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GETTING WHAT WE SHOULD FROM DOCTORS: RETHINKING PATIENT AUTONOMY AND THE DOCTOR-PATIENT RELATIONSHIP

Roger B. Dworkin[†]

The most ballyhooed achievement of the bioethics movement has been the triumph of patient autonomy over medical paternalism.¹ Largely through the development of the cause of action for lack of informed consent², but also through developments in the areas of reproductive rights³ and death and dying⁴, the law has appeared to

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¹ See, e.g., Alan Meisel, *Managed Care, Autonomy, and Decisionmaking at the End of Life*, 35 HOUS. L. REV. 1393, 1397-99 (1999) (focusing on the rise of citizen autonomy, especially in health care, in the twentieth century). For a persuasive critique of the triumph of autonomy, see also CARL E. SCHNEIDER, *THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS* (1998) (generally describing the influence of the autonomy movement and persuasively critiquing its triumph).

² *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Cobbs v. Grant*, 502 P.2d 1, 8 (Cal. 1972). See also Meisel, *supra* note 1, at 1399-1400 (including using the phrase "informed consent" in judicial opinions). See generally Susan M. Wolf, *Toward a Systemic Theory of Informed Consent in Managed Care*, 35 HOUS. L. REV. 1631, 1641 (1999) (discussing the impact bioethics had on the doctrine of informed consent).

³ E.g., *Planned Parenthood v. Casey*, 505 U.S. 833, 846-47, 851-52 (1992) (plurality opinion); *Webster v. Reproductive Health Services*, 492 U.S. 490, 538 (1989) (Blackmun, J., dissenting) (stating that the Constitution and case law both forbid states from passing laws that inhibit a woman's reproductive rights); *Roe v. Wade*, 410 U.S. 113 (1973).

⁴ E.g., *Superintendent of Belchertown State School v. Saikewicz*, 370

institutionalize the ethical preference for patient-directed decision making. Meanwhile, medical professionals have become so habituated to the asserted dominance of patient autonomy that in some fields of medicine, notably genetic counseling, they even refuse to offer patients advice or to answer the obvious question, "Doctor, what would you do?"⁵

The ascendancy of patient autonomy has fit oddly with the doctor-patient relationship. On the one hand, the doctor-patient relationship imposes on physicians an exclusive obligation to the patient⁶, which fits well with autonomy's focus on patient control. On the other hand, the relationship is said to be fiduciary in nature⁷, which creates a

N.E.2d 417, 426 (Mass. 1977) (construing privacy as encompassing free choice); *In re Quinlan*, 355 A.2d 647 (N.J. 1976); SOCIETY FOR THE RIGHT TO DIE, REFUSAL OF TREATMENT: A STATE BY STATE COMPILATION OF ENACTED AND MODEL STATUTES (1991).

⁵ For an excellent short description of the ethic of nondirectiveness and its hold on the genetic counseling profession, see Sonia M. Suter, "Sex Selection, Nondirectiveness, and Equality," 3 U. CHI. L. SCH. ROUNDTABLE 473, 478-80 (1996); Roger B. Dworkin, *The Human Genome Project's Implications for Autonomy, Respect, and Professionalism in Medical Genetics*, 7 JAHRBUCH FÜR RECHT UND ETHIK [ANN. REV. LAW & ETHICS], 1999, 115, 116-17, 117 n.9 [hereinafter *The Human Genome Project*]. See also Charles L. Bosk, *All God's Mistakes: Genetic Counseling in a Pediatric Hospital* (1992). For discussion and criticism of nondirective genetic counseling see DAVID H. SMITH ET AL., *Early Warning: Cases and Ethical Guidance for Presymptomatic Testing in Genetic Diseases* 12, 25, 134-36 (1998).

⁶ John Petrila, *Ethics, Money, and the Problem of Coercion in Managed Behavioral Health Care*, 40 ST. LOUIS U.L.J. 359, 377 (1996); Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. L.J. & MED. 241, 247 (1995).

Many commentators have noted the fiduciary nature of the doctor-patient relationship. E.g., Maxwell J. Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?*, 25 CONN. L. REV. 349, 367 (1993) (noting that most courts and commentators agree that the patient-physician relationship is a fiduciary one); David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141, 147 (1995); Petrila, *supra* note 6, at 359-61, 390-91; Rodwin, *supra* note 6, at 246-47; Grant H. Morris, *Dissing Disclosure: Just What the Doctor Ordered*, 44 ARIZ. L. REV. 313, 314 n.7 (2002); Alycia C. Regan, Note, *Regulating the Business of Medicine: Models for Integrating Ethics in Managed Care*, 30 COLUM. J.L. & SOC. PROBS. 635, 652 (1997) (discussing the fiduciary relationship between physicians and their patients).

In addition, as I have noted elsewhere, courts regularly reaffirm the fiduciary nature of the doctor-patient relationship. E.g., *Wohlgemuth v. Meyer*, 293 P.2d 816, 820 (Cal. Ct. App. 1956) (stating the doctor-patient relationship is a fiduciary relationship); *Schafer v. Lehrer* 476 So.2d 781, 783 (Fla. Dist. Ct. App. 1985) (holding the fiduciary nature of the doctor-patient relationship extends the doctor's duty beyond mere nonconcealment of medical facts); *Yates v. El-Deiry*, 513 N.E.2d 519, 522 (Ill. App. Ct. 1987) (asserting that physicians' unique role in society requires a fiduciary relationship to protect public policy interests in doctor-patient relations);

tension when the fiduciary yields control over the beneficiary's well-being in order to foster the beneficiary's autonomy. After all, the reason that persons are assigned fiduciary obligations is that their beneficiaries are thought to need special protections that the fiduciary is well situated to provide.

Patient autonomy and the exclusive and fiduciary doctor-patient relationship are supposed to represent the triumph of individualism in medicine. Evaluation then requires both an assessment of whether they actually promote and protect individualism and the extent to which individualism is the most appropriate value to foster. If other values are sometimes more important (as I shall suggest they are), or if individualism is not truly being served by the current regime (as I shall suggest it is not), then a rethinking is in order. The challenge will be to devise a system that does a better job than the present one of protecting individualism when individualism ought to dominate, while protecting other important values as well. What we need is a system that allows each person to receive as much benefit as possible from health care providers' expertise while assuring that professionals do not impose their power in areas beyond their expertise. This article will address that challenge, and make some tentative suggestions about designing that system. It will suggest that we reject the dominance of patient autonomy, abandon the exclusive, fiduciary nature of the doctor-patient relationship, and substitute a system in which professionals owe legally enforceable obligations to behave toward importantly affected individuals with respect for their well-being. Such a system would be more in keeping with the reasons a society has professionals and accords them special powers and privileges than is the present state of affairs. It would also be more consonant with the realities both of modern medicine and modern health care delivery and financing than is the current situation.

State *ex rel.* McCloud v. Seier, 567 S.W.2d 127, 128 (Mo. 1978); Shadrick v. Coker, 963 S.W.2d 726, 735-36 (Tenn. 1998). The hospital-patient relationship is also fiduciary. See *Wohlgemuth*, 293 P.2d 816. Other health care professionals are also in fiduciary relationships with their patients. See, e.g., National Society of Genetic Counselors Code of Ethics Section II (reprinted in DIANNE M. BARTELS ET AL., EDS., *PRESCRIBING OUR FUTURE: ETHICAL CHALLENGES IN GENETIC COUNSELING* 170 (1993)). Dworkin, *supra* note 5, at 115, n. 1.

I. AUTONOMY

Autonomy means self-rule.⁸ A rich philosophical literature explores the meaning and nature of self-rule in general and specifically in medicine⁹, but, as usual, the law shows little awareness or concern for philosophy. I have suggested elsewhere that two different meanings seem to attach to autonomy or the dominance of the self in American medical law.¹⁰ One is liberal individualism, the idea that each person has a right to make his or her own decisions about matters that affect that person in important ways and to act to effectuate those decisions. Freedom to make and act on decisions is to dominate unless and until one's decisions or actions affect other persons in a significant way; my right to swing my fist stops at your nose. This is the notion of liberty traditionally associated with John Stuart Mill.¹¹

A second understanding of autonomy has more to do with privacy than liberty. What I call physical essentialism is the view that one is entitled to be let alone, especially to have one's body let alone. More "primal" than a commitment to liberty, this represents a belief that the essence of a person is his or her body and that that body must not be intruded upon. On this view, not only can one not consent to murder or mayhem, one also cannot consent to invasions of one's bodily integrity that would change one's basic constitution. Whether this is a notion of autonomy that has relevance for persons who are capable of acting as liberal individualists, or whether it is only a default position

⁸ John Christman, *Constructing the Inner Citadel: Recent Work on the Concept of Autonomy*, 99 ETHICS 109, 109-10 (1988); Arthur Kuflik, *The Inalienability of Autonomy*, 13 PHIL. & PUB. AFFAIRS 271, 272 ("To be 'autonomous' is [literally] to be self-legislating or self-regulating").

⁹ For a survey of work about autonomy see generally Christman, *supra* note 8. See also GERALD DWORKIN, *THE THEORY AND PRACTICE OF AUTONOMY* (1988); Susan H. Williams, *A Feminist Reassessment of Civil Society*, 72 IND. L.J. 417 (1997). See generally IMMANUEL KANT, *ETHICAL PHILOSOPHY* (James W. Ellington trans., 1983) (discussing the metaphysics of morals and principles of virtue); JOHN STUART MILL, *ON LIBERTY* (Elizabeth Rappaport ed., 1978) (discussing the tension that arises between majority rule and minority rights). Discussions in the medical context include, e.g., JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984) (exploring the decision-making process in a doctor-patient relationship); Marjorie Maguire Schultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985) (examining patient autonomy); Alexander McCall Smith, *Beyond Autonomy*, 14 J. CONTEMP. HEALTH L. & POL'Y. 23 (1997) (exploring the role of autonomy in medicine).

¹⁰ See Roger B. Dworkin, *Medical Law and Ethics in the Post-Autonomy Age*, 68 IND. L.J. 727, 733 (1993) (discussing the different views on autonomy) [hereinafter *Medical Law and Ethics*].

¹¹ Mill, *supra* note 9.

for those who are incompetent to make choices, is not entirely clear.¹² Liberal individualism and physical essentialism sometimes, but not always point in the same direction. Sometimes they lead to diametrically opposed conclusions.¹³

Patient autonomy is clearly the dominant rhetorical value in American medical law and ethics. In ordinary situations (i.e., those in which the patient is a competent adult and in which issues involving sex, reproduction, experimentation, organ transplantation, or efforts to facilitate or hasten death are not involved), this is demonstrated most clearly by the law of informed consent. Tracing its lineage to Cardozo's oft quoted dictum, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body,"¹⁴ the cause of action has flourished since the early 1970's.

