be allowed to die and not be kept alive by
artificial means and heroic measures.” Which “extreme physical dis­
abilities” does this cover? Burns? If so, how severe? Quadriplegia?

PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO
FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL AND
LEGAL ISSUES IN TREATMENT DECISIONMAKING 140 (1983).

7. The mini-will is available from Concern for Dying and is provided in appreciation
for a contribution to the organization.

8. See supra note 7. This language is not representative of language used in the sam­
ple living wills offered in the state statutes. See, e.g., VA. CODE ANN. 54-325.8:4 (Supp.
1986):

   Declaration made this ________ day of ________ (month, year). I,
   ____________________, willfully and voluntarily make known my desire that my dying
shall not be artificially prolonged under the circumstances set forth below, and do hereby
declare:

   If at any time I should have a terminal condition and my attending physician has
determined that there can be no recovery from such condition and my death is imminent,
where the application of life-prolonging procedures would serve only to artificially prolong
the dying process, I direct that such procedures be withheld or withdrawn, and that I be
permitted to die naturally with only the administration of medication or the performance of
any medical procedure deemed necessary to provide me with comfort care or to alleviate
pain.

   In the absence of my ability to give directions regarding the use of such life-prolonging
procedures, it is my intention that this declaration shall be honored by my family and
Amputation? Of what particular limbs? Blindness? What means are artificial? This is not to say that individuals should be barred from making treatment decisions, including refusals of treatment, in these situations. Rather, these decisions, if not made in an emergency situation, usually would require more information and reflection than a quick-and-easy very general document requires. If the treatment decision must be made in an emergency situation, a preference in favor of treatment at least to stabilize the patient, restoring the capacity for decision-making, would ordinarily prevail.

If the importance of the document is that it reveals an individual's personal values as pro-refusal or pro-treatment, it is not so much an exercise of autonomy as it is a labelling. As a label for the information of persons who actually must make treatment decisions on behalf of the patient, it does not operate in the automatic or "binding" manner that the public perceives. Nor does the simple label or value choice necessarily identify a single correct decision among available options in particular circumstances.

This essay begins with a consideration of the context of the living will and its part in the process through which society is developing a series of resolutions to claims for autonomy in regard to medical treatment. The context of the legislation sets the stage for an examination of its structure, using Katz's analysis of informed consent as a model.

Physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration. . .

_________________________(Signed).

See also MO. REV. STAT. § 459.015(3) (Vernon Supp. 1986):

DECLARATION

I have the primary right to make my own decisions concerning treatment that might unduly prolong the dying process. By this declaration I express to my physician, family and friends my intent. If I should have a terminal condition it is my desire that my dying not be prolonged by administration of death-prolonging procedures. If my condition is terminal and I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw medical procedures that merely prolong the dying process and are not necessary to my comfort or to alleviate pain. It is not my intent to authorize affirmative or deliberate acts or omissions to shorten my life rather only to permit the natural process of dying.

Signed this _______ day of _________

__________________________

City, County and State of residence__________________________

Signature__________________________

Most of the living-will statutes do not require that the language of the statutory sample be used and do not make invalid documents that fail to use the statutory language, although the statutes do provide for severance of invalid clauses. See, e.g., VA. CODE ANN. 54-325.8:4 (Supp. 1986); MO. REV. STAT. § 459.015(3) (Vernon Supp. 1986). Several organizations have distributed living wills, including the Catholic Health Association.
The statutory structure reveals an overbroad deference to professional discretion and a misconception of autonomy as control that undercut the statutes' protection of patient autonomy. The essay assesses the likelihood that physicians and patients will succumb to the superficial attractions of silence and insulation so readily available in the structure of the living will. In its conclusion, the essay offers suggestions for improving the lot of physicians and patients within the confines of the decisions involved.

I. THE CALL FOR LEGISLATION

The living will is an expression of the drive for autonomy and individual control as against professional dominance over decisions regarding medical treatment. The popularity of the living wills and the legislation legitimizing these documents indicate the depth and breadth of the demand for individual control and the rejection of the "professionalization" of death.9 The legislation also manifests a rebellion against the "tyranny of technology"10 and the dread of technology controlled by others. It responds to the primal fear of premature burial in which one hovers in a physical limbo between life and death (or afterlife) entrapped, not by a coffin, but by "machinery" that one is helpless to release. It also stems from the anxiety, particularly common among the elderly, over the expense involved in dying an "artificially" prolonged death. The living will offers a shield against the psychological nakedness that is demanded in judicial procedures that examine the previously expressed and unexpressed desires of the now-incompetent patient and the motives of family members who seek official permission to stop treatment.

The living will substitutes for these fears the image of control by the individual rather than professionals. Individual control is particularly appealing here. It reflects the personal nature of a decision on the use of medical treatment, especially when such treatment presents both harm and benefit (p. 94). The characterization of treatment and

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9. Professional control of death is supported by a claim to special expertise on the part of medical or legal procedures. The reach of the professionalization of death is evident in John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 432 So. 2d 611 (Fla. Dist. Ct. App. 1983) in which the court speaks of the financial and emotional drain suffered by the family "awaiting the medico-legal death of a loved one." Id. at 618 (emphasis added).

