Medical Paternalism and the Rule of Law: A Reply to Dr. Relman

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ABSTRACT

In this Article, Professor Baron challenges the position taken recently by Dr. Arnold Relman in this journal that the 1977 *Saikewicz* decision of the Supreme Judicial Court of Massachusetts was incorrect in calling for routine judicial resolution of decisions whether to provide life-prolonging treatment to terminally ill incompetent patients. First, Professor Baron argues that Dr. Relman's position that doctors should make such decisions is based upon an outmoded, paternalistic view of the doctor-patient relationship. Second, he points out the importance of guaranteeing to such decisions the special qualities of process which characterize decision making by courts and which are not present when such decisions are made by doctors. Finally, he argues that Dr. Relman has overestimated the social costs of bringing *Saikewicz*-type cases before the courts and that those costs which are inevitable are more than offset by the qualities of process that the court system can offer in such matters.

I. INTRODUCTION

In an earlier edition of this journal,[1] I criticized the Massachusetts Supreme Judicial Court's opinion in *Superintendent of Belchertown State School v. Saikewicz*[2] for not going far enough in assuring, for the type of life and death question involved in that case, "the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created."[3] While criticizing the opinion on that ground, my Article implicitly approved[4] the *Saikewicz* decision's fundamental position that the job of deciding such life and death questions is the responsibility of the court system "and is not to be entrusted to any

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[1] Baron, *Assuring "Detached but Passionate Investigation and Decision": The Role of Guardians Ad Litem in Saikewicz-type Cases,* 4 AM. J. L. & MED. 111 (1978).

[2] 1977 Mass. Adv. Sh. 2461, 370 N.E.2d 417 (1977).

[3] *Id.* at 2501, 370 N.E.2d at 435.

[4] Baron, *supra* note 1, at 112-13.

other group purporting to represent the 'morality and conscience of our society,' no matter how highly motivated or impressively constituted."[5]

Subsequently, this journal published an Article by Dr. Arnold Relman in which he attacks head-on the proposition which was approved only in passing by my earlier Article. As to that proposition he states:[6]

> Contrast my description of medical practice with the recent assertion made by Charles Baron, in support of the *Saikewicz* decision, that "our society has never conferred upon its medical community the power to decide which of society's members shall live and which shall die." Now, if by that statement he means that physicians do not have the authority arbitrarily to terminate a patient's life, he is of course correct. But if he means to convey that doctors have no business deciding whether to institute or to withhold treatment, when such decisions may have life or death implications, then he is simply ignorant of the facts of medical practice. As I have tried to show, those kinds of decisions—always with the informed consent of patients or their families, when such consent is reasonably available—are being made all the time. There is nothing more crucial to a physician's professional role than the making of such decisions. *His responsibility for the welfare of his patients often requires that he deal with technical medical issues which are of vital importance to his patients but which they are unable to comprehend fully, if at all, and which they must therefore delegate to him. Unless he is willing to assume this decision-making role in the patients' behalf he is not really doing his job.*

In the remainder of his Article, Dr. Relman elaborates further upon, and urges additional justifications for, the position which he, and a substantial portion of the medical community,[7] would adopt regarding the

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[5] 1977 Mass. Adv. Sh. at 2501, 370 N.E.2d at 435.

[6] Relman, *The Saikewicz Decision: A Medical Viewpoint*, 4 AM. J. L. & MED. 233, 237 (footnote omitted; emphasis added).

[7] As an example of the reaction of the medical community to the *Saikewicz* decision, consider the following letter sent with the noted enclosures to all doctors associated with the Newton-Wellesley Hospital:

April 10, 1978

Dear Doctor:

We must regretfully advise you that as of April 18, 1978, the Newton-Wellesley Hospital will comply with the law under the so-called "Saikewicz Decision". The Board of Governors has instructed that the following statement be sent to all members of the Staff:

> All physicians in writing orders for patient care should have clearly in mind the principles which appear to have been established by the Massachusetts Supreme Judicial Court ruling in the case of the Superintendent of Belchertown State School and another versus Joseph Saikewicz. Until there is some change as a

role courts should play in making life and death decisions for incompetent patients. First, he claims that life and death decisions *are,* and always *have been,* "medical" in the sense that traditionally they have been made by doctors as part of the technical-medical-treatment decision-making process and that this tradition has been implicitly, if silently, endorsed by the patients with whom, and the societies in which, physicians ply their art.[8] Second, he argues that such decisions *should be* made by doctors because they involve technical-medical questions which cannot properly be appreciated by laypersons, because they repeatedly arise in emergency situations which require quick decisions by the treating physicians, and because the relationship of absolute trust which characterizes the physician-patient relationship will be undermined by a delegation of the decision to anyone but the treating physician.[9] Third, he characterizes the courts as incapable of handling properly such life and death decisions because they lack the necessary medical expertise; because they apply substantive principles regarding the value of life which lead them to make wrong decisions; and because court hearings involve procedures which exacerbate the pain of a dying patient's next of kin, complicate and delay important medical decisions, and make it impossible for the courts to handle the enormous number of such decisions which confront doctors at any given time.[10]

Because Dr. Relman's Article constitutes an exceptionally honest, intelligent, and comprehensive statement of the position of the medical community on this question, an effort to reply to it provides the ideal context in which to develop arguments for the positions which I raised only in passing in my earlier Article. Hence, the present Article will attempt to reply to Dr. Relman's arguments and to defend generally the position

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result of legislation or future court rulings, the hospital will proceed in accordance with the advice of legal counsel.

A copy of the Counsel's interpretation of the Saikewicz Decision is enclosed together with the memorandum which is being sent to all nurses and critical care personnel.

We deplore the Court's intrusion into an area which has always been highly private and deeply personal. Historically, the decision has been quietly and compassionately made by the patient and/or family and the physician. Now, the Court has established a cumbersome and expensive procedure which attracts notoriety. We anticipate many problems with this law, but we will do our very best to work with you to resolve difficulties.

The outlook for the future is not very good. Many believe that any substantive changes in the law may be months or even years away; however, we will advise you of any changes as they occur.

Sincerely yours,
/s/ William C. Christenson
William C. Christenson
Executive Director

[8] Relman, *supra* note 6, at 236-37.
[9] *Id.* at 237.
[10] *Id.* at 241.

of the supreme judicial court stated so eloquently in the following language from the *Saikewicz* opinion:[11]

> We do not view the judicial resolution of this most difficult and awesome question—whether potentially life-prolonging treatment should be withheld from a person incapable of making his own decision—as constituting a "gratuitous encroachment" on the domain of medical expertise. Rather, such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created.

First, I will defend the position that court determination of such questions regarding medical treatment does not constitute "a 'gratuitous encroachment' on the domain of medical expertise." Next, I will defend the claim that the deciding of such questions requires "the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of goverment was created." Finally, I will deal with Dr. Relman's claim that the costs of providing such a process inevitably doom to failure any effort to achieve such an ideal for *Saikewicz*-type cases.[12]

II. MEDICAL PATERNALISM

A decision to end the life of a terminally ill patient is no more a mere "medical question" to be decided by doctors than a decision to declare war is a mere "military question" to be decided by generals. Doctors are experts in the art and science of medicine who are trained to decide: (1) What is wrong with this patient? (2) What alternative courses should be considered for treatment of this patient? (3) What are the relative risks of cost and chances of benefit inherent in the choices of treatment which are to be considered? When the doctor-patient relationship is working as it should, a patient enters into that relationship implicitly trusting the doctor to make those decisions for him as capably as is humanly possible. But there is another decision which must be made before treatment can begin which can be made only by the patient himself: (4) What course of treatment offers me the chances of benefit that I wish at risks that I am willing to accept? Legal recognition of the fact that this decision normally is reserved to the patient is provided by the doctrine of "informed consent," which is bottomed on the notion that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own

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[11] 1977 Mass. Adv. Sh. at 2501, 370 N.E.2d at 435.