Even before Cardozo and the 1970's a cause of action existed for unconsented medical touchings. Thus, in the classic old case of *Mohr v. Williams*¹⁵ a patient was held to have a cause of action against her surgeon for failing to wake her from anesthesia to get a new consent before he performed the same operation on her right ear that she had agreed to have on her left ear. The surgery was skillfully performed, and it is clear that the patient was being compensated for her loss of autonomy, not for a form of medical malpractice.

Nonetheless, the informed consent cause of action lay largely dormant until it was resurrected first by a couple of cases in the late 1950's¹⁶ and then by the landmark cases of *Canterbury v. Spence*¹⁷ and *Cobbs v. Grant*¹⁸ in 1972. Those cases reformulated the cause of action from one for battery to one for negligence, with two important effects: Patients could no longer recover without proving that the doctor's failure to obtain informed consent had caused the patient to

¹² See, *In re Valerie N.*, 707 P.2d 770, 781-93 (Cal. 1985) (Bird, C.J., dissenting). A discussion of this case occurs at text accompanying notes 181-93, *infra*.

¹³ An excellent example appears in a comparison of the majority and dissenting opinions of the case cited above. E.g., compare *In re Valerie N.*, 707 P.2d 760, 762 (Cal. 1985), with *In re Valene N.*, 707 P.2d at 781-83 (Bird, C.J., dissenting).

¹⁴ *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

¹⁵ 104 N.W. 12 (Minn. 1905).

¹⁶ See, e.g., *Salgo v. Leland Stanford, Jr., Bd. Of Trs.*, 317 P.2d 170, 181 (Cal. App. 1957) (holding that while a physician has a duty to disclose the facts necessary to form an informed decision, the physician has the discretion to determine the extent of these facts). See generally *Natanson v. Kline*, 350 P.2d 1093, 1103 (Kan. 1960) (recognizing a claim for unauthorized treatment when the doctor fails to provide information regarding the consequences of a particular course of treatment).

¹⁷ 464 F.2d 772 (D.C. Cir. 1972).

¹⁸ 502 P.2d 1.

suffer physical injury, and any doubt about the applicability of the doctor's malpractice insurance was removed. Informed consent thus became a branch of the law of malpractice, useful mostly when the patient suffered an injury but could not prove that the doctor had performed any medical act negligently.¹⁹

Despite the requirement of physical injury, modern informed consent cases still talk about informed consent as serving the value of patient autonomy.²⁰ Some of them explicitly excoriate paternalism.²¹ Many reject the idea that the standard for the amount of information a doctor is required to disclose is the amount a reasonable doctor would ordinarily disclose and the accompanying rule that would require expert testimony to establish how much information that would be.²²

¹⁹ See Alan Meisel, *Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51 (1977) (discussing how the use of *res ipsa loquitar* and informed consent are causing a shift from a negligence to a strict liability standard in medical malpractice); Meisel, *supra* note 1, at 1399 and n. 27, citing Kenneth W. Simons, *Assumption of Risk and Consent in the Law of Torts: A Theory of Full Preference*, 67 B.U.L. REV. 213, 231 n. 60 (1987) (noting new importance of showing consent given).

²⁰ See, e.g., *Matthies v. Mastromonaco*, 709 A.2d 238, 249 (N.J. Super. Ct. App. Div. 1998) (recognizing New Jersey's "prudent patient" informed consent standard is "based primarily upon maturing concepts of patient autonomy and individual self-determination"); *Schrieber v. Physicians Ins. Co. of Wis.*, 579 N.W.2d 730, 734 (Wis. Ct. App. 1998) ("Basic to the informed consent doctrine is that a physician has a legal, ethical and moral duty to respect patient autonomy"); *Feeley v. Baer*, 679 N.E.2d 180, 184 (Mass. 1997) (explaining that the informed consent doctrine is based on the rationale that "autonomy demands that a competent adult consent to any invasion of his or her being"); *Bankert v. United States*, 937 F. Supp. 1169, 1173 (D. Md. 1996) ("The informed consent doctrine holds that a physician has a legal, ethical and moral duty to respect patient autonomy").

²¹ See, e.g., *Perez v. Wyeth Labs, Inc.*, 734 A.2d 1245, 1255 (N.J. 1999) ("Informed consent requires a patient-based decision rather than the [paternalistic approach of the 1970s]"); *Culbertson v. Mermitz*, 602 N.E.2d 98, 104 (Ind. 1992) (quoting 1992 code of Medical Ethics, prepared by the Council on Ethical and Judicial Affairs of the American Medical Association) ("Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy").

²² E.g., *Canterbury*, 464 F.2d at 783-85, 792 (reasoning that informing a patient of dangers and options is often a non-medical decision and should therefore be governed by a standard of reasonable care under the circumstances); *Cobbs v. Grant*, 502 P.2d 1, 10-11 (Cal. 1972); *Matthies*, 709 A.2d 247; *Largey v. Rothman*, 540 A.2d 504, 505 (N.J. 1988) (affirming the "prudent patient" standard); *Cox v. Bd. of Adm'rs of Tulane Educ. Fund*, 716 So.2d 441 (La. App. 1998) (requiring patient to provide expert testimony to establish a prima facie case); *Caputa v. Antiles*, 686 A.2d 356, 361-62 (N.J. Super. Ct. App. Div. 1996) (the court used the reasonable patient standard to measure doctor's disclosure duty and said expert not used to establish disclosure duty); *Rowinsky v. Sperling*, 681 A.2d 785, 789 (Pa. Super. 1996) (holding surgeon liable for failing to provide enough information to satisfy a reasonable patient

“The weighing of . . . risks against the individual *subjective* fears and hopes of the patient is not an expert skill. Such evaluation and decision is a non-medical judgment reserved to the patient alone.”²³ Some cases have gone so far as to require doctors to inform patients of the risks of not having procedures performed²⁴ and of the financial impact of medical decisions in terms of allowing the patient adequate time to get his affairs in order before his death.²⁵

In more dramatic situations patient autonomy also is said to be the value the law is attempting to serve. Thus, a woman’s right to obtain a pre-viability abortion without the state placing an undue burden in her path is largely justified by the assertion that the right to define one’s concept of the existence and meaning of the universe and the mystery of human life is at the heart of the concept of liberty.²⁶ In *Planned Parenthood v. Casey*, not only the joint opinion of Justices O’Connor, Kennedy, and Souter,²⁷ but also the separate opinions of Justices Blackmun²⁸ and Stevens,²⁹ emphasized the importance of maternal autonomy, which is not surprising given Justice Blackmun’s earlier quotation from one of Justice Stevens’s opinions that, “it is this general principle, the ‘moral fact that a person belongs to himself and not others nor to society as a whole’ . . . that is found in the Constitution.”³⁰

The widely recognized right of patients to reject life-saving or life-prolonging medical treatment is sometimes said to be rooted in the common law³¹ and sometimes in the Constitution³², but the right to

in the plaintiff patient’s position).

²³ *Cobbs*, 502 P.2d at 10 (emphasis added).

²⁴ *E.g.*, *Truman v. Thomas*, 611 P.2d 902 (Cal. 1980); *Matthies*, 709 A.2d at 251.

²⁵ *See* *Kimmel v. Dayrit*, 693 A.2d 1287, 1295-96 (N.J. Super. A.D. 1997), *aff’d as modified* by 712 A.2d 1129 (N.J. 1998) (holding a patient should not be informed so that personal decisions can be made); *contra*, *Arato v. Avedon*, 858 P.2d 589 (Cal. 1993) (holding a doctor need not inform a patient about non-medical interests).

²⁶ *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992).

²⁷ *Id.* at 851, 856-57, 896.

²⁸ *Id.* at 926-28 (Blackmun, J., concurring in part, concurring in the judgment in part and dissenting in part).

²⁹ *Id.* at 915-16, 919-20 (Stevens, J., concurring in part and dissenting in part).

³⁰ *Webster v. Reproductive Health Services*, 492 U.S. 490, 549 (1989) (Blackmun, J., dissenting) (quoting *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 777 (1986) (Stevens, J., concurring)).

³¹ *See, e.g.*, *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985) (recognizing a common law right to self-determination as the basis for the right to refuse life-sustaining treatment); *Saikewicz*, 370 N.E.2d at 427 (holding that there is a general right to refuse medical treatment in some circumstances); *In re Storar*, 420 N.E.2d 64,

reject medical care is treated as the flip side of the right to consent to medical care and as an important feature of each patient's autonomy.³³

Informed consent is the primary safeguard in the law of human experimentation. Federally funded research with human subjects must be approved in advance by local Institutional Review Boards.³⁴ Federal regulations give those Boards almost no guidance about evaluating proposals to assure that research is acceptably safe.³⁵ They provide detailed and specific requirements for obtaining informed consent,³⁶ however, with the result that the focus in deciding whether to approve research is the adequacy of the consent rather than the safety of the experiment. Special regulations exist to protect potential human subjects (fetuses,³⁷ children,³⁸ prisoners³⁹) who are thought to lack the capacity to make an autonomous decision about whether to participate in research.

The dominance of patient autonomy as the value apparently being fostered by American medical law is nowhere more evident than in cases involving persons who are incompetent to make their own medical decisions. Here surrogates must make decisions for patients. Depending on the circumstances the decision maker may be a court,⁴⁰ a parent,⁴¹ a guardian,⁴² a health care representative,⁴³ an attorney-in-

70 (N.Y. 1981); *Estate of Longway v. Conty. Convalescent Ctr.*, 549 N.E.2d 292, 297 (Ill. 1989) (holding a common law right to refuse artificial nutrition and hydration exists in Illinois).

³² See, e.g. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 278-79 (1990) (discussing constitutional provisions protecting liberty interests); *In re Quinlan*, 355 A.2d 647, 662-64 (N.J. 1976), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976) (finding that the right of privacy includes a patient's right to refuse medical treatment in some cases).

³³ See *Cruzan*, 497 U.S. at 270 (discussing the right to refuse treatment); *In re Storar*, 420 N.E.2d at 70; *In re Estate of Longway*, 549 N.E.2d at 297 (holding patients have a common law right to refuse treatment).

³⁴ 45 C.F.R. §§ 46.101, 46.103, 46.107, 46.122 (Oct. 2001).

³⁵ 45 C.F.R. § 46.111 (Oct. 2002).

³⁶ 45 C.F.R. § 46.116-17 (Oct. 2002).

³⁷ 45 C.F.R. § 46.201-07 (Oct. 2002).

³⁸ 45 C.F.R. § 46.401-09 (Oct. 2002).

³⁹ 45 C.F.R. § 46.301-06 (Oct. 2002).

⁴⁰ See *In re C.A.*, 603 N.E.2d 1171 (Ill. App. 1 Dist. 1992) (discussing the impact of the surrogate Health Care Act on courts); *Saikewicz*, 370 N.E.2d at 433 (noting the court's power to make decisions for persons under the court's protective jurisdiction).