10. Of course, technology cannot itself tyrannize human beings, as it remains incapable of so human an action. The sense of the tyranny of technology, however, is more than anthropomorphic; rather, it expresses as well the domination of the expert, armed with the power of technological expertise, over the individual who is the subject of the treatment. Veatch, Autonomy's Temporary Triumph, HASTINGS CENTER REP., Oct. 1984, at 38.
its results as either harmful or beneficial is dependent upon the individual's values. The impossibility of characterizing the result in many cases without an understanding of the individual's perspective is evident in the basic question of whether the result of "more life" or prolonging life is valuable or detrimental to a particular person. Whether a longer life is a harm or a benefit depends upon the individual's evaluation of the nature of that time. What is likely to enter that evaluation, depending upon the individual involved, is whether the extension promised by certain treatments will be an extension of suffering, of ability or inability to interact with friends and family, or of "this" life, barring passage to the "next."

Deference to individual control is attractive as well, however, because it is compatible with the values given primacy in what has been described as an age of social freedom. A high degree of deference to individual moral choices may lead to claims for "protection" from participation, or interference, by others in the process by which the choices are made. This protection from others during the decision-making process itself reflects the skepticism of the authority or persuasiveness of moral reasoning that has characterized this age of individual freedom. Reliance on personal choice allows the institutions that sanction particular choices to claim that it is not they who decided to remove life-sustaining treatment from an incompetent patient. Rather, the institutions — whether they be the courts, the legislature, the hospitals, the doctors or the family — are merely media for the expression of the desires and wishes of the only apparently silent patient.

Although decisions to discontinue or continue treatment for particular patients are made in a variety of forums, the most public of these has been the courts. In many cases, the concept of autonomy, identified by the courts as an appropriate decisionmaking base and embodied in substituted judgment, operates as described. The institution is merely a means through which the silent patients exercise choices once it is discovered through an examination of their previously expressed or implied desires. When the patient has never been capable

of exercising judgment on his or her own behalf, however, the right of self-determination is only poorly served by reference to substituted judgment, if at all. In these latter situations, the personal choice rationale is a sham. Such dishonesty provides dangerous comfort. Although a "best interest" approach has its own deficiencies, reliance on substituted judgment in these latter cases does nothing to remedy the problems.

The courts have been troubled not only by the question of how a decision to withdraw or withhold medical treatment is to be made, but whether that decision is permissible and falls within appropriate boundaries of individual choice. Because of their sense of frontier policymaking, judges have repeatedly called upon the legislatures to determine the appropriate boundaries. Courts have described the legislature as better suited for this task because the legislature can take a broad view, can consider a variety of scenarios, and can utilize expertise. Several courts have commended the task to the legislature because the legislature can weigh competing views and is a more majoritarian decisionmaker. The expectations of the courts for legislative relief, however, will not be met for several reasons.

First, the state legislatures will not deal with the hard cases. The living-will legislation has been the single response of most state legislatures to the question of discontinuation of life-sustaining medical

15. Capron, supra note 11, at 32.
17. See, e.g., Satz v. Perlmutter, 379 So. 2d 359, 360 (Fla. 1980) ("[I]t is the type issue [sic] which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions . . . can be presented and synthesized."); In re Conroy, 98 N.J. 321, 344, 486 A.2d 1209, 1220 (1985) ("Legislature is better able than any other single institution to reflect the social values at stake"); Colyer, 99 Wash. 2d at 139, 660 P.2d at 752 ("as these issues necessarily involve society's moral standards as well as legal and medical issues, the Legislature is the most capable of assessing the views of the people of this state").
18. See, e.g., In re Storar, 52 N.Y.2d 363, 370, 420 N.E.2d 64, 67 (1981) ("Unlike the Legislature, the courts are neither equipped nor empowered to proscribe substantive or procedural rules . . . ."). See also Satz, 379 So. 2d at 360.
19. See, e.g., Conroy, 98 N.J. at 344, 486 A.2d at 1220, which states:
Perhaps it would be best if the Legislature formulated clear standards for resolving requests to terminate life-sustaining treatment for incompetent patients. As an elected body, the Legislature is better able than any other single institution to reflect the social values at stake. In addition, it has the resources and ability to synthesize vast quantities of data and opinions from a variety of fields and to formulate general guidelines that may be applicable to a broad range of situations. See also Satz, 379 So. 2d 359, 360; John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 432 So. 2d 611, 618 (Fla. Dist. Ct. App. 1983) (quoting Satz, 379 So. 2d at 360).
treatment.20 This instrument requires that the patient be competent at the time of the execution of the document.21 The legislatures thus fail to provide any answers for the Saikewicz cases in which the silent patient has never been competent to indicate a choice and in which the limitations of the substituted judgment analysis as simple fact finding are most clear. Nor have the legislatures been decisive in handling the most recent of the difficult treatment decisions — the question of the appropriateness of discontinuing nutrition when provided by medical means.22

Second, the living-will legislation has not reached very broadly among possible treatment decisions. The living-will statutes typically confine the declaration to cases in which the patient is terminally ill and to treatments that are ineffective in remedying the patient’s fatal illness or condition.23 Thus confined, the living-will legislation governs only that individual decision that is most easily perceived as rational: the decision to refuse medical treatments that offer no chance of cure. In fact, a choice to pursue medical treatments that prolong the dying process of an individual who is incompetent24 might popularly be viewed as irrational because of the emphasis on interaction, choice, and thought as a measure of humanness.

Third, the limitation of the legislation to situations in which the patient is terminally ill and has expressed his or her choice of treatment reflects the inclination of state legislatures to be reactive rather than proactive.