[12] For the problems involved at the present time in giving precise meaning to the term "*Saikewicz*-type cases" and for my own working definition, see Baron, *supra* note 1, at 115-16 n.3.

body"[13] and that, therefore, every competent patient should be provided by his doctor with "an opportunity to evaluate knowledgeably the options available and the risks attendant upon each."[14]

Clearly the question of what course of treatment a patient wishes for himself is not "medical" in the sense in which questions regarding diagnosis and prognosis are "medical." What makes it difficult to keep these types of questions separate in practice, however, is the ease with which many doctors move into one kind of question from the other in a way which muddles the distinction between them and covertly makes a decision for a patient. An excellent example of this phenomenon is provided by the testimony of two psychiatrists in *Lane v. Candura,*[15] a recent decision of the Appeals Court of Massachusetts. In that case, the lower court had granted a petition appointing the daughter of a diabetic 77-year-old widow to be her mother's guardian for purposes of consenting to the amputation of a gangrenous leg. The mother had refused her consent to the operation on the grounds that "she has been unhappy since the death of her husband; that she does not wish to be a burden to her children; that she does not believe that the operation will cure her; that she does not wish to live as an invalid or in a nursing home; and that she does not fear death but welcomes it."[16] The lower court's decision seemed to be based in part on the testimony of a psychiatrist, Dr. Kelley, who testified that "in his opinion Mrs. Candura was incompetent to make a rational choice whether to consent to the operation."[17] In reversing the lower court, the appeals court said: "[Dr. Kelley's] testimony, read closely, and in the context of the questions put to him, indicates that his opinion is not one of incompetency in the legal sense, but rather that her ability to make a rational choice (by which he means the *medically* rational choice) is impaired by the confusion existing in her mind by virtue of her consideration of irrational and emotional factors."[18] And, in a footnote, the court reveals:[19]

> Another psychiatrist, Dr. Zeckel, who is apparently an associate of Dr. Kelley, and who offered an opinion that Mrs. Candura was competent, has been successful in eliciting from her the factors contributing to her choice. When asked to explain why his opinion differed from that of Dr. Kelley, Dr. Zeckel answered, "I think it is just a personal philosophy type of thing where I believe the person[s] themselves ought to be given the benefit of the doubt

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[13] Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

[14] Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir. 1972) (footnote omitted).

[15] 1978 Mass. App. Adv. Sh. 588, 376 N.E.2d 1232 (1978).

[16] *Id.* at 592, 376 N.E.2d at 1234

[17] *Id.* at 594, 376 N.E.2d at 1235

[18] *Id.* (emphasis in original).

[19] *Id.* at 594 n.5, 376 N.E.2d at 1235 n.5 (brackets in original).

> as to what they want to do with their lives, whereas, Dr. Kelley, I guess, is more protective. I can't really speak for him but his general philosophy is different from mine." Dr. Kelley stated, at one point in his testimony, "You know, it comes down really to a philosophical [difference], I hope there is no psychiatric argument in this case. It's the right of a patient to decide they want to die and I spend all my life trying to keep people alive so I take quite a different view."

It is one of the virtues of Dr. Relman's position that it does not depend upon any attempt to allow personal value judgments to masquerade as mere technical-medical decisions. He appears to realize that the ultimate decision to treat or not to treat involves a personal value judgment on behalf of the patient. The problem, he says, is that the patients "are unable to comprehend fully, if at all"[20] the technical data upon which to base their value judgments. As a result, the patients "must therefore delegate to"[21] the doctor the ultimate power to decide upon a course of treatment for them. Hence, Dr. Relman concludes, doctors are justified in making these decisions for their patients because (1) the patients have delegated to them the power to make these decisions for them because they *believe* that only the doctors, and not they themselves, can make these decisions for them in an informed and rational way; and (2) the patients *are right* in believing that only their doctors, and not they themselves, can make these decisions for them in an informed and rational way. Indeed, because of the fiduciary nature of the doctor-patient relationship, Dr. Relman argues that these facts *obligate* the doctor to make these decisions for his patients: "Unless he is willing to assume this decision-making role in the patients' behalf he is not really doing his job."[22]

But are doctors really in a position to make rational decisions for their patients? Professor Allen Buchanan, who has encountered Dr. Relman's attitude in many other physicians and has dubbed it "medical paternalism,"[23] points out how unlikely it is that they are:[24]

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[20] Relman, *supra* note 6, at 237.

[21] *Id.*

[22] *Id.*

[23] Of course, such attitudes are not restricted to doctors. More properly, we should speak of "professional paternalism," since the attitude is shared, *mutatis mutanda,* by members of professions other than medicine—including lawyers. For a very provocative study of "*legal* paternalism," see D. ROSENTHAL, LAWYER AND CLIENT: WHO'S IN CHARGE? (1974). Rosenthal's major conclusion seems applicable to the professions generally:

> Some will accept the validity and the generalizability of the evidence presented in this book and yet be unwilling to abandon the traditional model as the ideal pattern of behavior for the professional and client. This is a position justifiable according to at least two concepts of human nature—one conservative and one reformist. The conservative position would be founded on skepticism about the

> Such a judgment would have to be founded on a profound knowledge of the most intimate details of the patient's life history, his characteristic ways of coping with personal crises, his personal and vocational commitments and aspirations, his feelings of obligation toward others, and his attitude toward the completeness or incompleteness of his experience. In a society in which the personal physician was an intimate friend who shared the experience of families under his care, it would be somewhat more plausible to claim that the physician might possess such knowledge. Under the present conditions of highly impersonal specialist medical practice it is quite a different matter.

Moreover, empirical data indicates that many doctors are, in fact, not very good at judging what their patients want for themselves.[25] As an example, consider studies which show that the vast majority of doctors who deal

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potential for improvement of institutions so dependent upon the frailties of human nature. . . . The desirability of, as well as the potential for, extensive professional reform is questioned by many of this disposition. They tend to have a view of the development of social institutions such as professional-client relationships which sees existing institutions as a reflection of the desires and needs of those who live and work within these institutions and which mistrusts the ultimate constructiveness of basic institutional reform. "The relationship of authority-dependency between professional and client has developed as it has because that is the way people want it to be." If clients choose a relationship of dependency and if this dependency entails certain risks because of the limitations of professionals and because of the uncertain nature of professional problems then, in the words of Dostoyevski's Grand Inquisitor, it is because "man has no more agonizing anxiety than to find someone to whom he can hand over with all speed the gift of freedom with which the unhappy creature is born."

The reformist defense of the traditional ideal sees it as a potential source of tremendous good. Can it be doubted that many distinguished doctors, lawyers, scientists, teachers, and others have been inspired to careers of extraordinary generosity, probity, and responsibility by the traditional professional ideal? . . .

. . . .

I do not accept the appropriateness of the conservative defense of the traditional model because it relies, I believe, on an unduly pessimistic view of human nature, an undue willingness to tolerate what is wrong with existing institutions, and an unduly fearful attitude about the possibilities of constructive social innovation. Nor do I accept the reformist defense which asks too much from educated professionals and too little from educated laymen.

Id. at 151-52 (footnote omitted).

As evidence of my own concern with paternalism within the legal profession, see Baron & Cole, *Real Freedom of Choice for the Consumer of Legal Services: Mr. Dooley and the Closed Panel Option*, 58 MASS. L.Q. 253 (1973); Baron & Hofrichter, *Quality Control Moves to Center Stage*, 1 NEW DIRECTIONS IN LEGAL SERVICES 21 (1976); Baron, *Specialization: Is Bar Regulation the Answer to Quality Control?* 2 NEW DIRECTIONS IN LEGAL SERVICES 37 (1977).

[24] Buchanan, *Medical Paternalism*, 7 PHILOSOPHY & PUBLIC AFFAIRS 370, 381-82 (1978). For philosophical discussion of the same subject by other authors, see Dworkin, *Paternalism*, in MORAL PROBLEMS IN MEDICINE 185 (S. Gorovitz ed. 1976); Gert & Culver, *Paternalistic Behavior*, 6 PHILOSOPHY AND PUBLIC AFFAIRS 45 (1976).

[25] *See* Buchanan, *supra* note 24, at 376-87.

with cancer patients believe that the patients do not want to know the truth about their condition.[26] The physicians interviewed in one such study by Dr. Donald Oken showed very little doubt regarding the accuracy of their views:[27]

> Personal convictions were stated flatly and dogmatically as if they were facts. Thus, "Most people do not want to know," "It is my firm belief that they always know anyway," or "No one can be told without giving up and losing all hope." Highly charged emotional terms and vivid expressions were the rule, indicating the intensity and nature of feelings present. Knowledge of cancer is "a death sentence," "a Buchenwald," and "torture." Telling is "the cruelest thing in the world," "awful," and "hitting the patient with a baseball bat." It is not necessary even to read the words on the questionnaires. Heavy underlining and a peppering of exclamation points tell the story.

And yet, as Oken points out, these views fly in the face of study after study which reveals that the vast majority of cancer patients want to be told the truth about their condition.[28] From where, then, do the doctors develop their views? It is not from any empirical evidence, Oken concludes; "avoidance of telling reflects the psychological problems of the doctor."[29] He states:[30]

> Among the motivations for entering medicine, the wish to conquer suffering and death stands high on the list. Practicing physicians are not the kind of persons who can sit quietly by while nature pursues its course. . . .
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> . . . If any group is constantly bombarded with the awful fact of death it is doctors—the same group which has such strong needs to conquer it. No wonder the feeling: "I'm upset emotionally by treating a (cancer) patient. I cry on the inside."
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> Situations of this kind, associated with intense charges of unpleasant emotions, call forth a variety of psychological defenses

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[26] *See, e.g.*, Fitts & Ravdin, *What Philadelphia Physicians Tell Patients with Cancer*, 153 J.A.M.A. 901 (1953); Rennick, *What Should Physician Tell Cancer Patient?* 2 NEW MEDICAL MATERIA 51 (1960).