⁴¹ See *In re Hofbauer*, 393 N.E.2d 1009 (N.Y. 1979) (discussing parents' right to rear their children and the level of deference given to their choice of medical treatment for the child); *In re Fiori*, 673 A.2d 905, 911-12 (Pa. 1996) (holding that a substitute decision maker may determine whether the patient would have refused treatment when the patient is incompetent); *DeGrella ex rel. Parrent v. Elston*, 858 S.W.2d 698 (Ky. 1993) (allowing a parent to make the decision to take her child off

fact,⁴⁴ or, occasionally, an elaborate combination of persons and institutions.⁴⁵ Whoever makes the decision, however, autonomy is said to be the primary substantive value at stake.⁴⁶

Usually, the concern is for the autonomy of the incompetent patient.⁴⁷ However, when the reason for incompetence is merely nonage, courts often defer instead to the autonomy of the patient's parents.⁴⁸ Parents are usually allowed to make medical decisions for their children.⁴⁹ This is because parents are assumed to know more and have better judgment than children, because parents are assumed to care more about their own children than anybody else does, and because some entitlements are thought to accompany the obligations of parenthood.⁵⁰ Thus, ordinarily parents must be given the same kind and quality of information that an adult must receive under the doctrine of informed consent, and then the parents may decide

life support).

⁴² See, e.g., *Matter of Warren*, 858 S.W.2d 263, 265 (Mo. App.1993) (finding statutory authority for a guardian to make medical decisions without specific court authorization).

⁴³ See, e.g., IND. CODE ANN. §§ 16-36-1-2, 16-36-1-5, 16-36-1-8 (West 2001).

⁴⁴ See, e.g., IND. CODE ANN. §§ 30-5-6-1 to -5 (West 1994) (allowing, but not requiring, the attorney in fact to exercise powers of attorney).

⁴⁵ E.g., *In re Conroy*, 486 A.2d 1209 (N.J. 1985) (suggesting the decision-making process include the guardian, and ombudsman and, if necessary, the court).

⁴⁶ See *In re Quinlan*, 355 A.2d 647, 663-64 (N.J. 1976) (finding that when the patient is not competent to accept or decline treatment, the guardian may assert the interests of the patient and vindicate her right to privacy); *Saikewicz*, 370 N.E.2d at 430 (explaining that the focus is the wants and needs of the individual involved); *In re Valerie N.*, 707 P.2d 760, 773 (Cal. 1985) (noting constitutional guarantee as an assurance citizen protected in right to use his mind and body as he chooses).

⁴⁷ See *Quinlan*, 355 A.2d at 664 (holding that because the patient was incompetent, "independent right of choice" may be asserted by her guardian); *Saikewicz*, 370 N.E.2d at 430 (emphasizing substituted judgments of the individual). See generally *Valerie N.*, 707 P.2d at 762 (court noting handicapped still have same autonomy rights under the Constitution).

⁴⁸ E.g., *In re Hofbauer*, 393 N.E.2d 1009, 1013 (N.Y. 1979) (stating that while the state may intervene on the child's behalf if his or her life is in jeopardy, the court gives a high level of deference to the parents' decision as to treatment). See *Bowen v. American Hospital Association*, 476 U.S. 610 (1986) (holding that, pursuant to section 504 of Rehabilitation Act of 1973, parental consent is required when the youth is incompetent).

⁴⁹ E.g., *Matter of Baby K.*, 832 F. Supp. 1022, 1030-31 (E.D. Va. 1993) (discussing the constitutional rights of parents to make medical decisions for their minor children). See also ROGER B. DWORKIN, *LIMITS: THE ROLE OF THE LAW IN BIOETHICAL DECISION MAKING*, 140-41 (1996) [hereinafter *LIMITS*] (discussing the interaction between law and social issues created by technology).

⁵⁰ *The Human Genome Project*, *supra* note 5, at 128 n. 31 and accompanying text.

whether to accept treatment for the child. Parental decisions are almost never overruled. Some courts state explicitly that the obligation of parents is to make an informed, caring decision (like one would make for oneself), not necessarily the best decision.⁵¹ Deference to parents sometimes goes so far as to allow parents to insist on using medically disapproved alleged cures as long as they can find one licensed physician to support their choice.⁵²

When a patient is incompetent for some reason other than nonage, the patient's own autonomy usually appears to be the value courts try to serve. Thus, substituted judgment, a doctrine under which decision makers are supposed to decide what the incompetent person would choose for himself if he were competent, is the most frequent standard applied to decisions about whether to withhold or withdraw life support from incompetent persons.⁵³ Some states require a high degree of certainty that a person would choose to reject lifesaving medical care,⁵⁴ and the United States Supreme Court has upheld that approach.⁵⁵ Others follow the concept to absurd extremes, requiring surrogate decision makers to decide what a person with a mental age of 2 who had never been competent would decide if he were competent for one instant during which he understood everything about his condition, including the fact that he was incompetent.⁵⁶

The leading contender for a different substantive test of whether to withhold or withdraw life support from an incompetent person is the best interests of the patient,⁵⁷ but that test, which makes no pretense of promoting patient autonomy, is seldom applied. On the

⁵¹ *E.g.*, *In re Felicia D.*, 693 N.Y.S.2d 41 (N.Y. App. Div. 1999) (explaining that the standard parents should be measured is whether they have provided their children w/adequate medical treatment in light of the circumstances and not whether the parents provided the "right" medical treatment). *Cf.*, *Newmark v. Williams*, 588 A.2d 1108 (Del. 1990) (deferring to parents' religiously based objection to very intrusive medical care).

⁵² *See Hofbauer*, 393 N.E.2d at 1014 (weighing parents' reliance on one doctor's opinion over another's conflicting majority opinion in determining whether their chosen treatment constituted neglect).

⁵³ For a discussion and criticism of this approach, see *LIMITS*, *supra* note 49, at 118-19, 188.

⁵⁴ *E.g.*, *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (finding that guardians do not have the authority to withdraw hydration and nutrition).

⁵⁵ *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990).

⁵⁶ *See Saikewicz*, 370 N.E.2d at 431 (assuming that the decision would be made by the incompetent person as if they were competent). For a critic's clever response to this absurdity *see* text accompanying n. 243, *infra*.

⁵⁷ *See generally* *LIMITS*, *supra* note 49, at 118 (discussing the objective standard).

Supreme Court only Justice Stevens supports the best interests of the patient test in death facilitation cases.⁵⁸

Thus, patient (or patients' parents') autonomy seems firmly entrenched as the dominant value in American medical law. This is not surprising. It reflects not only longstanding American traditions of individualism, free choice, and a desire to be let alone (don't tread on me), but also American populism's distrust of authority and expertise. Americans are a suspicious yet hopeful lot, simultaneously refusing to recognize the superior understanding of professionals and seeking the perfect relief that experts cannot provide. Thus they increasingly rely on alternative medicine⁵⁹ even when most alternative practices cannot be demonstrated to be effective,⁶⁰ and when many are harmful.⁶¹ And they insist on believing that they are in control of decisions about their medical care and that the law will support that control. In fact, despite all the talk, however, the law does not support patient control over medical decisions, sometimes for good reasons and sometimes for bad. The rhetoric of autonomy facilitates treading on the interests of individual patients while providing an excuse for ignoring important interests of other persons.

A. What Have You Done For Me Lately?: Autonomy and the Patient

Patient autonomy is supposed to protect patient control over medical decision making or the integrity of patients' bodies or both. Most of the time it is clear that patient control over decision making is what courts mean by autonomy. Yet the cases themselves do little to

⁵⁸ *Cruzan*, 497 U.S. at 331 (Stevens, J., dissenting).

⁵⁹ See Kathleen M. Boozang, *Western Medicine Opens the Door to Alternative Medicine*, 24 AM. J.L. & MED. 185, 186 & n. 5, 187-88 (1998) (discussing the rise in patient use of alternative medicine and openness to experiment with unproven and unconventional therapies).

⁶⁰ *Id.* at 188. See also Ryan J. Huxtable, *Book Review*, 39 JURIMETRICS J. 327, 332 (1999) (noting reliance of public on unproven alternative medicine therapies despite lack of scientific support for therapy).

⁶¹ See, e.g., "Ontario Coroners to Track Alt. Med. Cases", Nat'l Council Against Health Fraud, Inc., NCRHI Newsletter (No. 3, Vol. 23, pg. 51, May 1, 2000); Jane E. Brady, *Personal Health: Taking Stock of Mysteries of Medicine*, N.Y. TIMES, May 5, 1998, at F7 (discussing the effectiveness of alternative therapies); Gina Kolata, *On Fringes of Health Care, Untested Therapies Thrive*, N.Y. TIMES, June 17, 1996, at A1 (noting that risks of alternative therapies can include death); J. Warren Willey II, *Insulin as an Anabolic Aid?*, 25 PHYSICIAN & SPORTSMED. 103, 103-04 (Oct. 1997); Victor Herbert, *Melatonin: Harms from a Pseudo Cure-All*, 30 NUTRITION TODAY 245 (1995); Michael Casey, *Alternative Therapies Taking Expanded Role*, Managed Care Newsperspective (Mar. 18, 1999).

facilitate patient centered decision making, and relevant statutes also promote other values at the expense of patient autonomy.

For example, only licensed practitioners of "healing arts" that the various state legislatures deem acceptable are allowed to diagnose and treat patients.⁶² Only drugs and medical devices that the Food and Drug Administration has decided are safe and effective may be entered into interstate commerce,⁶³ and thus, as a practical matter, only such drugs and devices are available to treat patients. If patient autonomy rather than the protection of patients from injury and fraud were the value being served, neither of these restrictions would apply. Patients would be able to consult whomever they choose about their health, and practitioners would be free to use snake oil, laetrile, or whatever alleged curative agents their patients preferred to receive.

If patient autonomy were really the dominant value in patient health care law, then doctors and patients would be free to bargain about the quality of care the doctor would provide to the patient. Malpractice law would be contract law, not torts, as one of the leading proponents of individual autonomy in many aspects of society advocated long ago.⁶⁴ Yet malpractice law remains a matter of tort as we attempt to maintain the fiction that all patients are entitled to the same level of care. Everyone is entitled to reasonable care, not the amount of care he might bargain for in order to save money and exercise his autonomous preference for other goods over high priced medical care. Even as managed care moves us inexorably in the direction of different standards of care for different patients,⁶⁵ autonomous patient decisions are not what is involved. Rather the government, private insurers, and employers make decisions about the level of care that members of various groups will receive.⁶⁶ The decisions are made in an across-the-board fashion at the time that

⁶² See Michael H. Cohen, *A Fixed Star in Health Care Reform: The Emerging Paradigm of Holistic Healing*, 27 ARIZ. ST. L.J. 79, app. at 155-59 (1995) (listing statutes).

⁶³ 21 U.S.C. § 355 (2000). See also 21 C.F.R. § 310 et seq (2002) (listing the requirements for new drugs).

⁶⁴ Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. B. FOUND. RES. J. 87.

⁶⁵ Recognizing the dangers of differential standards of care, Troyen Brennan argues that patients must be treated as a single class that must enjoy special and equal status. Troyen A. Brennan, *An Ethical Perspective on Health Care Insurance Reform*, 19 AM. J.L. & MED. 37, 56 (1993).