20. See supra note 3.
21. See, e.g., DEL. CODE ANN. tit. 16, § 2502(a) (1983); FLA. STAT. ANN. § 765.04(1) (West Supp. 1986); GA. CODE ANN. § 31-32-1 (1985); Mo. REV. STAT. § 459.025 (Vernon Supp. 1986); but see, ARK. STAT. ANN. § 82-3803 (Supp. 1986), which provides, “[i]f any person is a minor or an adult who is physically or mentally unable to execute or is otherwise incapacitated from executing” the document, it may be executed by the parent of a minor or the legal guardian of the declarant.
22. Several statutes exclude nutrition from the definition of procedures that may be refused through a living will. See, e.g., FLA. STAT. ANN. § 765.03(b) (West Supp. 1986); GA. CODE ANN. § 31-32-2(5) (1985); Mo. REV. STAT. § 459.015(3) (Vernon Supp. 1986); WIS. STAT. ANN. § 154.01(5)(b) (West Supp. 1986); and WYO. STAT. § 33-26-144(a) (iii) (Supp. 1986). Indiana excludes “the provision of appropriate nutrition and hydration.” IND. CODE ANN. § 16-8-11-4 (Burns Supp. 1986) (emphasis added). These provisions should not be read to extend beyond the living will and to prohibit the withdrawal of medically provided nutrition in all circumstances. See, e.g., Corbett v. D’Alessandro, 487 So. 2d 368 (Fla. Dist. Ct. App. 1986).
24. Many of the living-will statutes confine their effectiveness to patients who were competent at the time they executed the document but who are incompetent at the time the treatment decision must be made. See, e.g., IDAHO CODE § 39-4504 (1985); Mo. REV. STAT. § 459.025 (Vernon Supp. 1986); MONT. CODE ANN. § 50-9-103(1) (1986).
than leading in sensitive areas. By the time most of the state legisla­
tures finally acted, the courts had already established that the termi­
nally ill, once-competent patient who had expressed a clear choice to
refuse life-sustaining treatments was well within the bounds of accept­
able deference to the individual.\textsuperscript{25} Rather than identify the outer
boundaries of individual choice, the legislatures merely acted within
the framework that the courts had established. Of course, if the living
will is seen as simply giving legislative approval to an extra-judicial
procedure for the refusal of treatment, it does relieve the courts of
“easy” cases they might otherwise have to decide and does protect
families and others from judicial proceedings that offer no benefit to
the patient. The legislation, however, still demonstrates the unwill­ing­
ness or inability of legislatures to relieve the courts of establishing ap­
propriate boundaries.

Still, many courts have looked to the legislatures for a better or
more legitimate solution than the courts are able to provide.\textsuperscript{26} These
courts attribute to the legislatures a level of expertise and analysis that
generally is not reflected in the reality of legislative practice on the
state level.\textsuperscript{27} Legislatures do not always listen to the experts, arbitrate
the disputes, and come to a decision. Rather, the process is often one
of political compromise. Some courts implicitly have recognized the
compromising nature of the legislative process in their identification of
the majoritarian nature of legislatures.\textsuperscript{28}

Precisely because the legislatures reflect the rule of the majority,
however, deference to the legislature for boundary-setting may be in­
appropriate. Autonomy is a value that protects the individual from
the majority;\textsuperscript{29} thus, the view of the majority should not be the final
determinant of the boundaries of individual choice, although the ten­
sion between the role of the individual and the role of society in the
area of privacy has never been adequately resolved. To the extent that
the right to refuse medical treatment is based on a constitutional right
to privacy,\textsuperscript{30} the legislature cannot redefine or narrow that right be­
yond constitutional requirements, whatever they might be. At the

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\textsuperscript{25} Thirteen of the thirty-five states with living will legislation enacted the statutes in
1985. Otten, New “Wills” Allow People to Reject Prolonging of Life in Fatal Illness, Wall
\textsuperscript{26} See supra note 17.
\textsuperscript{27} See supra note 19.
\textsuperscript{28} See supra note 19.
\textsuperscript{29} Callahan, supra note 12, at 40.
\textsuperscript{30} Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 743,
379 N.E.2d 417, 426 (1977); In re Quinlan, 70 N.J. 10, 40, 355 A.2d 647, 663 (1976); In re
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least, the courts retain the responsibility to review the legislative action in light of the demands of the constitutional norm. 31

Legislation that has been drafted or influenced by the experts in the field will bear an expert’s mark, and the legislative solution may rest upon assumptions concerning the authority of experts. The resulting structure of the legislation may then reflect traditional expert-layman relationships, reflecting the public’s love-hate relationship with professionals in which laymen are fearful of contradicting professional expertise but resentful of professional control (p. 144). This ambivalence toward professional control, coupled with the competing claims of the professions and popular demand for individual control, sets the stage for compromise in the living-will legislation. The key compromise is evidenced in the typical living-will statute’s structure that has doctors and patients taking turns at controlling critical decisions, establishing a relationship of sequential domination. 32

II. THE REALM OF PROFESSIONAL JUDGMENT

In an early article on Salgo v. Leland Stanford, Jr. University Board of Trustees, 33 Katz attributed the failure of the doctrine of informed consent to the fact that “in delegating unspecified discretion to the medical profession to make judgments about patients’ self-determination, the court did not appreciate the futility of its endeavors, for it gave an undefined task to a group that had neither the experience nor the commitment to self-determination” (p. 62). Although his later discovery of an amicus brief submitted to the Salgo court by the American College of Surgeons caused him to recast the actors in his analysis, Katz still argues that “only self-conscious reflection can make it clear that such contradictory intentions as ‘full disclosure of facts’ and ‘[professional] discretion’ are reconcilable only in the kingdom of dreams” (p. 63). The strong, unrestricted affirmation of patient auton-

31. Capron discusses the negative implications of resting the right to refuse treatment on constitutional grounds rather than upon tort and contract. Capron, Borrowed Lessons: The Role of Ethical Distinctions in Framing Law on Life-Sustaining Treatment, 1984 Ariz. St. L.J. 647, 657-58 [hereinafter Capron, Borrowed Lessons]. See also Dinino v. State, 102 Wash. 2d 327, 684 P.2d 1297 (1984). In Dinino the Washington Supreme Court considered a claim that the state’s living-will statute violated Dinino’s constitutional right to privacy because it suspended the effect of the living will during pregnancy. The court held that the claim was not justiciable because the plaintiff was “neither pregnant nor suffering from a terminal condition.” Id. at 331, 684 P.2d at 1300. It thus reversed the lower court’s holding that the provision was unconstitutional.