[27] Oken, *What to Tell Cancer Patients: A Study of Medical Attitudes*, 175 J.A.M.A. 1120, 1125 (1961).

[28] *See, e.g.*, Branch, *Psychiatric Aspects of Malignant Disease*, 6 CA, BULL. CAN. PROG. 102 (1956); Kelly & Friesen, *Do Cancer Patients Want to be Told?* 27 SURGERY 822 (1950); Samp & Curreri, *Questionnaire Survey on Public Cancer Education Obtained from Cancer Patients and Their Families*, 10 CANCER 382 (1957).

[29] Oken, *supra* note 27, at 1127.

[30] *Id.* at 1126-27. For a study showing that other values of the physician also play a role, see Todres, Krane, Howell, & Shannon, *Pediatricians' Attitudes Affecting Decision-Making in Defective Newborns*, 60 PEDIATRICS 197 (1977).

> which reduce the intensity of feelings to manageable proportions. Among such defenses are those which involve the avoidance, negation, or denial of the existence of some unpleasant fact, and acting as if it were not real.

Understandably, the motivation and technical skills of physicians lead them to see hope and health as ends in themselves. As a result, many apparently are not able to accept as rational a patient's desire to know about and resign himself to impending death or to refuse treatment whose benefits the doctor believes outweigh concomitant risks. And the phenomenon is not restricted to the cancer ward. A surgeon who was successfully sued in an "informed consent" case[31] explained his unwillingness to inform the plaintiff of the risks of her surgery this way: "I feel that were I to point out all the complications—or even half the complications—many people would refuse to have anything done, and therefore would be much worse off."[32]

And what about Dr. Relman's claims that patients are unable to comprehend the technical data regarding their cases and that they, therefore, delegate to their doctors the ultimate power to make decisions for them? Again, studies indicate that patients generally do *not* believe that they have delegated decision-making power to their doctors and they believe that, where the doctor has the proper supportive attitude, they are capable of comprehending adequately the technical-medical issues surrounding their cases. One such study reports:[33]

> During [the] interviews patients expressed diverse opinions about the quality of communication in hospital, but certain themes recurred again and again. The conduct of ward rounds, for example, provoked heavy criticism. Patients disliked the way in which they were excluded from discussion by doctors who muttered among themselves at the end of the bed, using incomprehensible medical jargon. Such behaviour was regarded as insulting: patients thought that the doctors were underestimating their intelligence. For example, a 49-year-old man with peripheral vascular disease who had undergone a lumbar sympathectomy said: "On the ward rounds there are two professors, two senior registrars, [Dr. X] and all—they discuss you among themselves and say 'It'll be all right . . . pat you on the head as it were, and stick another lollipop in your mouth." Another commented, "We're not morons. Education has advanced and I think you should be treated as an intelligent person."

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[31] Congrove v. Holmes, 37 Ohio Misc. 95, 308 N.E.2d 765 (1973).

[32] *Id.* at 98, 308 N.E.2d at 768.

[33] Reynolds, *No News is Bad News: Patients' Views about Communication*, 1 BRIT. MED. J. 1673, 1674 (1978).

Of course, even in a society as individualistic as ours, there are likely to be many people who would prefer to give over decision making to their doctors. In the wake of the recent mass suicides in Guyana, there has been much public speculation regarding the nature of such desires to avoid autonomy. One psychologist was quoted as saying: "[T]he appeal of a man like Jim Jones was a silent call to those 'seeking an escape from freedom. They are people in search of a return to the comfort of childhood, escape from adult responsibility, a search for security in an individual who relieves them of making decisions.'"[34] Presumably, we do not want to encourage such attitudes as the norm in our society. Therefore, if anything, doctors should be encouraging patients to shoulder the burdens of decision making for themselves. But even if the medical community is not willing to take on the role of fostering citizen self-sufficiency in this fashion, it certainly has no right to encourage the opposite. Even less does it have the right to presume a willingness to delegate decision-making power to doctors in situations where the patient has never been asked explicitly whether he accepts the medical community's invitation to "escape from freedom."

Hence, in no sense suggested by Dr. Relman is the question of what course of treatment a competent patient wants for himself a "medical question." That is a question which only the patient himself can decide unless the patient explicitly has delegated decision-making power to the doctor. However, the *Saikewicz* decision did not involve a competent patient. In that case, and in all cases that are covered by its holding, the question is: "Who shall decide upon a course of treatment when the patient cannot decide for himself?" Here, at least, Dr. Relman might argue, the doctor should be authorized to decide. The patient cannot decide for himself. Why isn't the doctor, who already knows the case intimately and fully understands all of the technical-medical facts, a better "proxy decision maker" than a judge? An adequate answer to this question requires consideration of why such a decision-making process would be antithetical to "the rule of law."

III. THE RULE OF LAW

The choice between doctors and courts of law as proxy decision makers for incompetents is not primarily a decision between two kinds of people on the basis of their relative competence as individual decision makers. It is not a question of whether the doctors or judges are better trained to make life and death decisions for persons who cannot decide for themselves.[35] Properly viewed, the choice is between, on the one hand,

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[34] Philadelphia Inquirer, Nov. 26, 1978, at 14A, col. 1.

[35] Although my argument does not rest on a comparison of the training of lawyers and

unsystematic determination by individual persons, be they doctors or judges, and, on the other hand, the type of systematic determination of questions which characterizes the ideal of Anglo-American court systems. Hence, in deciding to entrust life and death decision making for incompetents to the court system rather than to individual doctors, the *Saikewicz* court was not expressing distrust for doctors. Rather, the court was expressing its special faith in the judicial system by requiring for the deciding of these very important questions the special qualities of process that characterize the ideal of our courts and give empirical content to the concept of "the rule of law."

Perhaps most important among these qualities of process is the public nature of judicial proceedings.[36] What a judge does must be done, for the most part, in the cold glare of public scrutiny. Not only are his trials open to the press and to the public, but he must reveal to the public in written form his findings of fact, his conclusions of law, and his ultimate judgment in the case. Of course, the vast majority of trials go unattended and the vast majority of legal opinions are never significantly read. But the judge must conduct his proceedings with the possibility in mind that they may be publicly reviewed. Even if the trial is unattended by anyone but participants, a trial transcript may later be used as a basis for criticism from a higher court, legal commentators, and the press. Moreover, the judge's written opinion is always available for study and trenchant criticism in legal treatises, in law reviews, and, perhaps most important, in law school classrooms. Many a judicial reputation has been made or broken in "case method" classes which employ judicial opinions as grist for their pedagogical mill.

A second important quality of judicial process is that a judge's decision must be principled. In writing his opinion, a judge must state the legal

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judges, on the one hand, with that of doctors, on the other, I think it can be claimed fairly that the former are better trained than the latter for wrestling with the subtle and important social issues involved in *Saikewicz*-type cases. Issues of this sort are at the focus of much of a lawyer's education, and he is trained from his first days at law school to consider the social advantages and disadvantages on both sides of every such issue. Such social issues are not, of course, even a significant part of the subject matter of medical education. Indeed, only recently have a small number of medical schools begun to offer courses in "medical ethics." *See* Veatch & Sollitto, *Medical Ethics Teaching: Report of a National Medical School Survey*, 235 J.A.M.A. 1030 (1976).

[36] As I note in a number of places in this Article, none of these qualities of process are perfectly realized in every proceeding or type of proceeding. However, so long as departures from the ideal are made in public, there is an opportunity for criticism of the departure, which can lead to correction. Somewhat paradoxically, this self-correcting feature can be seen at work even where there is a departure from the principle requiring judicial proceedings to be public. So long as the determination to make a trial secret is itself made public, law review commentators can criticize the move as contrary to fundamental principles of "the rule of law." *See, e.g.*, Note, *Trial Secrecy and the First Amendment Right of Public Access to Judicial Proceedings*, 91 HARV. L. REV. 1899 (1978).

principle that he has applied to the facts of the case at hand in arriving at his conclusion. Moreover, he must legitimate that legal principle by showing its sources in unreversed decisions of other cases, or relevant statutory material. To the extent that there are legal decisions that seem to be inconsistent with the principle which he intends to adopt in his decision, a judge must go to pains to distinguish the putative conflicting case from his own by showing that the two cases differ significantly in their "legally relevant" facts.[37] Backstopping the effort to work principle out of court decisions is a system of appellate courts which reviews the conclusions of law articulated by lower courts, to make sure that principles are developed consistently and in the proper direction. Backstopping the appellate courts are legislative bodies which have the power, within constitutional limits, to change the legal principles which are applied by the courts. And coaching at the sidelines are legal commentators of all sorts (from legal scholars and journalists, to callers-in on "two-way radio" talk shows) who are willing to play their part by telling anyone willing to listen what they think the legal principles should be.