⁶⁶ See Mehlman, *supra* note 7, at 351 ("Third-party payers, such as government entitlement programs, insurers, and employers are beginning to second-guess physicians' decisions by requiring prior approval before services are provided to patients or before the physicians' claims for reimbursement are paid").

health care plans are entered. Once the basic decisions have been made, the level of care the patient receives is imposed by the insurer or negotiated between the insurer and the provider. Patient protection, such as it is, comes from the law of torts. Patient autonomy has nothing to do with the matter.

The law of informed consent presents the clearest example of the absence of patient autonomy in the midst of maximal autonomy rhetoric. In theory, patient autonomy is the value being served by the requirement that doctors obtain a patient's informed consent before they perform a procedure on the patient. Yet that is plainly not the case. First, modern cases treat the cause of action for failure to obtain informed consent as a negligence claim.⁶⁷ That means that the patient cannot recover without proving that he has suffered a physical injury.⁶⁸ The injury to the patient's autonomy, which exists regardless of whether the patient was physically injured, is worth nothing. To put it another way, a physician will not be liable for failing to obtain informed consent and depriving the patient of autonomy unless the physician is unlucky enough to have a low probability bad outcome occur.

Second, the amount of information that a physician must provide in order to make a patient's consent to a procedure informed enough to prevent liability on the physician is either (depending on the jurisdiction) the amount of information that a reasonable physician would provide⁶⁹ or all material information,⁷⁰ that is, the amount of

⁶⁷ *E.g.*, *Cobbs v. Grant*, 502 P.2d 1, 8 (Cal. 1972) (treating lack of informed consent claim as a negligible action); *Sard v. Hardy*, 379 A.2d 1014, 1020 n. 4 (Md. 1977) (discussing the doctrine of informed consent). *See also* *Banks v. Wright*, 721 So.2d 1063, 1064-65 (La. Ct. App. 1998) (citing several secondary sources to support its decision that a lack of informed consent is a negligence claim).

⁶⁸ *E.g.*, *Canterbury v. Spence*, 464 F.2d 772, 790 (D.C. Cir.1972) (requiring a causal connection between lack of informed consent and harm from that omission); *Cobbs*, 502 P.2d at 11 (indicating patient must have suffered physical injury to bring a lack of informed consent claim).

⁶⁹ *E.g.*, *Pardy v. U.S.*, 783 F.2d 710, 714 (7th Cir. 1986) (applying Illinois law); *Cohen v. United States*, 540 F. Supp. 1175 (D. Ariz. 1982) (applying Texas law; holding a doctor is responsible to disclose what a reasonable physician would disclose); *Bloskas v. Murray*, 646 P.2d 907, 913 (Colo. 1982) (citing the standard of a reasonable medical practitioner who knew or should have known that a particular factor was important to a patients' decision); *Sherwood v. Carter*, 805 P.2d 452, 461 (Id. 1991) (finding the informed consent statute requires the professional medical standard for disclosure).

⁷⁰ *E.g.*, *Canterbury*, 464 F.2d at 786-87 (stating that material information is the correct standard because it most adequately addresses the patient's needs in giving informed consent); *Weiss v. Green*, 129 F. Supp. 742 (M.D. Pa. 2001) (applying Pennsylvania law); *Cobbs*, 502 P.2d at 1 (stating doctors must reveal all information material to a patient's decision); *Ketchup v. Howard*, 543 S.E.2d 371, 378 (Ga. App.

information a reasonable patient would want to have in order to make a rational decision whether to allow the procedure.⁷¹ Neither standard promotes patient autonomy. A reasonable physician standard addresses the needs and practices of the medical profession, not the choices of a patient. The materiality standard is an objective standard that requires the same amount of information to be delivered to all patients. A standard would have to be subjective, focusing on the particular needs, desires, and quirks of the individual patient, to serve patient autonomy.⁷² The whole point of autonomy is that each person is supposed to be able to make his own decisions, based on his own considerations, no matter how unreasonable those decisions and considerations may be.⁷³

Even the minimal bow to autonomy of requiring that *any* information be provided is often honored in the breach as several exceptions exist to the requirement that doctors provide significant information to their patients. Doctors are said not to have to provide material information for simple or common procedures when it is common knowledge that the risks are of very low incidence.⁷⁴ While this may make good practical sense, it has nothing to do with protecting patient autonomy. Almost no procedure is common to a patient, so if the exception only applies when the patient has a great deal of experience with the procedure, the exception will be almost worthless. Yet if the question is whether the procedure is common to the doctor or is a procedure that is commonly performed in the United States, then the exception provides a gigantic loophole in the protection of patients' autonomy. The same can be said of the requirement that it be common knowledge that the risk is of very low incidence. Again the question is common to whom. Only if the

2000) (holding that physicians must reveal material risks associated with a particular procedure or treatment); *Carr v. Strode*, 904 P.2d 489 (Haw. 1995) (holding that a physician's failure to inform patient and his wife that less than one percent of vasectomy patients father children after surgery was not material); *Pauscher v. Iowa Methodist Med. Ctr.*, 408 N.W.2d 355, 359 (Iowa 1987) (holding that patient must be given material information to enable "a truly informed and intelligent decision"); *Sard*, 379 A.2d 1014 (discussing the materiality of information withheld by physician when informing patient about sterilization procedure).

⁷¹ For a collection of state authorities and the standards they adopt, see the *Appendix* in *Ketchup*, 543 S.E.2d at 381-86.

⁷² See *Morris*, *supra* note 7, at 328-29 (explaining that the standard should be measured by the patient's individual needs).

⁷³ *Id.* at 329.

⁷⁴ *E.g.*, *Cobbs*, 502 P.2d at 11 (holding doctors are not required to reveal material information for common procedures with low incidence of risk); *Sard*, 379 A.2d at 1022 (discussing the materiality of information provided by physicians). See also *Pauscher*, 408 N.W.2d at 360 (listing exceptions to the duty of disclosure).

patient personally knows that the risk is of very low incidence is the patient's autonomy being served.

Physicians do not have to provide information to a patient in an emergency.⁷⁵ Again this makes good sense, but it has nothing to do with autonomy. It makes good sense because most reasonable people want to receive treatment that will save their lives or prevent serious disability, and the law understands that doing what most people want and avoiding death and disability is a good idea. This is deference to objectivity, majority rule, and the value of good medical care. It has nothing to do with autonomy, which would attempt to ascertain whether each particular patient confronting a health care emergency really wanted to be treated in the way the doctors had in mind.

Under the so-called therapeutic privilege, a doctor does not have to provide information to the patient if the doctor reasonably believes that the receipt of the information itself will harm the patient.⁷⁶ In other words if being told that a proposed treatment poses a risk of nerve damage is reasonably likely to cause the patient to suffer a heart attack, the doctor does not have to tell the patient about the risk of nerve damage. I have always doubted whether any situations that are true examples of the therapeutic privilege exist, but if they do, the privilege is a high water mark for paternalism, a striking example of denying information and choice to a patient for the patient's own good.

The only exception to the information requirement that serves autonomy is the exception that allows a physician to withhold information if the patient has asked not to be informed.⁷⁷ While voluntarily disabling oneself from acting autonomously may seem an odd way to exercise one's autonomy, it can be understood as an

⁷⁵ *E.g.*, *Canterbury*, 464 F.2d at 788-89 (noting that the physician should attempt to obtain a relative's consent if feasible); *Cobbs*, 502 P.2d at 10 (stating doctors are not required to reveal information in emergencies); *Sard*, 379 A.2d at 1022.

⁷⁶ *Canterbury*, 464 F.2d at 789; *Sard*, 379 A.2d at 1022. For an over-broad statement of the privilege that, if taken seriously, would provide a gigantic loophole in the disclosure requirement, see *Cobbs*, 502 P.2d at 12 ("[a] disclosure need not be made . . . when a doctor can prove . . . he relied upon facts which would demonstrate to a reasonable man the disclosure would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks to refusing to undergo the recommended treatment").

⁷⁷ *See, e.g.*, *Cobbs*, 502 P.2d at 12 (stating doctors need not share information with patients who have asked not to be informed); *Laskowitz v. CIBA Vision Corp.*, 632 N.Y.S.2d 845, 848 (App. Div. 1995) (listing four defenses under law for failure to secure a patient's informed consent).

expression of an individual's preference for psychological comfort (ignorance is bliss) over the need to make hard choices.

Finally, if a situation exists in which a doctor was required to provide information and failed to do so, the patient consented, and the procedure injured the patient, the patient still cannot recover without proving causation.⁷⁸ That means that the patient must prove that if he had been properly informed, he would not have consented to the procedure.⁷⁹ The problem is obvious: With 20/20 hindsight even an honest patient is likely to believe that he would not have consented if he had known that the disaster that befell him was a possibility.⁸⁰ Therefore, many courts refuse to allow the patient's own testimony about what he would have done to get the patient's case to the jury.⁸¹ Instead they say that the question is what a reasonable patient would have done if properly informed.⁸² Again, the focus on the objective reasonable patient standard destroys all pretense that the individual, subjective patient's autonomy is being served.⁸³

Surrogate decision making also does not serve the value of autonomy. Obviously, a decision by somebody other than the patient is an example of (often desirable) imposition on the patient, decision making *for* the patient, not *by* the patient. No matter how one dresses it up, A deciding for B is not an exercise of B's autonomy.

Even deference to parental autonomy in the context of medical decision making for children is far from universal. First, all the features of informed consent law that militate against the autonomy of competent adult patients also militate against the autonomy of parents acting for their children.

In addition, exceptions exist to the rule that the consent of a parent is required to provide medical care to a child. Parents' refusals to consent or the absence of parental consent are overridden in some circumstances. As with adult patients consent is assumed when an emergency exists if the parents are not reasonably available.⁸⁴

⁷⁸ *E.g.*, *Cobbs*, 503 P.2d at 11 (holding patients must prove a causal link between doctor's lack of disclosure and injury to recover).

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.* at 11-12.

⁸² *Id.*

⁸³ *See Morris*, *supra* note 7, at 330-31 (explaining that the patient is free to decide on the treatment and the standard for the physician to disclose should not be the reasonable patient standard but should be one that is measured by the patient's own needs).

⁸⁴ Alexander M. Capron, *The Competence of Children as Self-Deciders in Biomedical Interventions*, in *WHO SPEAKS FOR THIS CHILD: THE PROBLEMS OF PROXY CONSENT* 62, 95-114 (W. Gaylin & R. Macklin eds., 1982).

Parental consent is not required to provide treatment to mature⁸⁵ or emancipated minors⁸⁶ or often in cases of gunshot wounds,⁸⁷ drug⁸⁸ and alcohol abuse,⁸⁹ pregnancy⁹⁰ and venereal disease.⁹¹ In addition, elaborate rules exist about the role parents may play when their minor daughters seek abortions.⁹²

The mature and emancipated minor exceptions are merely efforts to use status rather than age to determine competence. An emancipated minor is essentially treated like an adult with the same degree of deference and lack of deference to his autonomy that an adult has.⁹³ The mature minor rule is a bit trickier. There is no clear definition of a mature minor. Basically, a mature minor is a smart, old minor. Such a person is allowed to make some relatively trivial decisions about his own health care.⁹⁴ He can consent to have his arm set, but not to risky brain surgery. This rule gives mature minors more authority to exercise their autonomy than immature minors, and correspondingly reduces the authority of their parents, but it retains substantial parental control and rejection of the minor's autonomy.