32. See supra text at p. 115.

omy that underlies informed consent theory and that appears in the landmark cases was abandoned in the structure of the doctrine of informed consent as it finally emerged (pp. 80-92). The courts abandoned their promise, according to Katz, when they deferred to professional discretion and control the selection of the information that should be given to the patients concerning particular treatments (p. 69). Although there were many motives for deference to professionals, including a concern for the physician's economic well-being, a primary rationale was the perceived necessity of relying on professional wisdom and knowledge in medical decisionmaking. The living-will legislation offers only an illusory triumph for autonomy because it similarly defers to professional judgment both inappropriately and too completely, at a point critical to the effectiveness of the claim of autonomy.

The living-will legislation generally confines the effect of a living will to situations in which the patient is terminally ill and in which the available treatments only prolong the dying process. The statutes generally defer to professional judgment the determination that a patient's condition and treatment options fall within these limitations.

The living-will statutes vary in the treatment limits established for the operation of the document. As previously noted, several living-will statutes exempt medical procedures to provide nutrition and hydration from the medical treatments which the living will may control. This exclusion has more to do with legislative compromise and judgment than physician dominance. Other treatment-centered pre-


35. Katz also discusses other implications of the court's choice of negligence law, rather than battery, for informed consent cases. These implications include the failure of damages to remedy dignitary injuries standing alone.


37. See supra note 22.

38. The National Conference of Catholic Bishops, for example, in November, 1984, issued Guidelines for Legislation on Life-Sustaining Treatment, which generally supported living-will legislation, but maintained that nutrition and hydration should not be included among life-sustaining treatments that may be refused through use of the document. This does not indicate that Catholic doctrine categorically opposes the withdrawal of nutrition or hydration in all circumstances. See, e.g., McCartney, Catholic Positions on Withholding Sustenance for the Terminally Ill, HEALTH PROGRESS, Oct. 1986, at 38. The Judicial
conditions, however, do indicate a misplaced reliance on professional expertise. The Arkansas statute, for example, provides that only treatments that the doctor finds "extraordinary" may be refused through a living will. The weighing of harm and benefit involved in a conclusion as to whether a treatment is extraordinary is clearly a patient's and not a professional's task. As Katz observes, "[t]he weighing of benefit and harm, which are intentioned and dependent on individual preferences, can only be carried out by patients with the assistance of their physicians. It cannot be assigned solely to physicians no matter how pure their altruistic intent" (p. 94).

In addition to treatment limitations, however, most living-will statutes confine the operation of a living will to patients whose conditions meet a particular statutory definition of terminal illness. These definitions suffer from several conceptual flaws that flow both from inappropriate deference to the medical profession and from a lack of clarity in the role of the status of terminal illness as a limit on individual choice. The Missouri and Indiana statutes, for example, provide that the living will is effective only when a physician finds that the patient's death will occur within a "short time" whether or not available treatments are provided. Montana requires that a terminal condition is one which "will, in the opinion of the attending physician, result in death within a relatively short time." This definition gives to the physician authority to answer a question that is not entirely a matter of professional judgment. An individual's evaluation of a pe—


39. ARK. STAT. ANN. § 82-3801-3802 (Supp. 1986). See also MISS. CODE ANN. § 41-41-103(b) (1984) which provides: "Withdrawal of life sustaining mechanisms shall mean the cessation of use of extraordinary techniques and applications, including mechanical devices, which prolong life through artificial means."

40. See infra notes 41-42.

41. MO. REV. STAT. § 459.010(6) (Vernon Supp. 1986): A terminal condition is "an incurable or irreversible condition which, in the opinion of the attending physician is such that death will occur within a short time regardless of the application of medical procedures." See also IND. CODE ANN. § 50-9-102 (1985).

period of time as "short" depends on the goals and values of that individual. The same objective time frame can be perceived as either short or long, depending on subjective factors such as the presence or absence of pain.

Other living-will statutes attempt to define a terminally ill patient as one who, in the opinion of the physician, will die within a particular period of time. Wisconsin, for example, specifies that a terminal condition is one "that reasonable medical judgment finds would cause death within thirty days." Asking such a question of a physician as if there were always an answer ignores the real presence of uncertainty in medical decisionmaking (pp. 165-206). Should a "good doctor" take the rule of the statute seriously and refuse to certify someone as terminally ill when he is unable to render a professional judgment with any reasonable certainty concerning the number of days remaining for his patient? What level of certainty or probability is acceptable? Is the acceptable level of certainty or probability also a question that must be deferred to the doctors? Or should the "good doctor" simply play the game established by the statute and certify the patient as terminally ill when, in the doctor's opinion, or the patient's, further treatment is undesirable?