A third critical quality of judicial process is the effort it makes to keep the decision maker impartial. Only facts which are made relevant by the legal principles to be applied may be considered by the court in reaching a decision. Thus, for example, in a suit brought for breach of an employment contract, a judge may not consider the fact that the defendant is a fascist or a communist in determining whether or not the defendant wrongfully discharged the plaintiff. He may consider only evidence which goes to the question of whether the plaintiff was discharged for a reason which was justified under the provisions of the contract. Of course, judges are human, so the law prefers relying on more than the judge's self-control to eliminate consideration of prejudicial irrelevancies. First, it attempts to assure to the parties a trier of fact[38] who knows as little as possible about the case in advance of trial. Second, at trial, through the rules of evidence, it attempts to keep the trier of fact from learning anything which might be persuasive on grounds of prejudice (that is, reasons which are not relevant under the legal principle) rather than on grounds which are relevant to the legal principle involved.[39] If the trier of fact does not know the politics of an employer, it obviously cannot illegitimately take that fact

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[37] *See* notes 52-60 *infra* and accompanying text.

[38] This might be a jury rather than a judge. Indeed, one reason for preferring a jury, in some cases, is that the judge frequently must decide close questions of whether an item of evidence is a "prejudicial irrelevancy." Once the judge has learned of the fact for purposes of disposing of this preliminary question, he may have difficulty in disregarding it thereafter as he must in those cases where he decides to exclude it and he sits as the trier of fact. This is not a problem in a jury trial, where the jury never should learn of the fact if the judge determines to exclude it.

[39] *See, e.g.*, FED. R. EVID. 403.

into consideration in deciding a breach of contract case to which he is a party.

The fourth, and last, quality of the judicial process which will be mentioned is its adversary nature.[40] In many respects, this quality is the key to the proper operation of the others which have been mentioned. It is certainly the two contending advocates who are in the best position to make sure that all critical aspects of their case are brought into the public eye. It is they who also have the major responsibility for supplying the judge with all of the favorable legal sources and arguments he can use to write his opinion, on the one hand, or with facing the judge with all of the contradicting legal sources and arguments that he must explain away, on the other. And it is they who are responsible for making sure that all and only relevant evidence comes before the trier of fact. Although in theory it is the judge who bears the ultimate responsibility for rendering a decision which passes public muster as impartial and properly principled, the responsibility is in fact largely that of the advocates. It is they who must in fact carry the burden of fully developing the evidence and arguments in the case, and it is they who are in the best position to make sure that any given judge stays true to the principles of the judicial process which we have discussed.

Of course, it is only the ideal of the judicial system which can be said to embody these qualities of process in fully realized form. In practice, any given judicial proceeding will depart from the ideal to some degree in one or more respects. But there is at the very least a fundamental commitment to a public system of principled decision making. Contrast this decision-making process of "the rule of law" with that of "medical paternalism." My experience[41] in working with doctors who have deliberated upon life and death decisions involving incompetents is that their decision-making processes show none of the qualities of process that characterize a court system. There are no institutional frameworks that require doctors to develop principles of decision making that are consistent from one doctor to another and from one time to another. As a result, few doctors have worked out principles of decision making that will survive even the most rudimentary criticism, and decisions which are made on the same set of facts will differ from day to day and from doctor to doctor. Hence, whether an incompetent will be allowed to die depends upon who his doctor is and on what day the decision has to be made. Moreover, the decision is likely

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[40] It was the lack of this quality of process in the handling of *Saikewicz*-type cases in Massachusetts that prompted my earlier Article. *See* Baron, *supra* note 1.

[41] This includes a two-week stint as a "medical-ethics" consultant at a chronic care hospital as well as a variety of less structured working relationships in the area of medical ethics with a number of Boston-area doctors over the last eight years.

I should say here that I have great respect for the doctors with whom I have worked, not only as fine physicians but also as sensitive and conscientious human beings.

not to be impartial because the doctor is familiar with numerous prejudicial irrelevancies about his patient which are likely to affect the decision that he makes. For example, the guardian ad litem for the 67-year-old mentally retarded patient in *Saikewicz* stated in his report that he suspected that "the medical personnel involved may have been reluctant to recommend treatment because of the uncooperative nature of the patient and the desire to put their resources elsewhere."[42] Of course, the doctor's lack of impartiality may rise to the level of conscious consideration of criteria which he believes should be relevant even though society might not be willing to tolerate their use as criteria—for example, the patient's intelligence, personality, or social or economic status, or the expense of maintaining the patient.[43] But what is disturbing about this more conscious use of such criteria is that all of this decision making goes on in the relative secrecy of intensive care units. If the doctors making such decisions are convinced of the rightness of the criteria which they use, one would expect them to show the courage of their convictions by making public what they are doing and why they are doing it. In fact, one finds them making such decisions "in the closet"[44] so that society will never have an opportunity to

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[42] Schultz, Swartz, & Appelbaum, *Deciding Right-to-Die Cases Involving Incompetent Patients: Jones v. Saikewicz*, 11 SUFFOLK U. L. REV. 936, 941 n.26 (quoting Appendix to Brief for Appellant at 9-10, Jones v. Saikewicz, No. 711 (Mass. Sup. Jud. Ct. July 9, 1976)).

[43] *See* D. SUDNOW, PASSING ON 97-107 (1967). My own discussions with doctors confirm that these factors are often taken into consideration as criteria in such cases.

Among Sudnow's observations:

> One's location in the age structure of the society is not the only factor which will influence the degree of care he gets when his death is considered to have possibly occurred. At County Hospital a notable additional set of considerations can be generally termed as the patient's presumed "moral character." The detection of alcohol on the breath of a "DOA" is nearly always noticed by the examining physician, who announces to his fellow workers that the person is a drunk, and seems to constitute a feature he regards as warranting less than strenuous effort to attempt revival. The alcoholic patient is treated by hospital physicians, not only when the status of his body as alive or dead is at stake, but throughout the whole course of medical treatment, as one for whom the concern to treat can properly operate somewhat weakly. . . . Among other categories of persons whose deaths will be more quickly adjudged, and whose "dying" more readily noticed and used as a rationale for palliative care, are the suicide, the dope addict, the known prostitute, the assailant in a crime of violence, the vagrant, the known wifebeater and other persons whose moral characters are considered reproachable.

Id. at 100-01.

> If one anticipates having a critical heart attack, he best keep himself well-dressed and his breath clean if there is a likelihood he will be brought into the County Emergency Unit as a "possible."

Id. at 102. *See also* Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 213, 263 (1975).

[44] This expression is one which has been given wide currency within the medical literature. Thus, Professor Charles Fried has greeted as follows inchoate efforts on the part of the

approve or disapprove what they are doing. Of course, such decisions are typically also being made without opportunities for advocacy of the positions for and against termination of life. Hospital staff who are likely to be present at the time when doctors are making life and death decisions are neither trained nor encouraged to present value arguments opposed to the position toward which the doctor seems inclined at any given moment.

Corroboration of the contrast between these two models of decision making is supplied by Dr. Relman himself. In his Article in this journal, he admits that, given the very same facts, different doctors are very likely to make different ethical decisions about termination of care. For example, he concedes that "medical advice may be divided"[45] as to whether or not a baby with Down's syndrome should be allowed to die of an easily cor-

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medical community to begin systematizing its "no code" (that is, "do not resuscitate this patient") decisions:

> The hospitals are coming out of the closet! It is an event of the first importance that responsible administrators at two great hospitals—independently I believe—should promulgate and discuss publicly explicit policies about the deliberate withdrawal or nonapplication of life-prolonging measures. That such measures are in fact regularly withheld or withdrawn is an open secret, but the course of decision and the testimony in the *Quinlan* case show how wary the medical profession can be when the spotlight of publicity illuminates its practices. That is why the Massachusetts General Hospital [Pontopiddan, *et al., Optimum Care for Hopelessly Ill Patients: A Report of the Clinical Care Committee of the Massachusetts General Hospital,* 295 NEW ENGLAND J. MED. 362 (1976)] and Beth Israel Hospital [Rabkin, Gillerman, & Rice, *Orders Not to Resuscitate,* 295 NEW ENGLAND J. MED. 364 (1976)] statements are so noteworthy. Of course, they are incomplete and troublesome in various ways. The role of the patient is rather vague in the MGH statement. In the Beth Israel statement it is much clearer (and stronger), but the scope of the policy—limited as it is to cardiopulmonary resuscitation—is so narrow as to raise questions about the practice in the wide variety of other, analogous situations, to which the MGH statement does apply. So inevitably important questions are raised, but surely we are far likelier to arrive at reasonable answers now that hospital trustees, physicians and administrators are willing to go out on a limb and admit openly what we all know is often done anyway.