The abortion rules represent the ambivalence the Supreme Court feels about abortion.⁹⁵ The other exceptions, which are also chinks in

⁸⁵ *Id.* at 75-76, 95-114 (table listing the various exceptions to the parental consent rule in each state).

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *See, e.g.,* Ohio v. Akron Ctr. for Reprod. Health, 497 U.S. 502 (1990) (upholding a statute that prohibits an abortion on an unemancipated female under eighteen unless (1) one parent consents in writing; or (2) the physician has given notice to one parent or a guardian; or (3) a court has given authority based on maturity, parental abuse of the minor, or a finding that notice would not be in the minor's best interest; or (4) the court has failed to act fast enough); H.L. v. Matheson, 450 U.S. 398 (1981) (upholding a requirement that a minor's parents be "notified if possible" for a minor seeking an abortion who is living with and dependent on her parents, is not emancipated, and has made no claim or showing with regard to her maturity or her relationship with her parents); Bellotti v. Baird, 443 U.S. 622 (1979) (upholding a parental consent requirement for abortion if the state provides a minor a satisfactory alternative to obtaining parental consent); Planned Parenthood v. Danforth, 428 U.S. 52, 72-75 (1976) (invalidating a Missouri statute that required parental consent before a minor could obtain an abortion). For a more complete discussion of minors and parental consent in abortion situations, see LIMITS, *supra* note 49, at 33-36.

⁹³ Capron, *supra* note 84, at 65-69.

⁹⁴ *Id.* at 69-76.

⁹⁵ *See* LIMITS, *supra* note 49, at 33-36 (discussing various court decisions in this area, emphasizing the difficulty in forming any type of consensus).

the armor of autonomy, either represent a preference for health over parental autonomy⁹⁶ or a recognition of the needs of public health⁹⁷ or mistrust of parents whose children have been engaged in forbidden activities.⁹⁸

Finally, parents' refusals to permit treatment for seriously impaired newborns are sometimes subject to judicial oversight⁹⁹, thus casting further doubt on whether either the infant's or the parents' autonomy interests are being served.

B. Autonomy in Controversial Cases: Abortion and Death Facilitation

The real test of the law's commitment to a value is its willingness to foster that value in highly controversial cases. It is easy to spout autonomy talk when all that is at stake is whether a patient who cannot prove negligent medical performance should be compensated for medically caused injuries. Even there, as we have seen, the law's commitment to the rhetoric of autonomy far exceeds its commitment

⁹⁶ *Capron, supra* note 84, at 63-64. Capron discusses two more general exceptions, the "physician-judgment" exception and the "best interests" exception. The physician-judgment exception, embodied in the statutes of seven states, says that if in the physician's judgment an attempt to secure parental consent would increase the risk to the minor's health, consent is then not required, *even if the condition requiring care is not an emergency*. Similarly, the "best-interests" exception is generally invoked when parents refuse to consent to a "relatively simple" procedure and failure to give treatment will result in substantial risk of death or permanent impairment of health. *Id.*

⁹⁷ *Id.* at 75.

⁹⁸ *See, e.g.*, N.J. STAT. ANN. § 9:17A-4 (West 2002) (authorizing a minor who appears or professes to be infected with a venereal disease, is the victim of a sexual assault, or is using or is dependent on drugs or alcohol to consent to treatment as if that minor had reached the age of majority); CAL. FAM. CODE § 6929(b) (2003) ("[a] minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem"); ARIZ. REV. STAT. ANN. § 44-133.01 (West 2003) (a "minor twelve years of age or older who is found, upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, which includes withdrawal symptoms, may be considered an emergency case and such minor is to be regarded as having consented to hospital or medical care needed for treatment for such"); ALA. CODE § 22-11A-19 (Michie 1997) (minor 12 years of age or older who may have come into contact with any sexually transmitted disease as designated by the State Board of Health may give consent to the furnishing of medical care related to the diagnosis or treatment of such disease).

⁹⁹ *See generally* The Child Abuse Prevention and Treatment Act, 42 U.S.C. §§ 5106a, 5106g (2000) (discussing funding qualifications). *See also* *Infant Doe v. Baker*, No. 482 S 140 (Ind. Ct. App. May 27, 1982), *cert. denied*, 464 U.S. 961 (1983).

to the value of autonomy. How much less likely it is that the law will truly pursue patient autonomy when other hot button issues are at stake.

Of course, the hottest hot button of them all remains abortion. Twenty-nine years after *Roe v. Wade*¹⁰⁰ abortion concerns still cause violence,¹⁰¹ litmus test voting and decisions about judicial appointments,¹⁰² unceasing efforts at legislative nullification of Supreme Court decisions,¹⁰³ skewed legal responses to other issues

¹⁰⁰ *Roe v. Wade*, 410 U.S. 113 (1973).

¹⁰¹ For instance, the fatal shooting of Dr. Barnett Slepian, an abortion provider, outside his home in Buffalo, NY on October 23, 1998, is just one well-publicized incident of violence spurred by the abortion controversy. Joseph Berger, *Abortion Foe is Charged in Killing of Clinic Doctor*, N.Y. TIMES, May 7, 1999, at B5.

¹⁰² The abortion issue weighed heavily in the Senate's respective confirmation and rejection of current Supreme Court Justice Sandra Day O'Connor and former Supreme Court Justice candidate Robert Bork. Regarding his failed Supreme Court nomination, Bork himself has said that "*Roe v. Wade* was probably the litmus issue." *Legends in the Law: A Conversation with Robert H. Bork*, Bar Report (District of Columbia Bar), Dec/Jan 1998, available at <http://www.dcbbar.org/> (last visited December 30, 2001) (on file with author). Justice O'Connor, in her confirmation hearing, responded positively that she was against abortion, and, according to Republican Policy Committee, President Reagan "assured prolife (sic) Senators that they will not be unhappy with this nominee." *Senate Vote Record Analysis, O'Connor Nomination*, UNITED STATES SENATE REPUBLICAN POLICY COMMITTEE, 97th Congress, 1st Session, Vote No. 274, Sept. 21, 1981, available at <http://www.senate.gov/~rpc/rva/971/971274.htm> (last visited December 29, 2001) (on file with author).

¹⁰³ See, e.g., A.C. 1085, 210th Leg., 2002 Sess. (NJ 2002), available at <http://www.njleg.state.nj.us> (last updated Mar. 12, 2002) (providing that any person who intentionally kills an "unborn child" at any stage of gestation is subject to the same penalties as those convicted of murder, while excluding acts of the pregnant woman, including abortion); S.B. 2210, 2002 Leg. Reg. Sess. (Miss. 2002), available at <http://billstatus.ls.state.ms.us/2002/html/history/sb/sb2210.htm> (last modified Feb. 5, 2002) (requiring a battery of physical tests, such as a family history of breast cancer, and psychological tests, such as strong religious convictions, on a pregnant woman prior to the performance of an abortion to determine whether she is capable of making an "informed" choice. There are criminal and civil penalties for non-compliance. This bill was introduced and referred to the Senate Committee on Public Health and Welfare on Jan. 10, 2002); H.B. 33, 2002 Leg. (Ms. 2002), available at <http://billstatus.ls.state.ms.us/documents/2002/html/HB/0001-0099/HB0033IN.htm> (introduced Jan 8, 2002, referred to House Comm. On Universities and Colleges) (prohibits University of MS Medical Center School of Medicine from performing or teaching how to perform an abortion); H.R. 6003, 2002 Sess. (Kan. 2002), available at <http://www.kslegislative.org/cgi-bin/fulltext/index.cgi> (last visited Mar. 17, 2002) (introduced Jan. 25, 2002, referred to House Comm on Fed. And State Affairs) (states that unborn children have an equal and unalienable right to life from conception/fertilization and that allowing the termination of "lives of innocent human beings even before birth" violates the Kansas Constitution. Requires KS Attorney General to seek final resolution regarding abortion in front of the KS Supreme Court);

such as those posed by genetic advances¹⁰⁴ and assisted reproduction,¹⁰⁵ and a high level of irrationality, fury, and wasted energy. Moreover, the Supreme Court itself continues to manifest ambivalence about abortion¹⁰⁶. What chance is there that autonomy will flower in such contaminated soil?

Before *Roe v. Wade* and its companion case, *Doe v. Bolton*,¹⁰⁷ abortion had been a crime in every state.¹⁰⁸ Traditionally, the only exception was that abortion was permitted to save the life of the mother.¹⁰⁹ In the years leading to *Roe* and *Doe* eighteen states had modified their criminal anti-abortion laws. Four of those states permitted abortion for any reason until about the time of fetal viability.¹¹⁰ Fourteen had adopted less far-reaching statutes¹¹¹ modeled after a proposal in the Model Penal Code.¹¹² Those statutes expanded the exceptions to the criminalization of abortion so that

S.B. 926 2001 Leg. (Mass. 2001), available at <http://www.state.ma.us/legis/legis.htm> (last visited March 7, 2002) (introduced Jan. 3, 2001, set aside for study by the Joint Comm. on Judiciary June 19, 2001) (prohibits a physician from performing abortion if pregnancy has reached greater than 16 weeks, health of the mother exception); H.B. 4128 2001 Leg. (Mass. 2001) (introduced Apr. 26, 2001, set aside for study in Joint Comm. on Judiciary, June 26, 2001) *Id.* For a comprehensive list of abortion legislation pending in all states, see The National Abortion Rights Action League, at <http://www.naral.org> (last visited Mar. 1, 2002).

¹⁰⁴ See *LIMITS*, *supra* note 49, at 100 (discussing the impact of the abortion controversy).

¹⁰⁵ *Id.* at 61-84, for a discussion about the law and alternative reproductive techniques.

¹⁰⁶ Compare *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989) (holding that a statute prohibiting use of public employees and facilities to perform abortions was not invalid since it placed no governmental obstacle in the path of a woman who chose to have an abortion) with *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (offering a thorough explanation of the rationale behind a woman's right to an abortion). See also *Danforth*, 428 U.S. 52 (1976). See also *Bellotti v. Baird*, 443 U.S. 622 (1979) (demonstrating the ambivalence of the Court as it wrestles with a minor's abortion rights question). Further discussion of this *Bellotti* challenge may be seen in *LIMITS*, *supra* note 49, at 35.

¹⁰⁷ 410 U.S. 179 (1973).

¹⁰⁸ See *LIMITS*, *supra* note 49, at 20-22, for an overview of the history of abortion legislation.

¹⁰⁹ See *id.* at 19 (discussing the historical exception in the abortion statutes); see also Eugene Quay, *Justifiable Abortion – Medical & Legal Foundations*, 49 *GEO. L.J.* 395, 437 (1961) (noting that protecting the life of the mother was exempted from many abortion laws).