Further, it is not uncommon that treatments present a probability of benefit or "cure" rather than a guarantee of either success or failure. In the face of this uncertainty, a broader role for the patient in the determination of the preconditions for operation of the living will is essential. Although not self-evident, the determination of the presence of terminal illness is itself a question that involves an assessment of risk and a balancing of the benefits and burdens of treatment that might reduce that risk. If the patient has a particular cancer that responds to chemotherapy fifty percent of the time, should the patient be considered terminally ill and the patient's living will be understood as

43. See also In re Conroy, 98 N.J. 321, 363, 486 A.2d 1209, 1231 (1985), which used a predicted one-year lifespan as a limit on compliance with refusal of medically provided nutrition. In a New York Times article on post-Conroy treatment of patients, the Ombudsman charged with the task of initially deciding whether to allow removal of medically provided nutrition from nursing home patients, denied approval in the first case brought to him because it was not clear that death would occur within one year, as the Conroy court required. The patient was in an irreversible coma and had clearly indicated previously her desire not to be maintained in a vegetative state. Although three physicians testified that she had less than a year to live, two physicians appointed by the Ombudsman concluded that the patient could live for years. The Ombudsman concluded that "medical experts find it impossible to state with authority that [the patient] will die within a year." Ombudsman Bars Food-Tube Removal, N.Y. Times, Mar. 7, 1986, at B2, col. 1. See infra note 46.

44. WISC. STAT. ANN. § 154.01(8) (West Supp. 1986).
a refusal of this treatment? If the treatment is successful twenty-five percent of the time? Less than ten percent? These questions cannot be answered by medical expertise alone. Statutes that give doctors control over the determination of whether a patient is terminally ill often inappropriately defer to professional judgment mixed questions of expertise and personal values.

The statutory treatment of "terminal illness" as though it were solely a question of fact also ignores the lack of agreement concerning the purpose or validity of some notion of terminal illness as a limit on the patient's right to choose to refuse treatment. Does the patient with end-stage renal disease who refuses hemodialysis fall within the limit? The patient receiving nutrition through a gastrostomy tube due to permanent dysfunction of the esophagus? The patient in the early stages of a slowly progressing terminal cancer who develops pneumonia and refuses antibiotics? A very elderly patient suffering from a confluence of chronic diseases that may include diabetes, heart disease and progressive kidney failure? These patients will die sooner rather than later if the treatments they refuse are not given. Is it the nature of the disease or illness that creates the boundaries on choice? Should the boundaries be the same for competent patients as for incompetent patients? If terminal illness is chosen as a boundary on the individual choice of the incompetent patient, what function is that boundary serving?

The legislatures have failed to confront a critical issue in the process of establishing boundaries on the choice to refuse treatment.46

45. Some of the confusion regarding the role of terminal illness as a boundary on the right to refuse treatment may arise from the mistaken placement of this right under the same analytical scheme as the right to choose abortion. Capron analyzes the differences between the choice of abortion and the choice to refuse treatment. He concludes that the right to refuse treatment based on the right of privacy is the same for all patients; it does not grow or diminish depending on the patient's condition. For example, a competent patient with cancer who decided to discontinue the chemotherapy believed by his physicians to offer his only hope of overcoming an otherwise fatal disease would be exercising his right of privacy — that is, his authority to decide whether to accept or reject medical interventions. There should be no suggestion in the law that a patient's right to make this choice only arises when he or she becomes permanently unconscious or is near death despite medicine's best efforts to prolong life.

Capron, Borrowed Lessons, supra note 31, at 658.

46. Several courts have acted in what may be called a "legislative capacity" in designing detailed procedures for the legitimization of decisions by patients in the future to refuse treatment. The New Jersey Supreme Court's opinion in Conroy is a recent example. In acting "legislatively" this court set as a boundary a requirement that the death of the incompetent nursing home patient, who may have previously indicated a refusal of life-prolonging treatments and for whom the question of whether to provide nutrition medi-
They have tried to avoid the complex issue of the relationship of the individual and society in regard to refusal of treatment. Although the statutes repeat the now familiar refrain that the individual's right of self-determination is limited by the state's interests in life and medical ethics, they do not explore these limitations. The exploration of these boundaries within the legal system remains for the courts.

Deferring to the medical profession the question of whether a particular individual is terminally ill thus allows the professional's values to dominate: "Just as patients bring different values to bear on their ultimate choice, so do physicians, although doctors' value judgments are often obscured by their homogenizing all values under the single rubric of medical judgment" (p. 96).

One cannot rely on the "good faith" of the physician in the application of the indeterminate statutory language of the living-will legislation to a particular situation (p. 94). Because there is "no one clear path to well-being," one cannot rely entirely on a presumed "identity of interests" between physician and patient to assist the living-will legislation in its achievement of its goal of protecting individual control over medical treatment decisionmaking (p. xviii). If this is so, all that the legislatures have accomplished by enacting such legislation is to shift the final decisionmaking authority from one profession (as represented in the guardianship proceedings of the courts) to another (the physicians). Professional control over an individual's decision to refuse medical treatment may remain practically unaltered by these statutes.

III. THE REIGN OF INDIVIDUAL CONTROL

Once the physician has established that the patient is within the limits that the statute allows the physician to determine, the individual has complete control over the decision to refuse treatment. This high degree of individual control grows out of the public's demands for a shield against professional domination. It may also be viewed as an effort to equalize the position of the patient as against the physician by granting the patient his or her own counterbalancing area of domination. Thus equally armed, the patient and the physician are then set upon each other to make decisions as best they can.