Fried, *Terminating Life Support: Out of the Closet!* 295 NEW ENGLAND J. MED. 390 (1976). Dr. Relman himself accepts the appropriateness of the expression:

> In Massachusetts the immediate disruptive consequences of the *Saikewicz* ruling have already appeared. In some cases physicians and next of kin probably defer urgent medical decisions, both positive and negative, pending court approval. In other cases decisions that had formerly been made expeditiously, but only after full and explicit consultation, will now be made hastily and even furtively, thus returning "to the closet" questions that need open and thorough discussion.

Relman, *The Saikewicz Decision: Judges as Physicians,* 298 NEW ENGLAND J. MED. 508 (1978) (footnote omitted).

> The number of potential *Saikewicz* cases is huge. That so few have reached the courts thus far simply indicates the widespread confusion following in the wake of the original decision, which has led to the avoidance of difficult decisions, or, more likely, to "closet" decisions, without discussion or legal approval.

Relman, *supra* note 6, at 241.

[45] *Id.* at 238.

rected physical defect rather than helped to survive into a child of low mentality. He does not seem at all concerned, however, about the lack of fairness evident in such inconsistent decision making by the medical community. Rather, he expresses astonishment at the behavior of a judge in such a case who expressed his allegiance to "the rule of law" by stating that, while "he personally believed it would be better if the child did not survive," he felt "*bound by law* to order the operation."[46] Moreover, Dr. Relman suggests that one of the things that is bothering doctors about the involvement of courts in these decisions is that the courts, unlike the doctors, are unwilling to take into consideration criteria like the low value to society of the life of the incompetent.[47] But, if those criteria are, as the courts believe, "prejudicial irrelevancies," doctors should not be taking them into consideration either. On the other hand, if the medical community truly believes that they are not, its members ought to be willing to argue before courts and legislatures for a change to legal principles which recognize such factors as relevant.

In an editorial in *The New England Journal of Medicine,* Dr. Relman said of the *Saikewicz* decision: "This astonishing opinion can only be viewed as a resounding vote of 'no confidence' in the ability of physicians and families to act in the best interests of the incapable patient suffering from a terminal illness."[48] A strikingly similar sort of reaction was displayed by the psychiatric community of Georgia to a federal suit challenging, on procedural due process grounds, a state statute which allowed "voluntary commitment" of minors to mental institutions without court hearing if there was consent to the commitment by the parents. In that case, the psychiatrist defendants asserted that any claim that they could not be trusted to protect the best interests of the minors involved amounted to

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[46] *Id.* at 239 (emphasis added).

[47] *Id.* at 235-36, 238-40, 241. Dr. Relman himself never takes an explicit stand on this issue. However, at several points he criticizes the *Saikewicz* court for refusing to consider "the quality of life involved in determining whether to terminate support." *Id.* at 235, 241. Either he misunderstands what the court meant by the quality of life criterion it was prohibiting, or else he believes that the courts should take into consideration the degree of value to society of the life of the incompetent. The *Saikewicz* court made clear that it was not prohibiting consideration of "quality of life" when that is "understood as a reference to the continuing state of pain and disorientation precipitated by the chemotherapy treatment." 1977 Mass. Adv. Sh. at 2495, 370 N.E.2d at 432 (1977). The "substituted judgment" test *requires* consideration of just such questions of what life will be like for the incompetent. But the court makes clear that it will not permit consideration of the value of the incompetent's life to society because "the chance of a longer life carries the same weight for Saikewicz as for any other person, the value of life under the law having no relation to intelligence or social position." *Id.* at 2493, 370 N.E.2d at 431.

Whatever Dr. Relman's position, my own conversations with doctors have uncovered strong feelings on the part of a number of them that intelligence or social position should play a role as a criterion in these decisions. *See also* SUDNOW, *supra* note 43, at 97-107.

[48] Relman, *The Saikewicz Decision: Judges as Physicians,* 298 NEW ENGLAND J. MED. 508 (1978).

"indicting the entire psychiatric branch of the medical profession."[49] In holding the statute unconstitutional, the court replied:[50]

> To suggest, as we here do, that psychiatrists are not infallible is not an indictment of psychiatry. It is simply to say that psychiatrists like all humans are capable of erring. Since they are capable of erring, psychiatrists like parents cannot statutorily be given the power to confine a child in a mental hospital without procedural safeguards being imposed to guard against errors in judgment and/or the arbitrariness that the best of us humans exhibit from time to time.

The court buttressed its own language with that of Judge Bazelon from an opinion in a similar case:[51]

> Not only the principle of judicial review, but the whole scheme of American government, reflects an institutionalized mistrust of any such unchecked and unbalanced power over essential liberties. That mistrust does not depend on an assumption of inveterate venality or incompetence on the part of men in power, be they President, legislators, administrators, judges, or doctors. It is not doctors' nature, but human nature, which benefits from the prospect and the fact of supervision.

But the benefits of subjecting life and death decision making for incompetent patients to "the rule of law" are not limited to the protections which procedural due process affords to the individual patient. Another enormously important benefit is the opportunity which court decision making provides for the gradual development of a body of common law principles, based in societal values, that can be used for deciding fundamental questions with which a "new technology" is now challenging our society. The ability of Anglo-American court systems to develop principles for what appear to be radically new problems on the basis of established principles reflecting court-developed societal responses to problems in analogous areas is an article of faith of Anglo-American jurisprudence.[52]

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[49] J. L. v. Parham, 412 F. Supp. 112, 138 (1976).

[50] *Id.*

[51] *Id.* at 139 (quoting Covington v. Harris, 419 F.2d 617, 621-22 (D.C. Cir. 1969)).

[52] This article of faith is not shared, of course, by those who believe that legal reasoning is an exercise in syllogism and that sophisticated computers could replace judges in interpreting laws and applying them to the facts of cases. It is not shared also by those who know only black-letter legal rules and have no sense of the larger policies of which they are applications. Holmes, whose faith in the development of common law was strong and abiding, showed both his own faith, and a concern for those who did not share it, in the following well-known passages:

> The next thing which I wish to consider is what are the forces which determine [the law's] content and its growth. You may assume, with Hobbes and Bentham and

This faith is derived from close familiarity with a few basic precepts of legal reasoning. The first is that the hallmark of "the rule of law" is consistency—that like cases must be treated alike. The second is that, in deciding which cases are alike—that is, which facts of two cases are to be considered legally relevant—a value judgment is being made which should reflect the societal ends which are to be served by a decision. As an example of this, Professor H. L. A. Hart provides us with the following:[53]

> A legal rule forbids you to take a vehicle into the public park. Plainly this forbids an automobile, but what about bicycles, roller

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> Austin, that all law emanates from the sovereign, even when the first human beings to enunciate it are the judges, or you may think that law is the voice of the Zeitgeist, or what you like. It is all one to my present purpose. Even if every decision required the sanction of an emperor with despotic power and a whimsical turn of mind, we should be interested none the less, still with a view to prediction, in discovering some order, some rational explanation, and some principle of growth for the rules which he laid down. In every system there are such explanations and principles to be found. It is with regard to them that a second fallacy comes in, which I think it important to expose.
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> The fallacy to which I refer is the notion that the only force at work in the development of the law is logic. . . . The danger of which I speak is . . . the notion that a given system, ours, for instance, can be worked out like mathematics from some general axioms of conduct. This is the natural error of the schools, but it is not confined to them. I once heard a very eminent judge say that he never let a decision go until he was absolutely sure that it was right. So judicial dissent often is blamed, as if it meant simply that one side or the other were not doing their sums right, and, if they would take more trouble, agreement inevitably would come.
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> This mode of thinking is entirely natural. . . . The language of judicial decision is mainly the language of logic. And the logical method and form flatter that longing for certainty and for repose which is in every human mind. But certainty generally is illusion, and repose is not the destiny of man. Behind the logical form lies a judgment as to the relative worth and importance of competing legislative grounds, often an inarticulate and unconscious judgment, it is true, and yet the very root and nerve of the whole proceeding. You can give any conclusion a logical form. You always can imply a condition in a contract. But why do you imply it? It is because of some belief as to the practice of the community or of a class, or because of some opinion as to policy, or, in short, because of some attitude of yours upon a matter not capable of exact quantitative measurement, and therefore not capable of founding exact logical conclusions.

Holmes, *The Path of the Law,* 10 HARV. L. REV. 457, 465-66 (1897).

> Every effort to reduce a case to a rule is an effort of jurisprudence, although the name as used in English is confined to the broadest rules and most fundamental conceptions. One mark of a great lawyer is that he sees the application of the broadest rules. There is a story of a Vermont justice of the peace before whom a suit was brought by one farmer against another for breaking a churn. The justice took time to consider, and then said that he had looked through the statutes and could find nothing about churns, and gave judgment for the defendant. . . . If a man goes into law it pays to be a master of it, and to be a master of it means to look straight through all the dramatic incidents and to discern the true basis for prophecy.