¹¹⁰ See *Roe v. Wade*, 410 U.S. 113, 140 n.37 (1973) (listing the Alaska, Hawaii, New York, and Washington statutes repealing criminal penalties for abortions performed in early pregnancy by a licensed physician).

¹¹¹ *Id.* (listing the fourteen state statutes modeled after the Model Penal Code at the time *Roe* was decided).

¹¹² MODEL PENAL CODE § 230.3 (Proposed Official Draft 1962).

abortion was legal to save the mother's life or her physical or mental health, or if there was strong reason to believe the baby would be born with a significant physical or mental defect, or if the pregnancy had resulted from rape or incest. In addition, Alabama¹¹³ and the District of Columbia¹¹⁴ had long allowed abortions to preserve the mother's health as well as her life.

Roe v. Wade invalidated Texas's traditional anti-abortion law,¹¹⁵ and *Doe v. Bolton* invalidated Georgia's modern Model Penal Code-type law.¹¹⁶ By now everybody knows the outline of the *Roe* decision, which was by far the more important of the two. The Supreme Court held that the liberty that is protected from deprivation without due process of law by the fourteenth amendment includes a right of privacy; that right is "broad enough" to encompass a woman's decision whether to terminate her pregnancy; it is a fundamental right, which can only be overridden to the extent necessary to serve a compelling state interest. In the abortion context, the state's interest in maternal health is compelling from the end of the first trimester of pregnancy; its interest in the potential life of the fetus is compelling from the time the fetus becomes viable. Accordingly, the state may regulate abortion to the extent necessary to protect maternal health from the end of the first trimester on, and it may regulate or even prohibit abortion to preserve fetal life from the time of fetal viability as long as it continues to permit abortions to save the mother's life or health.¹¹⁷

One might have thought that some notion of autonomy underlay the Supreme Court's decision in *Roe v. Wade*. But the Court was careful to reject the claim that a woman has a right to do whatever she wants with her body,¹¹⁸ and the Court explicitly approved state regulation of abortion to protect the mother's health after the end of the first trimester.¹¹⁹ Indeed, the Court also allowed the states to prohibit anyone other than a licensed physician from performing an abortion even during the first trimester.¹²⁰ Thus, from the outset of its

¹¹³ ALA. CODE tit. 14, § 9 (1958).

¹¹⁴ D.C. CODE ANN. § 22-101 (2001).

¹¹⁵ *Roe* at 118 n. 1 (citing TEX. PENAL CODE ANN. §§ 1191-1194, 1196 (Vernon 1960)).

¹¹⁶ *Doe*, 410 U.S. at 202 (Appendix A citing GA. CODE ANN. § 26-1202(b)).

¹¹⁷ The majority provides a comprehensive recap of the *Roe* framework at the end of the opinion, 410 U.S. at 164-65.

¹¹⁸ *Roe*, 410 U.S. at 154.

¹¹⁹ *Id.* at 163.

¹²⁰ *Id.* The Court uses the example of a state requiring a licensed physician to perform abortions to illustrate the sorts of regulations that would be permissible to protect the health of the mother.

abortion jurisprudence the Supreme Court rejected autonomy as the value at stake and adopted rules that are inconsistent with the pursuit of autonomy.

That remains the case to this day. In 1989 when the Court came close to overruling *Roe v. Wade* in *Webster v. Reproductive Services*,¹²¹ *Roe's* author Justice Blackmun filed an anguished dissent.¹²² There he (belatedly) stated an autonomy rationale for the abortion right: "it is this general principle, the 'moral fact that a person belongs to himself and not others nor to society as a whole' . . . that is found in the Constitution."¹²³ Yet immediately after making this pronouncement, Justice Blackmun reaffirmed his support for regulating abortion after the first trimester to protect maternal health,¹²⁴ regulation that is inconsistent with maternal autonomy.

By 1992 the Supreme Court seemed to be ready to adopt an autonomy rationale for a woman's right to terminate her pregnancy. In *Planned Parenthood v. Casey*,¹²⁵ the Court was badly split. Three justices, O'Connor, Kennedy, and Souter, issued a joint opinion in which they reaffirmed what they characterized the central holding of *Roe*.¹²⁶ According to them this so-called "central holding" has three parts: (1) There is a right to abortion before viability without undue interference by the state; (2) the state may restrict abortions after viability as long as there are exceptions for abortions that threaten the mother's life or health; and (3) the state has a legitimate interest from the outset of pregnancy in the health of the mother and the life of the fetus.¹²⁷

Among the reasons for reaffirming this "central holding" were the three justice's view that "the right to define one's concept of the existence, of meaning, of the universe, and of the mystery of human life"¹²⁸ is "[a]t the heart of [the concept of] liberty"¹²⁹ and their opinion that the unique and intimate suffering undergone by women in pregnancy and childbirth requires that a woman's destiny be shaped by "her own conception of her spiritual imperatives and her place in

¹²¹ 492 U.S. 490 (1989).

¹²² *Id.* at 537 (Blackmun, J., dissenting).

¹²³ *Id.* at 549 (quoting *Thornburgh v. American College of Obstetrics and Gynecologists*, 476 U.S. 747, 777 (1986) (Stevens, J., concurring)).

¹²⁴ *See id.* (stating that regulation after the first trimester is acceptable because a state has a legitimate interest in protecting a pregnant woman's health).

¹²⁵ 505 U.S. 833 (1992).

¹²⁶ *Id.* at 845-46.

¹²⁷ *Id.* at 846.

¹²⁸ *Id.* at 851.

¹²⁹ *Id.*

society.”¹³⁰ These views were supported by cases which supported intimate relationships and decisions and by cases protecting personal autonomy and bodily integrity.¹³¹ In separate opinions, Justices Blackmun and Stevens also emphasized bodily integrity¹³² and the freedom to make important personal decisions.¹³³ Thus, a majority of the Justices in *Casey* seemed to root the abortion right at least partly in autonomy, both in the liberal individualism sense and in the physical essentialism sense.

Nonetheless, the Court’s apparent commitment to autonomy remains rhetorical, not real. The Court still permits abortion regulation to protect the health of the mother,¹³⁴ a concession that is totally inconsistent with the pursuit of autonomy as the goal. Moreover, the Court in some ways increased the states’ ability to regulate abortion, thus restricting women’s autonomy even more than earlier cases had. The Court recognized that the states’ interest in maternal health and fetal life exist from the outset of pregnancy,¹³⁵ and that some restrictions to serve those interests are therefore permissible before the end of the first trimester (maternal health)¹³⁶

¹³⁰ *Id.* at 852.

¹³¹ *Id.* at 846-50, 852 (giving the historical background behind the right of a woman to terminate a pregnancy and the court’s rationale behind that right); *Carey v. Population Servs. Int’l*, 431 U.S. 678 (1977) (holding that personal decision of an individual to use contraceptives are afforded Constitutional protection). *See also* *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (stating that “[i]f the right of privacy means anything, it is the right of the *individual* . . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (holding that the Constitution does not permit a state to forbid a married couple to use contraceptives).

¹³² *Casey*. 505 U.S. at 915. (Stevens, J., concurring in part and dissenting in part) (“In counterpoise [to the State’s interest in potential human life] is the woman’s constitutional interest in liberty. One aspect of this right is a right to bodily integrity, a right to control one’s person”) (citations omitted); *Id.* at 926-27 (Blackmun, J., concurring in part and dissenting in part) (“. . . restrictive abortion laws force women to endure physical invasions for more substantial than those this Court has held to violate the [C]onstitutional principle of bodily integrity in other contexts”) (citations omitted).

¹³³ *Id.* at 915 (Stevens, J., concurring in part and dissenting in part) (“The woman’s constitutional liberty interest also involves her freedom to decide matters of the highest privacy and the most personal nature”)(citations omitted); *Id.* at 927-28 (Blackmun, J., concurring in part and dissenting in part) (“[W]hen the State restricts a woman’s right to terminate her pregnancy, it deprives a woman of the right to make her own decision about reproduction and family planning – critical life choices that this Court long has deemed central to the right to privacy”).

¹³⁴ *Id.* at 878.

¹³⁵ *Id.* at 846.

¹³⁶ *Id.* at 875-76 (recognizing a state’s interest in protecting the health and life

and before fetal viability (potential life of the fetus).¹³⁷ The authors of the joint opinion also weaken the woman's right. If their view prevails, the abortion right is no longer a fundamental right that can only be restricted to the extent necessary to a compelling state interest. Now the right must simply not be unduly burdened.¹³⁸ It is not even clear from the joint opinion whether the strength of the state's interest is relevant to determining whether a burden on the abortion right is undue.¹³⁹ Finally, at the practical level, the Court upheld one new restriction on the abortion right, a twenty-four hour waiting period (unless the wait would endanger the woman's life or health)¹⁴⁰ that specifically handicaps a woman's opportunity to make a decision and act on it, *i.e.*, her autonomy.

Thus, the Supreme Court's abortion decisions, far from representing the triumph of autonomy, demonstrate how far from wholehearted the commitment to autonomy is and how deep the concern for other values remains. Some concern for autonomy is present, although how important it is as opposed to the more practical concern of enabling women to lead lives freed from the adverse consequences of unwanted pregnancy and motherhood,¹⁴¹ is unclear.

of a pregnant woman); *id.* at 872 (“[t]hrough the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed”).

¹³⁷ *E.g.*, *id.* at 873, 876.

¹³⁸ *Id.* at 874 (“[o]nly where state regulation imposes an undue burden on a woman's ability to make [the decision whether to have an abortion] does the power of the state reach into the heart of the liberty protected by the Due Process Clause”) (citations omitted); *Id.* at 876 (“[i]n our view, the undue burden standard is the appropriate means of reconciling the State's interest with the woman's constitutionally protected liberty”).

¹³⁹ *Casey* does not talk about comparing the woman's interests to those of the state, but simply defines undue burdens as “substantial obstacle[s].” *Id.* at 877 (opinion of O'Connor, Kennedy, and Souter, JJ.)

¹⁴⁰ *Id.* at 885-86.

¹⁴¹ There is some discussion in *Roe* about the potential psychological and subsequent physical consequences of an unwanted pregnancy. *Roe*, 410 U.S. at 153. Blackmun's majority opinion merely disagrees that these consequences of unwanted pregnancy should make the abortion right absolute; instead, Blackmun cites the state interests in safeguarding health, in maintaining medical standards, and in potential life as justifying state regulation *at some point*. *Id.* Blackmun also questions whether the “unlimited” right asserted by some amici to do with one's body as one pleases has much relationship to the privacy right. *Id.* There is no statement of how much, or where, the concern for a woman's physical and psychological autonomy factors into the right to have an abortion, but what is clear is that if the state can regulate the abortion decision at *any* point, autonomy is not the overriding principle. Likewise, Justice O'Connor in *Casey* notes the grave consequences for mother, society, and child of unwanted pregnancy, and indeed defines the constitutional issue before the

Yet other values are present and served too. Of course, the Court recognizes and grapples with the value of the potential life of the fetus.¹⁴² It also continues to support the value of good medical care even when that value interferes with patient autonomy.¹⁴³

I have argued elsewhere that the profound value conflict in the area of abortion is one reason that the abortion issue is unsuitable for constitutional response.¹⁴⁴ Regardless of whether one accepts that argument, however, it is plain that the Supreme Court recognizes, as everyone must, that multiple values are at stake in the abortion controversy. One value cannot be allowed to triumph because the loss of other matters of great importance would be too great to accept. Autonomy is important in deciding about abortion, but it is not all there is. It would be bizarre if the Supreme Court or any other sensible legal body acted as if it were.