Of course, autonomy is not subsumed completely by the concept of individual control. Individual control is at best a poor relative of...
autonomy but it is a tangible manifestation, and so becomes attractive in itself. The equation of autonomy with control may not be fair to the more sophisticated concept of autonomy in ethics. An awareness of the popular notion of autonomy, however, is important to an analysis of the likely impact of living wills upon the relationships of physicians and patients.\(^47\) To understand the impact of the substitution of individual control for autonomy, a comparison of this truncated notion with Katz's more sophisticated analysis of autonomy is helpful. In contrast to the one-dimensional popular view of individual control, Katz separates autonomy into two dimensions: self-determination and autonomy. Katz defines self-determination as “the right of individuals to make their own decisions without interference from others” and defines autonomy as “psychological autonomy” which denotes “the capacities of persons to exercise the right to self-determination” (p. 105). This separation supports Katz's attention to the individual's decisionmaking process and his call for a duty of reflection and for respectful dialogue. In contrast, the living-will statutes elevate documentation over conversation. They encourage individuals to make decisions concerning refusal of treatment in the lawyer’s office rather than the doctor’s office, by filling out a form rather than engaging in open discussion with persons involved in the process.

In some situations, for example when the living will is executed by a healthy individual in anticipation of the unpredictable, that may be the best that can be done. But in many situations, there are other, possibly more difficult, paths that may be taken. Simple refusal becomes the easier road, and true autonomy supported by reflection and conversation with other persons becomes the road less traveled. Giving each aspect of the decision (that is, ultimate sovereignty and exercise of that sovereignty) equal stature strengthens claims of a right to exclude others from the process.

The creation of a realm of individual control shielded from participation by others ignores the widely held skepticism of the capacity of individuals to make their own medical decisions. This skepticism affects both physicians and patients. In anticipation of the perceived incapacity of patients, physicians may manipulate the boundaries of the arena in which patients may exercise their control. In anticipation

\(^{47}\) “While it is not altogether fair to hold a good concept sensibly deployed to the test of its proof against popular misuse, concepts must always be used in some culture unless they are to remain solely in dictionaries and textbooks. How they react with that culture may tell us more about their inherent possibilities than any purely conceptual analysis could reveal.” Callahan, supra note 12, at 41.
of their own weakness in the face of doctors' expertise, patients either may avoid necessary dialogue with their physicians or may defer entirely to their physicians' judgment. Katz himself admits that "human psychological capacities for autonomy are limited. . . ." (p. 111). His solution to that limitation is not to ignore or to submit to it as living-will legislation does, but to advocate "respectful conversation" that will enhance the autonomy of the patient. Katz eloquently defends his call to conversation and reflection as necessary to true autonomy. The need for conversation is especially acute in the particular types of decisions over which the living will is to govern.

The service of a living will upon the physician as a substitute for conversation will block the physician's understanding of the patient, which is itself essential to implementation of the patient's choices in the living will. If statutory terms such as "benefit" or "terminal condition" may be interpreted by the physician in a manner that respects the individual patient's values, the physician must have the opportunity to understand how the patient perceives the situation and what the patient values in the portion of his or her life remaining. Further, most living-will statutes allow the patient to add clauses to the document that may expand its scope considerably. For example, statutes that exclude nutrition from the definition of medical treatments that may be refused by means of a living will frequently would allow the patient to add a clause specifically refusing medically-provided nutrition. These statutes, however, would not give the document its statutory effect as to this clause.48 In these cases, the physician either could decide to abide by the patient's expressed wishes or could seek a judicial order concerning the action. In either case, the physician's understanding of the reasons for or meaning of the patient's expression would be relevant and would increase the likelihood that the patient's choice would be understood and satisfied.

If the living will has a broader impact on the nature of medical decisionmaking and if its scope is expanded in practice, it will mute open discussion of the morality of the choices that may become available. There is a social dimension to the life of an individual even in decisions as private as medical ones. Merely mechanical observance of patients' self-determination easily can be a refuge from the sometimes painful consideration of other moral values; for example, those that may be associated with the family or broader community.49 The im-

48. See, e.g., FLA. STAT. ANN. § 765.05 (West Supp. 1986); MO. REV. STAT. § 459.015(3) (Vernon Supp. 1986); and WYO. STAT. § 33-26-145(d) (Supp. 1986).
49. Callahan, supra note 12, at 41.
pact of conversation, discussion, and persuasion between physician and patient is not necessarily one-way. Just as patients are influenced by physicians, physicians may be influenced by patients and may gain insight into human nature and the complexity of moral choices. Doctors may find their own views challenged and may change.

The sequential domination of physician and patient legitimized by these statutes will not change fundamentally the hierarchial nature of doctor-patient relationships, a nature that discourages the exchange of relevant information. Of course, many of the living-will statutes explicitly encourage patient-physician conversation, but these provisions alone will not offset the negative effect of the structure of the legislation upon the relationship.

If the world of doctor and patient would be as silent and isolated as depicted, one may be skeptical that patients and doctors will succumb to the superficial attraction of conducting their relationship through an exchange of documents. Again, Katz's analysis of the nature of the relationship between patient and physician substantiates his claim that relying on "the fictional propensity of physicians to discuss with patients is dangerous nonsense" (p. 29) and reveals why the same is true in the context of the living-will legislation.

IV. THE ATTRACTION OF SILENCE

As one aspect of the informed-consent dynamic, the decision to refuse life-sustaining treatment must contend with the tradition of silence powerfully presented by Katz. Because these particular decisions involve choices with regard to death or choices made by patients either facing imminent death or in contemplation of their death, the tradition of silence is at its strongest. Katz alludes to the difficulty physicians have in communicating a dire prognosis to individual patients. Although this reluctance may be based on an expressed desire to spare patients the distress of knowing their conditions, Katz attributes the reluctance more to the inability of the doctors themselves to confront the prognosis. In addition, physicians may avoid informing the patients of the fatal nature of their condition because they believe such a revelation would be harmful and anti-therapeutic (p. 20).