Id. at 474-75.

[53] Hart, *Positivism and the Separation of Law and Morals,* 71 HARV. L. REV. 593, 607-08 (1958).

> skates, toy automobiles? What about airplanes? Are these, as we say, to be called "vehicles" for the purpose of the rule or not? . . .
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> . . . If a penumbra of uncertainty must surround all legal rules, then their application to specific cases in the penumbral area cannot be a matter of logical deduction, and so deductive reasoning, which for generations has been cherished as the very perfection of human reasoning, cannot serve as a model for what judges, or indeed anyone, should do in bringing particular cases under general rules. In this area men cannot live by deduction alone. And it follows that if legal arguments and legal decisions of penumbral questions are to be rational, their rationality must lie in something other than a logical relation to premises. . . . [I]t seems true to say that the criterion which makes a decision sound in such cases is some concept of what the law ought to be . . . .

A third precept is that mankind is much better at making right and principled decisions on the facts of specific cases (at least where the processes of "the rule of law" are present) than at articulating, in advance of cases, principles which will explicitly treat like cases alike. It was for this reason that Lord Mansfield once argued: "All occasions do not arise at once; . . . a statute very seldom can take in all cases, therefore the common law, that works itself pure by rules drawn from the fountain of justice, is for this reason superior to an act of parliament."[54] Toward the same end, Professor Lon Fuller has used an example from Wittgenstein:[55]

> Someone says to me: "Show the children a game." I teach them gambling with dice and the other says "I did not mean that sort of game." Must the exclusion of the game with dice have come before his mind when he gave me the order?

Our society is increasingly being challenged by new problems in a variety of fields where vastly improved technology presents it with new questions to decide. It is largely because doctors have new options for keeping patients alive that problems of euthanasia have recently come to the fore. And new options in biomedical research and treatment, such as genetic engineering and cloning, present their own questions which must be answered for society. But, though the specific problems are new, they are like older problems in that they provoke value questions similar to those which have been raised and resolved by the courts in the past. The question, however, in each case is: In terms of societal values, which cases are "like" which others? If one is not justified in killing a young adult

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[54] Omychund v. Barker, 1 Atk. 21, 33, 26 Eng. Rep. 15, 22-23 (Ch. 1744).

[55] Fuller, *Human Purpose and Natural Law*, 53 J. PHILOS. 697, 700 (1956).

because he is mentally retarded, can one be justified in refusing life-saving treatment to him for that reason? If one is not justified in refusing life-saving treatment to a young adult because he is mentally retarded, can one be justified in refusing such treatment on those grounds to a neonate? On the other hand, if one is justified in aborting a fetus because amniocentesis shows it to have Down's syndrome, are we then justified in killing a neonate with Down's syndrome? If intelligence is to be an important criterion, what about our treatment of animals that are more intelligent than some humans? If it is not, what about our treatment of animal life in general? The genius of common law decision making is that it must deal with such contending analogies in attempting to draw direction from the decisions of the past and that this act is performed in a public forum which invites societal criticism of the process and its end product:[56]

> What does the law forum require? It requires the presentation of competing examples. The forum protects the parties and the community by making sure that the competing analogies are before the court. The rule which will be created arises out of a process in which if different things are to be treated as similar, at least the differences have been urged. In this sense the parties as well as the court participate in the law-making. In this sense, also, lawyers represent more than the litigants.
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> Reasoning by example in the law is a key to many things. It indicates in part the hold which the law process has over the litigants. They have participated in the law-making. They are bound by something they helped to make. Moreover, the examples or analogies urged by the parties bring into the law the common ideas of the society. The ideas have their day in court, and they will have their day again. This is what makes the hearing fair, rather than any idea that the judge is completely impartial, for of course he cannot be completely so. Moreover, the hearing in a sense compels at least vicarious participation by all the citizens, for the rule which is made, even though ambiguous, will be law as to them.

Of course, decision making by individual doctors protects neither the parties nor the community in this fashion. Neither does Dr. Relman's suggested procedure requiring "concurrence by several colleagues who have no vested interest in the decision [which concurrence] should be documented in the medical record."[57] Nor does the concurrence by a hospital ethics committee which is required by the *Quinlan* decision.[58] Like

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[56] LEVI, AN INTRODUCTION TO LEGAL REASONING 5 (1948) (footnote omitted).

[57] Relman, *supra* note 6, at 242.

[58] *See In re* Quinlan, 70 N.J. 10, 55, 355 A.2d 647, 671 (1976).

other such administrative agencies, a hospital ethics committee is too likely to become biased in favor of the interests of the representatives of the regulated industry who constantly appear before it.[59] Moreover, *Saikewicz*-type cases do not present us with the type of problem which is most appropriate for administrative agency determination—that is, one in which the societal value questions are relatively settled, and the thorny questions are technical ones which require an administrator's expertise in determining which rules are most likely to achieve those ends. Rather, such cases involve an effort to begin to build a societal response to the challenges of the new technology out of the values which society has deposited in the common law. As Professor Louis Jaffe points out: "The jurisdiction and experience of the judge embrace all of the social conflicts regulated by law. His canon of legal objectives may be correspondingly broader than the administrator's, or at least less likely to be distorted by specialized interest and responsibility."[60] Medical expertise is, of course, crucial to these cases. But it can be supplied adequately by expert witnesses who make their expertise available to the decision maker. And the decision maker himself needs medical expertise much less than he needs a sense of participation in the continuum of development of the common law and in a system characterized by those qualities of process which constitute "the rule of law."

IV. IS DUE PROCESS FOR INCOMPETENTS TOO COSTLY?

Dr. Relman's last line of defense is the claim that society simply cannot or will not pay the cost of providing the protections of the judicial process to incompetent patients who face a decision that will lead to an early termination of their lives:[61]

> The number of potential *Saikewicz* cases is huge. That so few have reached the courts thus far simply indicates the widespread confusion following in the wake of the original decision, which has led to the avoidance of difficult decisions or, more likely, to "closet" decisions, without discussion or legal approval. "No-treatment" or "withdrawal of treatment" decisions for incompetent patients are being made all the time throughout the hospitals of Massachusetts, but very few are being brought to judicial attention. The reasons are obvious enough, and are implicit in what

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[59] *See* Davis, ADMINISTRATIVE LAW TEXT § 1.03 at 8 (1959). *See also* FELLMUTH, THE INTERSTATE COMMERCE COMMISSION: THE PUBLIC INTEREST AND THE ICC (1970); GREEN, THE CLOSED ENTERPRISE SYSTEM (1972); SILVERMAN, VANISHING AIR (1970); TURNER, CHEMICAL FEAST (1970); ZWICK, WATER WASTELAND (1972).

[60] L. JAFFE, JUDICIAL CONTROL OF ADMINISTRATIVE ACTION 131 (1965).

[61] Relman, *supra* note 6, at 241.

> has already been said. Neither relatives nor physicians want to go to the trouble and expense of obtaining a court judgment, particularly when they have no confidence that the judgment will be medically or ethically sound. If there is real doubt that the court will consider the quality of the life involved, and if the medical recommendations of the physicians in charge of the case, as well as the wishes of the family, are to be examined in an adversarial courtroom proceeding, then most families and most physicians would prefer to stay away from the courts. At present, it commonly is believed that they take very little risk in doing so, but that view could of course be changed by future developments.

Two categories of costs are pointed to here: (1) those which are incurred by the participants in the hearing process; and (2) those which are incurred by the court system.

As to the costs to be incurred by the participants, some of them are *desirable* as the unavoidable correlatives of what I have shown to be the benefits of "the rule of law." Nobody likes to be second-guessed as to his decisions. Criticism, however constructive, always brings some discomfort to the person subject to review. The *Saikewicz* court did not suggest that life and death decisions for incompetent patients should be brought to court just so the courts could "rubber stamp" choices which the relatives and doctors involved had already concluded to be "medically and ethically sound." Court review was required in part precisely because ad hoc, "closet" decision making by physicians and family might lead to treatment of incompetents which was different from that which would emanate from principled, public decision making by a court. This is not to say that efforts should not or could not be made to reduce inconvenience and expense to the participants to the minimum consistent with "the rule of law." Presumably, one reason for vesting jurisdiction of these cases in the probate courts is the experience which such courts have in dealing with a variety of delicate personal problems. To the extent that specific procedures involved in *Saikewicz*-type cases seem to impose pointless costs on the participants, one would expect the courts to be open to suggestions for making the procedures as humane as possible within the constraints of due process requirements.[62]

The threatened costs to the court system are all a function of the enormous number of cases—many of them emergencies—which Dr. Rel-

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[62] For one thing, it seems unfair that relatives of an incompetent patient should be forced into the position of parties to the litigation and have to bear court costs and legal fees. One potential method for avoiding this unfairness is captioning each *Saikewicz*-type case as "In the Matter of [alleged incompetent's name]" and then guaranteeing adversary process by appointing two guardians ad litem to try the case against each other. *See* Baron, *supra* note 1, at 129.

man predicts will bury it if *Saikewicz* is taken seriously. But it is very hard to deal constructively with this threat in the abstract. If the medical profession would actually make good on its prediction, the courts could not only begin to make an accurate count of numbers of cases but also begin to perceive the outlines of patterns of types of cases that might call for less burdensome treatment than the *Saikewicz* paradigm. For example, it is conceivable that the courts might recognize a "living will" option for patients even without an enabling act from the state legislature.[63] *Saikewicz* procedures are required only for the protection of incompetents. They are not required for competent persons who "refuse medical treatment in appropriate circumstances."[64] Consistent with this principle, the courts of Massachusetts might give effect to advance instructions to a doctor made while a patient is competent for the purpose of authorizing termination of care under certain circumstances once he becomes incompetent. If such a device were widely used, *Saikewicz*-type court proceedings would be restricted largely to situations involving persons who had never been competent, such as minors and mentally retarded persons.