The same thing may be said about death facilitation, although the reasons to consider more than autonomy there are less clear than in abortion because of the absence of any equivalent of a fetus in the death facilitation cases.

Before 1976 the law, at least in theory, prohibited all forms of death facilitation – withholding and withdrawing life support as well as assisted suicide and euthanasia.¹⁴⁵ This was, of course, inconsistent with patient autonomy, and increasingly the prohibition has been challenged. In truth the prohibition was never as absolute as it appeared, and the move toward autonomy is not as successful either as it appears or as some would like. Once again too many values are at

Court in terms of a woman's liberty. *Casey*, 505 U.S. at 850, 852. Yet *Casey*, citing, among other things, *Roe*'s expressed state interest in protecting potential life, permits state regulation. *Id.* at 873-76. Essentially, what trumps the woman's autonomy interest is the autonomy interests of a potential life that, while perhaps capable of living outside of the woman, does not. *Id.* at 870-77.

¹⁴² *E.g.*, *Roe v. Wade*, 410 U.S. 113, 725-26; *Casey*, 505 U.S. at 870-71.

¹⁴³ For instance, *Roe* cites as examples of permissible regulations after the first trimester the qualifications of those who may perform an abortion, the licensure of those persons, and in what sort of facility abortions may be performed. *Roe* at 163.

¹⁴⁴ See *LIMITS*, *supra* note 49, at 52 (discussing the problems with a constitutional response to abortion).

¹⁴⁵ Terminological confusion about various forms of death facilitation is common. All forms of death facilitation could be called euthanasia, which simply means good death. I use the term, "euthanasia," however, only to refer to the well motivated affirmative act (commission) of a person other than the patient of killing the patient by some means other than simply removing life support. Assisted suicide means the act of a patient killing himself after another person has provided him with the means to do so. Withholding or withdrawing life support means just what it says. Death facilitation refers to all forms – euthanasia, assisted suicide, and withholding and withdrawing life support.

stake to allow one value (either autonomy or the pre-1976 commitment to the value of life) to prevail.

Before 1976 all forms of death facilitating behavior were crimes, often first degree murder.¹⁴⁶ Yet no health professional was ever convicted (and hardly any were ever prosecuted) for any form of death facilitating behavior¹⁴⁷ despite the fact that both empirical and anecdotal evidence demonstrate that death facilitating behavior by physicians was common.¹⁴⁸ The pre-1976 situation was an example of one form of legal compromise. Extreme law that ignored one set of values was on the books, but the law in action and the human beings who run the system respected other values as well and reduced the threat of the written law to almost nothing. Undoubtedly there was less death facilitation than some persons preferred, as a theoretical threat combined with most physicians' view of themselves as law abiding persons to prevent many acts of death facilitation. But there was more death facilitation than the written law or its supporters would have preferred. How close the compromise came to ideal in terms of the number of instances of death facilitation and the appropriateness of individual decisions one cannot say, but it is likely that it came closer than serious enforcement of the written law or free access to withholding and withdrawing medical care, assisted suicide, and euthanasia would come.

Serious reform began in 1976 with the famous case of Karen Ann Quinlan.¹⁴⁹ There a previously healthy young woman slipped into a coma from which she had no chance to emerge. Her father sought to be appointed her guardian for the purpose of having the respirator that kept Ms. Quinlan alive removed. The New Jersey Supreme Court decided that the principle that allows a woman to decide to terminate her pregnancy under some circumstances is broad enough to allow a person to decide to reject life-sustaining medical care in some

¹⁴⁶ See LIMITS, *supra* note 49, at 112 (citing the definition of first degree murder in WAYNE R. LAFAVE & AUSTIN W. SCOTT, JR., CRIMINAL LAW § 7.7, at 642-43 (2d ed. 1986)); Donald G. Collester, Jr. *Death, Dying, & the Law: A Prosecutorial View of the Quinlan Case*, 30 RUTGERS L. REV. 304, 309 (1977) (explaining that motive irrelevant if the intent and act of ending another's life are present). See also *In re Quinlan*, 355 A.2d 647, 669-70 (N.J. 1976) (determining that a death resulting from withdrawal of life sustaining procedures is not homicide, but rather allowing death from natural causes).

¹⁴⁷ LIMITS, *supra* note 49, at 113.

¹⁴⁸ See *id.* (citing Leonard H. Glantz, *Withholding and Withdrawing Treatment: The Role of the Criminal Law*, 15 LAW MED. & HEALTH CARE 231, 232 (1987/88)).

¹⁴⁹ *In re Quinlan*, 355 A.2d 647 (N.J. 1976) *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976).

instances.¹⁵⁰ Therefore, it decided that if Ms. Quinlan were competent, she could choose to have life support terminated.¹⁵¹ The court then held that an incompetent person has the same right with regard to withdrawal of life support as a competent person,¹⁵² and it adopted procedures and a substantive standard for allowing the incompetent Ms. Quinlan's right to be exercised on her behalf.¹⁵³

Later cases throughout the United States have similarly recognized a right to have life support withheld or withdrawn and have taken the position that both competent and incompetent persons have that right.¹⁵⁴ Courts have differed about the procedure for implementing the right for incompetent persons,¹⁵⁵ and about the substantive standard to be applied when deciding whether to do so.¹⁵⁶

¹⁵⁰ *Id.* at 663.

¹⁵¹ *Id.* at 663-64.

¹⁵² *Id.* at 664.

¹⁵³ *Id.* at 671.

¹⁵⁴ *E.g.*, *Saikewicz*, 370 N.E.2d at 417 (authorizing an incompetent cancer patient's guardian to refuse chemotherapy on the patient's behalf); *In re Spring*, 405 N.E.2d 115, 117-18 (Mass. 1980) (authorizing wife and son of a disoriented end-stage renal disease patient to terminate life-saving dialysis treatments for the patient, despite the fact that the patient had never expressed any desire to die or have treatment discontinued). *See also In re Guardianship of Browning*, 568 So. 2d 4 (Fla. 1990) (holding that an incompetent patient in persistent vegetative state may be taken off life-sentencing treatment pursuant to guardian's request and as indicated by patient's living will); *Mitchell ex rel. Rasmussen v. Fleming*, 741 P.2d 674, 686 (Ariz. 1987).

¹⁵⁵ *Compare, e.g.*, *Saikewicz*, 370 N.E.2d at 435 (requiring that decisions whether to withhold or withdraw life support be submitted to the probate court for adjudication) and *In re Spring*, 405 N.E.2d at 120-21 (Mass. 1980) ("clarifying" *Saikewicz* by setting out factors for determining whether a hearing is necessary) with a string of New Jersey cases declaring different procedures for different scenarios, including *In re Conroy*, 486 A.2d 1209 (N.J. 1985) (adopting procedures for removal or withholding of life support from elderly, once-competent, nursing home patients with about one year to live); *In re Peter* 529 A.2d 419, 425, 429 (N.J. 1987) (holding that for patient's in a "persistent vegetative state" whose wishes are unclear, a guardian can refuse life-sustaining treatment for the patient only after certain safeguards have been met); *In re Jobes*, 529 A.2d 434 (N.J. 1987) (adopting a different set of procedures for incompetent, non-elderly patients who are not in a nursing home).

¹⁵⁶ Two major competing standards have been offered for deciding whether to withhold or withdraw life support. First is an objective standard that attempts to determine the best interests of the patient. The second, and more subjective standard, is a substituted-judgment approach, under which a substitute decision-maker is supposed to make the same decision for the incompetent patient that the patient would make for himself. For a more complete discussion of the two standards, see *LIMITS*, *supra* note 49, at 118-21. *See also Washington v. Glucksberg*, 521 U.S. 702 (1997) (holding prohibitions against assisted suicide do not offend the Constitution); *Vacco v. Quill*, 521 U.S. 793 (1997) (noting the differences between the right of competent

Every state legislature has enacted one or more statutes to permit terminally ill persons to have life support withheld or withdrawn.¹⁵⁷ However, only Oregon has gone farther and authorized physician assisted suicide in some circumstances,¹⁵⁸ and no state allows euthanasia.

The United States Supreme Court has considered death facilitation twice. In 1990 the Court decided *Cruzan v. Director, Missouri Department of Health*.¹⁵⁹ In that case the parents of a young woman in a persistent vegetative state sought permission to end the artificial feedings that were keeping their daughter alive. The Missouri Supreme Court had denied that permission, holding that life support could only be withdrawn from a previously competent patient if there was clear and convincing evidence that the patient would have wanted the support withdrawn, and holding that the evidence in Ms. Cruzan's case was not clear and convincing.¹⁶⁰ The United States Supreme Court affirmed.

The Court stated that its prior decisions supported an inference that competent persons have a constitutionally protected interest in refusing treatment.¹⁶¹ The Court then *assumed* (because given their decision it made no difference) that the Constitution grants competent persons the right to reject nutrition and hydration.¹⁶² Even if it does, however, the state has two interests that may override the right – the interest in preserving life¹⁶³ and the interest in safeguarding the personal element of choice.¹⁶⁴ The Court held that the clear and convincing evidence standard serves both ends when it is applied to the case of a person who, at the time of decision making, is incompetent to make her own choice.¹⁶⁵

More recently in *Washington v. Glucksberg*¹⁶⁶ and *Vacco v. Quill*,¹⁶⁷ decided on the same day, the Supreme Court has considered

persons to refuse life sustaining treatment and that of assisted suicide); *Saikewicz*, 370 N.E.2d at 431 (explaining “substituted judgment” as a commendable standard).

¹⁵⁷ See LIMITS, *supra* note 49, at 126-31 (discussing the variety of legislative approaches to the right-to-die issue).

¹⁵⁸ The Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800-127.897 (2000).

¹⁵⁹ *Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261 (1990).

¹⁶⁰ *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988).

¹⁶¹ *Cruzan*, 497 U.S. at 278.

¹⁶² *Id.* at 279.

¹⁶³ *Id.* at 280.

¹⁶⁴ *Id.* at 281-83.

¹⁶⁵ *Id.* at 282.

¹⁶⁶ *Washington v. Glucksberg*, 521 U.S. 702 (1997).