Doctors are not alone in refusing to speak honestly with an individual who confronts impending death. Lawyers share this inadequacy and have their excuses as well. Friends and family also may

50. Katz quotes a physician as commenting, "It is not the patient who cannot tolerate hearing the truth. I could not tolerate telling my patients the truth." Katz, supra note 2, at 19.
disguise their knowledge of the patient’s prognosis with false assurances. If it is so common to avoid discussions of death, the execution of a living will by the terminally ill patient realistically cannot be expected to alter the pattern of avoiding dialogue since the necessary decisions have been “taken care of.”

At the same time that doctors are silent toward their patients, patients have been silent toward their doctors. Anyone doubting the existence of the patients’ silence need only read any of the newspaper physician-columnists to see that patients frequently prefer to write the columnist for advice rather than ask their own doctors simple questions concerning the effect of prescribed medications or the risks and effectiveness of surgery their own doctors have scheduled. One explanation for this may be a patient’s desire to avoid imposing on a “busy” doctor.

Katz offers another explanation, however, for the silence of patients toward their physicians. Katz argues that patients fear conflict with their physicians because “good” patients comply with doctor’s orders while only “bad” patients question the doctor’s authority. Patients are afraid that if forced to justify their decisions they will lose control because of the doctor’s greater expertise (p. 163). Rather than telling the doctor that they have decided to discontinue medication, for example, they simply do it. Accordingly, patients are likely to execute a living will and give it to a family member or lawyer to give to the doctor only when it is needed.

As much as patients resent the professionalization of death, doctors resent being ordered by their patients. Presentation of the living will, if presented as a fait accompli by the patient to the doctor, may itself result in the closing off of conversation and the relegation of the decision, along with the document, to the filing cabinet. If physicians and patients are already inclined to avoid conversation, institutionalization of such an inadequate relationship becomes not only a potential outgrowth of living will legislation but unfortunately a likely one.

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51. A patient’s feeling of being either good or bad may arise from the impact of transference and countertransference in physician-patient interactions. KATZ, supra note 2, at 142-50.

52. If all final authority is vested in patients, the danger is great that in situations of either a total refusal to give an account of one’s reasons or an unwillingness to explore one’s possible confusion — when the need for conversation is greatest — doctors will wittingly and unwittingly give up on conversation and patients prematurely because they have been stripped of all power to stop even the patient’s most inexplicable self-destructive course. KATZ, supra note 2, at 163.
CONCLUSION

The traditional reluctance of patients and physicians to interact on an honest and reflective basis cannot be cured with the stroke of a pen. The temptation for lawyers is to leave the reordering of the relationship to the parties — the physicians and the patients. No doubt the medical profession, by changing its education and training, and the patients, in demanding information and taking responsibility, must take the lead. Katz has revealed, however, the significant, though often unconscious, effect of law in institutionalizing professional domination and maintaining the tradition of silence.

Some situations governed by the living will may be beyond the reach of effective conversation. These include cases, such as those described previously, in which a person with no foreseeable proximity to death or incapacity signs a living will to govern the unpredictable. In these cases, conversation between doctor and patient may have to take place in such an unreal context that it is ineffective to cause substantial reflection by either the doctor or the patient. Dialogue may result in the communication of relevant information, however, such as a doctor's blanket refusal to comply with living wills. In light of the significant risks of misunderstandings and indeterminacy of a living will executed in anticipation of unpredictable events, a proxy, designated by the patient while competent could assist in the interpretation of any document executed by the incompetent patient or could perform a decisionmaking function.

With a proxy chosen by the patient, the physician, who often may be unfamiliar with the now-incompetent patient, has a source of important information about the patient's choices which may be more accurate than a simple document might reflect. The proxy also serves as a necessary agent who can force or encourage the doctor to admit and reveal that there are choices to be made.53

Proxy decision making has its own difficulties, of course. Families

53. The advantages and disadvantages of proxy decisionmaking in this context are discussed in the following articles: Martyn & Jacobs, Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney, 63 Neb. L. Rev. 779 (1984); Note, Appointing an Agent to Make Medical Treatment Choices, 84 Colum. L. Rev. 985 (1984) [hereinafter Appointing an Agent]; Note, Proxy Decisionmaking for the Terminally Ill: The Virginia Approach, 70 Va. L. Rev. 1269 (1984). Legislation on proxy decisionmaking has the advantage of conforming to the custom of the medical system in referring treatment decisions to kith-and-kin substitutes in cases of the patients' incompetency. See, e.g., Capron, Informed Consent to Catastrophic Disease Treatment and Research, 123 U. Pa. L. Rev. 340, 424-25 (1974). Because this custom is so firmly established in medical practice, physicians may continue to be greatly influenced by the kith-and-kin substitute even when he or she directly contradicts the patient's living will.
are not always the benign social unit of mutual support that we would like to assume. The well-being of the individual patient-member is not always the primary concern of the family; nor does the family always have the capability to act in a patient-centered manner. Patient-designated proxies, however, generally will be less subject to these obstacles and may serve as valuable participants in medical treatment decisionmaking.