It is also conceivable that the Massachusetts Supreme Judicial Court may begin to carve out classes of cases for which advance court approval is not required even though no "living will" has been executed. One would expect the court to be very gradual and deliberate in developing such classes. At a minimum, the court should be satisfied (1) that there is a clearly articulated and easily applied principle of decision making involved which can be applied easily and accurately by doctors to the specific facts of the cases before them; (2) that there is a likelihood that a subsequent hearing will be demanded by some interested party if the principle is applied mistakenly (for example, a civil action brought by the estate of the deceased or a criminal action against the doctor); (3) that the operative facts are of a type that makes them as easily proved or disproved at a subsequent hearing as at a prior hearing (for example, certain EKG or EEG data); and (4) that there is some important societal need that outweighs the policy in favor of providing a hearing prior to terminating the life of the incompetent patient.[65] Moreover, in the case of minors and mentally retarded persons, who have always enjoyed special protection from the courts, the supreme judicial court should not relax its requirements of a prior hearing even where these criteria have been met.

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[63] For a discussion and critique of California's "living will" statute (the first in the nation), see Steinberg, *The California Natural Death Act—A Failure to Provide for Adequate Patient Safeguards and Individual Autonomy*, 9 CONN. L. REV. 203 (1977).

[64] 1977 Mass. Adv. Sh. at 2480, 370 N.E.2d at 426.

[65] None of the four elements were present in the case of *In re* Dinnerstein, 1978 Mass. App. Adv. Sh. 736, 380 N.E.2d 134 (1978), where a three-judge panel of the Massachusetts intermediate appeals court seemed to recognize an amorphous and possibly enormous class of exceptions to the *Saikewicz* requirement of advance court approval. In that case, the

Regarding the suggestion that courts cannot handle *Saikewicz*-type cases on the emergency timetable required by good medical practice, there are two answers. First, the courts of Massachusetts and the trial bar are

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question was whether Mrs. Dinnerstein's doctor could lawfully "no code" his patient—that is, note on her chart that resuscitation measures should be withheld in the event of cardiac or respiratory arrest. Because Mrs. Dinnerstein was terminally ill and suffered from a growing number of complications of her illness, her doctor and her immediate family believed that a "no code" order would be in her best interests. Since she had been rendered incompetent by her illness, she could not be consulted as to her wishes. As a result, the Newton-Wellesley Hospital, where Mrs. Dinnerstein was a patient, felt constrained to follow the requirements of "the so-called 'Saikewicz Decision,'" *see* note 7 *supra* (letter to Newton-Wellesley doctors), and seek court approval before allowing a "no code" order to be issued. But the hospital's counsel determined to use the situation also as a test case for limiting severely the scope of the *Saikewicz* holding. As a result, when the hospital's counsel brought Mrs. Dinnerstein's case to the Norfolk County probate court for hearing, they asked for approval of the "no code" decision by that court only if it found that *Saikewicz* required such approval. Their primary request was for a ruling that "no code" orders could be issued without prior court approval where the next of kin and attending physician agree that such an order is appropriate.

Hospital counsel got what they were after. Because of the important legal questions raised in the case, the probate court reported it to the appeals court without a decision but with extensive findings of fact made upon a hearing in the matter. Ultimately, a three-judge panel of the appeals courts held:

> This case does not offer a life-saving or life-prolonging treatment alternative within the meaning of the *Saikewicz* case. It presents a question peculiarly within the competence of the medical profession of what measures are appropriate to ease the imminent passing of an irreversibly, terminally ill patient in light of the patient's history and condition and the wishes of her family. That question is not one for judicial decision, but one for the attending physician, in keeping with the highest traditions of his profession, and subject to court review only to the extent that it may be contended that he has failed to exercise "the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession." *Brune v. Belinkoff*, 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968).
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> The case is remanded to the Probate Court, where a judgment is to enter in accordance with the prayers of the complaint for declaratory relief, declaring that on the findings made by the judge the law does not prohibit a course of medical treatment which excludes attempts at resuscitation in the event of cardiac or respiratory arrest and that the validity of an order to that effect does not depend on prior judicial approval.

1978 Mass. App. Adv. Sh. at 746-48, 380 N.E.2d at 139 (footnotes omitted). The case was never ruled on by the supreme judicial court, but hospital counsel attempted to diminish that defect in the extent of their victory by making the following surprising claim in a subsequent article:

> The fact that the *Dinnerstein* decision was an interpretation by a lower court of the Supreme Judicial Court's decision in *Saikewicz* does not affect the extent to which medical personnel can rely on it. The decision reflects the considered judgment of a three-judge panel of competent jurisdiction, and since the decision was not appealed, it is final authority. The Appeals Court did not purport to reverse or modify the Supreme Judicial Court's opinion but merely to clarify its reasoning as applied to a fact situation not presented to the Court in *Saikewicz*.

Schram, Kane, & Roble, *"No Code" Orders: Clarification in the Aftermath of Saikewicz*, 299 NEW ENGLAND J. MED. 875, 877 (1978). Of course, *Dinnerstein* is "final authority" in Massachusetts only in the sense of being res judicata as to the parties to the case and not in the sense of

doing their best to accommodate the needs of the medical profession in this regard. Panels of volunteer guardians ad litem have now been established to handle such cases on a pro bono publico basis,[66] and judges and

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being a binding precedent covering any case that may later be brought to the supreme judicial court. And its power as "persuasive authority" is likely to be much diminished by the fact that there are major deficiencies in the logic of the *Dinnerstein* opinion.

Perhaps the most disturbing thing about the *Dinnerstein* opinion is the court's admission that it interprets the *Saikewicz* decision as it does because of the threat of widespread disobedience of the law by the medical community in Massachusetts. Faced with the fact that *Saikewicz* appears to "establish a rule of law that unless [prior court approval] has been obtained, it is the duty of a doctor attending an incompetent patient to employ whatever life-saving or life-prolonging treatments the current state of the art has put in his hands," 1978 Mass. App. Adv. Sh. at 741-42, 380 N.E.2d at 137, the appeals court argues that the supreme judicial court couldn't really have *intended* such a rule because:

> As it cannot be assumed that legal proceedings such as the present one will be initiated in respect of more than a small fraction of all terminally ill or dying elderly patients, the *Saikewicz* case, if read to apply to the natural death of a terminally ill patient by cardiac or respiratory arrest, would require attempts to resuscitate dying patients in most cases, without exercise of medical judgment, even when that course of action could aptly be characterized as a pointless, even cruel, prolongation of the act of dying.

Id. at 742, 380 N.E.2d at 137 (footnote omitted). Since the *Saikewicz* opinion makes clear that such cruel prolongation of the act of dying is "neither intended nor sanctioned by the *Saikewicz* case," *id.* at 742, 380 N.E.2d at 137, the appeals court concludes that the supreme judicial court could not have intended to require court approval in cases "such as the present one." *Id.* But the dilemma which the appeals court presents is phony. Instead of assuming that there would be widespread flouting of the law by the medical community, the supreme judicial court had assumed that pointless, cruel prolongation of the act of dying would be avoided by means of doctors availing themselves of the court approval procedures laid down in that decision. Therefore, the supreme judicial court might very well have intended to require approval in cases "such as the present one."

Because the real underlying principle of its decision—that court approval is not required in any case where the medical community will refuse to seek court approval—is obviously in conflict with *Saikewicz*, the appeals court attempts to carve out a more narrow principle on which to base its decision. However, there are obvious problems with each of these attempts. For example, the court argues at one point:

> It is apparent as well from the factual situation to which the principles of law announced in [*Saikewicz*] were addressed, from the precedents cited in support of those principles, and from the inherent sense of the case read as a whole, that, when the court spoke of life-saving or life-prolonging treatments, it referred to treatments administered for the purpose, and with some reasonable expectation, of effecting a permanent or temporary cure of or relief from the illness or condition being treated. "Prolongation of life," as used in the *Saikewicz* case, does not mean a suspension of the act of dying, but contemplates, at the very least, a remission of symptoms enabling a return towards a normal, functioning, integrated existence.

Id. at 743-44, 380 N.E.2d at 137-38. It is hard to know precisely what distinction is being offered by the appeals court here. If it is between, on the one hand, efforts to treat some underlying chronic condition, and, on the other hand, efforts to treat unrelated complications that may arise, the distinction is probably unworkable and, in any event, does not distinguish *Dinnerstein* from *Saikewicz*. In light of the fact that the supreme judicial court believed that a hearing was necessary to decide whether it was proper to refuse to Joseph Saikewicz chemotherapy which would prolong his life for only a year, it is hard to believe that the

guardians are attempting to train themselves and organize themselves in such a fashion that they will be able to handle *Saikewicz*-type cases as efficiently as possible. Second, much of the emergency could be removed from such cases by instituting two simple practices in the medical community: (1) seeking court permission (not to treat) as soon as the patient becomes incompetent instead of waiting until a treat/no-treat question is imminent; and (2) until court permission is obtained, taking all steps necessary to maintain life that would be taken if the patient were competent and requested them. What is required to make this system work is cooperation between the medical and legal communities and a shared desire to make it work. The legal community has already given evidence of its willingness to cooperate. It is to be hoped that the medical community will do the same.

V. CONCLUSION

The public business is public business. Decisions which bear on public attitudes regarding the value of human life should not be made in the relative secrecy of hospital wards nor should they be made by individuals who are not institutionally responsible to the public for making principled and impartial decisions. It is the qualities of process of the judicial system

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court would be any less concerned with the question, for example, of whether he should be refused life-prolonging treatment for appendicitis simply because he was going to die of cancer anyway.

The only prima facie compelling argument made by the court is one based on the fact that, in light of the hopeless condition of Mrs. Dinnerstein, no competent patient would opt for resuscitative efforts:

> The judge's findings make it clear that the case is hopeless and that death must come soon, probably in the form of cardiac or respiratory arrest. Attempts to apply resuscitation, if successful, will do nothing to cure or relieve the illnesses which will have brought the patient to the threshold of death. The case does not, therefore, present the type of significant treatment choice or election which, in light of sound medical advice, is to be made by the patient, if competent to do so. The latter is the type of lay decision which the court in the *Saikewicz* case had in mind when it required judicial approval of a negative decision . . . by the physician in attendance and by the family or guardian of a patient unable to make the choice for himself.

Id. at 746, 380 N.E.2d at 138-39. Presumably, there is no point in requiring a court hearing to decide what is in the best interests of an incompetent where it is clear that *all* competent persons would choose to refuse treatment. But, first, the probate court's findings in *Dinnerstein* were only that "[t]he vast majority of competent terminally ill patients decline to request that extraordinary means of treatment be provided them in the event of cardiac or respiratory failure." *In re* Dinnerstein, No. 78F0941, Findings of Fact (Mass. Probate Court, Norfolk County Div. June 1, 1978). Second, this argument does not meet the four criteria I suggest in the text. Among other things, it does not seem to me that the principle that "a no code may issue without court approval in any situation where no competent person would request resuscitative efforts" can be easily and accurately applied by doctors to the specific facts of the cases which may come before them.

[66] *See New Guardian List Set*, 7 MASS. L. WEEKLY 21 (1978).

which make it the necessary forum for making life and death decisions for incompetents. Of course, the courts do not always work in a fashion which accords in all respects with the model I have presented of "the rule of law." But the system contains within it structural features which limit the extent of abuse and provide a basis for ongoing reform. In this respect, it typifies the democratic political structure of which it is a part. "Democracy is the worst of all political systems, except for every other system," Churchill once said. Our political system was established as it was not because it was the best available assuming some philosopher king would run it but, rather, because it was the best available assuming the candidacy of only flesh-and-blood and fallible human beings. Much the same is true of our court system.

As just one example of the court system both failing and succeeding at the same time, consider the opinion of the Appeals Court of Massachusetts in *Lane v. Candura.*[67] In that case, the appeals court reversed a lower court decision which had authorized the amputation of the gangrenous leg of a 77-year-old widow who had refused to consent to the amputation even though the gangrene posed a threat to her life. The appeals court found that there had not been adequate proof that Mrs. Candura was incompetent and held that, as a competent person, she had a legal right to refuse the amputation. In result, this decision may be unassailable. However, the court's opinion does not exactly conform to the model of principled decision making in which a court legitimates its legal principles by showing their sources in other decisions which seem to be authority, on the one hand, and scrupulously distinguishing putative conflicting cases, on the other. In fact, the court seems to engage in some jurisprudential sleight of hand which covers the fact that it is actually *broadening* the application of certain principles which had been laid down in very limited form in *Saikewicz*. The supreme judicial court's opinion in *Saikewicz* makes very clear that the court is approving, on the facts of the case before it, only the right of a patient to refuse *life-prolonging,* as opposed to *life-saving*, treatment. At the point in the opinion where it is identifying certain state interests in favor of life which must be weighed in euthanasia decisions, the *Saikewicz* court states:[68]

> It is clear that the most significant of the asserted State interests is that of the preservation of human life. Recognition of such an interest, however, does not necessarily resolve the problem where the affliction or disease clearly indicates that life will soon, and inevitably, be extinguished. The interest of the State in prolonging a life must be reconciled with the interest of an individual to

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[67] Lane v. Candura, 1978 Mass. App. Adv. Sh. 588, 376 N.E.2d 1232 (1978).

[68] 1977 Mass. Adv. Sh. at 2477-78, 370 N.E.2d at 425-26.

> reject the traumatic cost of that prolongation. There is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where, as here, the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended.

Because chemotherapy could at best prolong Joseph Saikewicz's life for a short period but could not cure his leukemia, the court recognized his right to refuse chemotherapy. But Mrs. Candura would live indefinitely if the amputation were consented to. Amputation was being recommended to save her life. Despite this important difference between the cases, the *Candura* opinion cites *Saikewicz* as authority without ever alluding to the difference. Indeed, the appeals court draws a veil over the distinction by mischaracterizing the *Saikewicz* decision as follows:[69]

> Although the *Saikewicz* case also recognizes certain countervailing interests of the State which may in some cases outweigh the right of a competent individual to refuse *life saving or life prolonging treatment,* the case before us does not involve factors which would bring it within those lines of cases and thus warrant a court's overriding the will of a competent person.

Clearly, the court should have dealt directly and openly with the differences between the two cases. If, after recognizing the differences, it felt justified in extending *Saikewicz* as it did, it would have had to wrestle openly with why it believed the extension to be consistent with the spirit, if not the letter, of *Saikewicz.*

What needs to be stressed, however, is that, although the *Candura* opinion shows the judicial process failing in one respect, it also shows the system succeeding overall. The important thing to be noted is the fact that the failing in principled decision making was made public by the fact that it was required to be recorded in a published opinion. Anyone who is willing to take the time to read the *Saikewicz* opinion and compare it with *Candura* can see that the logic of the latter decision is just not as simple as the appeals court made it seem. Legal commentators can point out the failing in logic by criticizing the decision in law reviews such as this one. Practicing lawyers can do the same in cases where they wish to diminish the effect of the decision as persuasive authority. And, to the extent that such arguments are made by the advocates who appear before the next court to consider the question, that court may be forced to grapple with the issues which were passed over by the appeals court in *Candura.*

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[69] 1978 Mass. App. Adv. Sh. at 589-90, 376 N.E.2d at 1233 (footnote omitted; emphasis added).

At this point, let me remind the reader that this exchange of Articles began with one in which I criticized the judiciary for not going far enough in *Saikewicz* to assure for life and death decisions one of the special qualities of process of the court system—that is, the adversary process. Lawyers don't want to play doctor and they don't want to spend their time criticizing doctors who want to play judge. Lawyers wield only intellectual scalpels and they work best in dissecting legal institutions and the legal principles, rules, and decisions that these institutions produce. Once *Saikewicz*-type decisions become an integral part of common-law development, the opinions which are produced become subject to such dissection, and the criticism is no longer of doctors but of the courts. I suggest that the new focus of debate regarding *Saikewicz* should move from *whether* these questions are to be decided by the courts to *how* and *under what principles* they are to be decided by the courts. But doctors should feel as free to take sides in the new debate as they did in the old one. Whatever doctors may feel about the right of non-doctors to offer opinions about medicine, there is no question that non-lawyers have a right to criticize the law. Indeed, that right—the right of every citizen to know about and freely criticize every aspect of the legal system—may well be the *sine qua non* of "the rule of law."