At the least, state legislatures should proceed to authorize proxy decisionmaking as an alternative to the living will. Absent such legislation, attorneys may want to attempt to use the state's durable power of attorney statute to appoint a proxy. While this method may not be effective to create a proxy with authority to make medical treatment decisions, the appointment may be useful in identifying an individual whom the client desires to be his guardian should a guardianship be sought, or to indicate clearly that particular kith-and-kin proxies do not have authority to speak on his behalf. Planning of this sort is particularly important for the adult client who may be engaged in personal relationships not recognized as marital relationships and who may not want parents or other traditional proxies to control. Even in circumstances in which this factor is not present, there may be dispute among family members concerning treatment, which, in the absence of a designated proxy, may have to be resolved in court.

In other situations, the opportunity for conversation between the patient and the doctor, prior or as a supplement to the execution of a living will, does exist. This may occur when an adult of any age has a condition that is potentially life-threatening. A similar situation oc-


55. See, e.g., Mo. Rev. Stat. § 475.050 (Vernon Supp. 1986), which provides that "the court shall consider the suitability of appointing . . . any eligible person . . . nominated in an instrument in writing signed at [the incompetent person's] request, before the inception of his incapacity or disability, at a time within five years before the hearing when he was able to make and communicate a reasonable choice."

56. See Appointing an Agent, supra note 53, at 994-95.
curs in the case of an elderly individual who may be subject to conditions that threaten severe physical or mental deterioration. At this stage, if the patient is aware of this diagnosis, conversation between the patient and doctor concerning the choices available can be quite beneficial to the patient's well-being. Conversation between doctor and patient would also tend to reveal the doctor's view of his or her own role in caring for the terminally ill patient. This would allow the patient to learn of conflicts that are best resolved prior to the patient's incompetency, perhaps by engaging a different doctor.

The ability of law alone to encourage such conversation is limited. One opportunity that does exist, even within the structure of the living-will statutes, is that afforded the courts interpreting those statutes. A physician's determination of whether the patient meets the preconditions for the operation of the living will should be based on the patient's expressed choice, if known. Giving patients a role in the determination of the existence of the preconditions would encourage patients to contact their doctors and let their desires be known rather than allow the doctors to make these decisions on their behalf or require the courts to intervene. In situations in which a particular course is likely, the patient may execute a living will that more explicitly defines the preconditions required. This is especially critical in light of the uncertainty in diagnoses of terminal illness, the ambiguity of the term, and the lack of a defined purpose for the terminal illness boundary.

Lawyers will play a significant role in the implementation of the living will because many clients will request that they execute this document. In this task, the lawyer should not always simply resort to use of the statutory form. Rather, the lawyer must advise the client of the limitations of the document and encourage discussion between patient and doctor. There are many reasons for this advice, including the role of the doctor in determining the preconditions that trigger the document and the implementation of added clauses, such as refusals of medically provided nutrition. In addition, if the client's doctor refuses to comply with living wills because of the doctor's own ethical beliefs, the client should be made aware of this while the opportunity to choose a different doctor still exists. Moreover, if the client's family opposes the client's living will, the physician and lawyer can be the patient's allies, with the living will serving as evidence of the mutual consent among them. Of course, lawyers have to devise a cost-efficient manner of communicating this information. In this regard, while law-
yers push doctors to take the time to inform patients fully, we might do well to follow our own prescription.

Finally, neither the courts nor the legislatures should consider their task complete merely because of the recognition of the living will. Clearly, the courts will continue to be involved in this area in interpreting the statutes and in dealing with situations not covered by the living-will legislation. In light of the deficiencies of living wills, the courts should not establish policies that implicitly require that patients sign living wills as the only effective method through which their choices will be honored. Nor should they limit the scope of individual choice to that set by the legislature in the living will.

At the bottom line, patients must have final authority to make the decisions concerning their medical treatment. But the nature of the process for reaching this bottom line is important for the quality of life of the patient and the physician. Katz concedes that his call for the enhancement of autonomy through conversation is paternalistic (p. 128). The same can be said about criticisms of living-will legislation based on a belief that its mechanical form will have a negative impact on the relationship of physicians and patients. Acknowledging that the call to conversation is paternalistic, however, is not to concede that this paternalism destroys the individual's autonomy, as may indeed be the case in other conflicts. Rather, the insistence on conversation as an element of the process of autonomy may equally be characterized as creating an environment for the exercise of autonomy. The legal doctrine of informed consent focuses not solely upon consent, but rather upon decisionmaking, whether consent or refusal, and upon the communication of relevant information to the patient for careful consideration. There is a critical link between information and a particular treatment decision. It is this link that the living will totally abandons. Without that interaction, patients will make decisions to refuse or to demand medical treatment in a vacuum deprived of necessary information (p. 209).

The call to conversation in the face of the history of silence is one that undoubtedly will be met with a healthy skepticism.\(^{57}\) It is certainly idealistic to create a duty of reflection and dialogue while simul-

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57. The tradition of silence has severely undermined patients' trust of physicians in a quiet way that erupts during conflicts such as these. Katz quotes Richard C. Cabot, a physician:

We think we can isolate a lie as we do a case of smallpox, and let its effect die with the occasion that brought it about. But is it not common experience that such customs are infectious and spread far beyond our intention and beyond our control? They beget, as a rule, not any acute indignation among those who get wind
taneously calling physicians and patients to a new level of conversation. One may argue that individual control should not be sacrificed in favor of an idealized relationship. Nor should the individual be sacrificed, however, to an empty notion of autonomy that brings with it isolation and abandonment and which can be "undermined by hopeful promises, blind misconceptions, and false certainties" (p. 141).

of them (for 'how,' they say, 'could the doctor do otherwise'), but rather a quiet, chronic incredibility which is stubborn.

KATZ, supra note 2, at 25.