¹⁶⁷ *Vacco*, 521 U.S. at 793.

whether the Constitution includes a right to commit suicide and to assistance in doing so. The Court held that it does not. In reaching this conclusion the Court explicitly rejected the claim that the Constitution protects a general right of personal autonomy.¹⁶⁸ Indeed, the Court refused to root its decision in any principle at all. Instead, it simply distinguished assisted suicide from withholding and withdrawing care, by treating the withholding and withdrawing cases as involving rejecting or refusing to consent to medical care, and noting that as a matter of history and tradition the United States has long accepted the idea that a person has a right to decide whether to consent to medical care, but has not accepted a right to assisted suicide.¹⁶⁹ The Court also made plain its intent to reject any claim that the Constitution protects a right to euthanasia by saying that one reason not to permit assisted suicide was to avoid starting down the path to euthanasia.¹⁷⁰ Thus, in the death and dying area, as elsewhere, it is plain that patient autonomy is not the primary value being served by American medical law no matter how many autonomy statements one can find in the cases and no matter how many bioethicists would like to believe that it is.

C. The Trouble with Autonomy

Patient autonomy is the dominant rhetorical, but not the dominant real value being served by American medical law. The largely rhetorical triumph of autonomy leaves the law in a very unattractive condition in which patients' needs are often ignored, patients are susceptible to abuse, and important needs of other persons are either ignored or are recognized in a sporadic, arbitrary fashion.

II. IGNORING PATIENTS' NEEDS

Patients consult doctors and other health professionals because they need or want their professional expertise. Unless a patient is a physician, the patient's doctor will know more about diagnosing and treating the patient's condition than the patient will. Moreover, even if the patient is a physician, the doctor will be better able to evaluate the patient's condition than the patient will because the doctor will not be emotionally involved. It is the patient, not the doctor who is

¹⁶⁸ *Washington*, 521 U.S. at 723-28.

¹⁶⁹ *See Vacco*, 521 U.S. at 800-07 (discussing the distinction between refusing medical treatment and assisted suicide).

¹⁷⁰ *Washington*, 521 U.S. at 723-28; *Vacco*, 521 U.S. at 809 (noting that by prohibiting assisted suicide, the important public interest against euthanasia will be upheld).

frightened and/or suffering. Medical care can and should be committed and compassionate, but in order to provide the best (i.e., most likely to be successful) treatment for the patient, it must also be dispassionate in order to maximize the likelihood of clear thinking and minimize mistakes born of fear, pain, or other distress. Patients need dispassionate experts to deal with their medical conditions. If doctors do not serve that function, who will?

The doctor is not, however, an expert in non-medical matters. The goal of the system should be to enable patients to get maximum medical professional benefit from their doctors without being burdened by the doctor's non-expert preferences.

The focus on patient autonomy prevents patients from getting maximum medical professional benefit from their physicians. Perhaps that would not be the case if autonomy were properly understood, but as the concept has been translated from philosophy to law and from law to the workaday understanding of physicians, it has become a device for depriving patients of some of the benefits they pay professionals for.

In law autonomy means either liberal individualism or physical essentialism.¹⁷¹ Liberal individualism in this context means the right of a patient to make his own decisions about important personal matters and to effectuate those decisions (or have them effectuated). Properly understood this would mean that the patient is entitled to all the information relevant to the decision, including information the patient does not know he wants or needs. To exercise autonomy the patient would have to be fully informed and counseled about what decision to make. Mill himself recognized and explicitly argued that freedom to make choices does not mean that one should act in a vacuum.¹⁷² Other persons should remonstrate with a person, argue with him, and attempt to get him to do the right thing. Being autonomous does not mean being let alone.

In practice, of course, it is not possible to give a patient all information. The law of informed consent instead requires that the patient be given either all material information¹⁷³ or whatever

¹⁷¹ *Medical Law and Ethics*, *supra* note 10, at 733-36.

¹⁷² See JOHN STUART MILL, ON LIBERTY 91-3 (Curran V. Shields ed., The Liberal Arts Press, Inc. 1956) (1859) (discussing the concept that while individuals should have freedom to make choices, they must also accept the consequences).

¹⁷³ E.g., *Arato v. Avedon*, 858 P.2d 598 (Cal. 1993) (holding a physician has a duty to disclose all rational information to a patient); *Cobbs v. Grant*, 502 P.2d 1, 11 (Cal. 1972) (stating that doctors must provide all material information); *Canterbury v. Spence*, 464 F.2d 772, 786-87 (D.C. Circ. 1972) (describing the standard as objective in helping the patient be informed and allowing the physician to make the judgment

information a reasonable doctor would provide.¹⁷⁴ Thus, the standard of information disclosure does not foster patient autonomy for perfectly understandable practical reasons. Yet doctors are taught by ethicists that autonomy is the dominant value, and they see that failure to do what the law requires can lead to liability. Therefore, they do two things: First they treat informed consent as a legal hurdle to be leaped rather than an opportunity to communicate with their patients. This is reflected in the use of the word, "consent" as a transitive verb: "Who is going to consent the patient?" Whoever "consents" the patient will not be practicing the furtherance of patient autonomy.¹⁷⁵ Second doctors refuse to remonstrate with their patients. Patients are free to do whatever they want. Moreover, doctors have been taught that only the patient knows his own condition, what is important to him, etc. Therefore, they abandon their patients to make the most awesome choices guided by fear, misunderstanding, and whatever anecdotes the patient has heard from his Uncle Fred or the health segment on the local 11:00 news. This is autonomy?

Autonomy becomes almost a caricature of itself in the field of genetic counseling.¹⁷⁶ There, autonomy leads to the practice of nondirective counseling, telling patients the facts and explaining their options, but doing no counseling at all, steadfastly refusing in the name of ethics to give the patient any advice or even the professional's own opinion.¹⁷⁷ I have discussed elsewhere the impossibility of genetic counseling being truly nondirective and my observation that, like autonomy in general, nondirectiveness is often

of what amount of information would allow for informed consent).

¹⁷⁴ *E.g.*, *Hook v. Rothstein*, 316 S.E.2d 690 (S.C. Ct. App. 1984), *cert. denied* 320 S.E.2d 35 (S.C. 1984) (adopting the professional standard when dealing with the duty on the part of the physician to inform the patient of inherent risks of the proposed medical procedure).

¹⁷⁵ *See Morris*, *supra* note 7, at 315, referring to the right to patient self-determination as "empty rhetoric," quoting Alexander Capron describing informed consent as "a charade, a symbolic but contentless formality." *Id.* at 316 (quoting Alexander Morgan Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 367 (1974-75), and citing other authors to the same effect, *Morris* at 316, note 16).

¹⁷⁶ *See The Human Genome Project*, *supra* note 5, at 118-19 (explaining that because genetic health questions affect more than just the "target" person, true autonomy is not practical); *see generally* DAVID H. SMITH ET AL., *EARLY WARNING: CASES AND ETHICAL GUIDANCE FOR PRESYMPTOMATIC TESTING IN GENETIC DISEASES* (1998) [hereinafter *EARLY WARNING*]; CHARLES L. BOSK, *ALL GOD'S MISTAKES: GENETIC COUNSELING IN A PEDIATRIC HOSPITAL* (1992).

¹⁷⁷ *See LIMITS*, *supra* note 49, at 98-99 (discussing the difficult position in which genetic counselors are placed, with little assistance from the law).

honored in the breach.¹⁷⁸ However, to the extent that professionals do practice or try to practice nondirective counseling they deprive their patients of the very thing the patients came to them for – their professional expertise.

While liberal individualism seems to be the dominant understanding of autonomy in medicine, some judges also talk in physical essentialist terms. Physical essentialism means that one's body is the essence of oneself. Autonomy means having one's body let alone. In *Planned Parenthood v. Casey* the joint opinion and the opinions of Justice Stevens and of Justice Blackmun all spoke of the importance of private control of one's body as well as the importance of freedom to make important, intimate decisions for oneself.¹⁷⁹ This is a bit confusing because it makes it difficult to perceive exactly what notion of autonomy these five justices are applying. In truth, they must be applying liberal individualism. After all, abortion of a competent woman is not about protecting her from having someone invade her body. It is about her freedom to choose to have someone make just such an invasion.

Moreover, if a patient is competent, physical essentialism either makes no sense or it is inextricably tied to liberal individualism. Only if a patient is incompetent, can physical essentialism be a value apart from liberal individualism. In those cases it is a value whose pursuit may or may not help the patient.

If a patient is competent, it is senseless to say that there is an independent value of bodily integrity (physical essentialism) apart from freedom of choice (liberal individualism). If there were, it would mean that a patient could not choose to have his bodily integrity invaded, for example, by undergoing surgery, even for his own good.¹⁸⁰ Therefore, in cases involving competent patients talk about bodily integrity reduces to a concern for freedom of choice. A doctor may not invade a patient's body without the patient's consent. Of course, to be meaningful consent has to be voluntary and informed. Therefore, we are back to serving the value of free choice with all the problems discussed above.

¹⁷⁸ *The Human Genome Project*, *supra* note 5, at 118-19.

¹⁷⁹ *Planned Parenthood v. Casey*, 505 U.S. 833, 846-51, 915, 926-28 (1992). See *supra* notes 132-33 for quotations.

¹⁸⁰ In extreme cases physical essentialism may be relevant apart from liberal individualism. For example, if the law were to prohibit self mutilation or plastic surgery, that would protect the body from even the freely choosing patient. In that case physical essentialism autonomy would be purchased at the cost of liberal individualism autonomy.

If a patient is incompetent, however, bodily integrity may be an important value to consider and may be a more realistic focus of concern for autonomy than liberal individualism. However, serving the value may actually harm the patient. A wonderful example of the conflict between liberal individualism and physical essentialism involving an incompetent patient is the case of *Conservatorship of Valerie N.*¹⁸¹

Valerie N. was a mentally incompetent young California woman who was sexually aggressive toward men. Her parents, acting on medical advice, sought to have her sterilized, but they were stymied because a California statute prohibited sterilizing mentally incompetent persons.¹⁸² The parents challenged the constitutionality of the statute. The California Supreme Court held the statute unconstitutional. The majority applied liberal individualist reasoning in this case of an incompetent patient, where such reasoning makes little sense. Recognizing that Valerie could not choose for herself whether to be sterilized, the majority considered the issue to be whether Valerie had a constitutional right to have someone else make the decision for her.¹⁸³ They concluded that she did in order to serve her important interest in developing to her fullest potential.¹⁸⁴ At a level of practicality (*i.e.*, not theory or constitutional law) this seems right. As long as sufficient safeguards are in place to assure that only persons who will truly benefit from sterilization are sterilized, sterilization makes sense. For a person like Valerie it maximizes her chance to live outside of an institution, to perform a job within her capabilities, to enjoy sexual relations, and to go about life generally unsupervised. None of this has anything to do with her freedom to choose to be sterilized. It simply shows the court's respect for Valerie as a human being by doing what is best for her in all ways, including maximizing her opportunity to exercise as much autonomy as she is capable of exercising.

Chief Justice Bird dissented.¹⁸⁵ She thought it made no sense to focus on choice in a case about a person who could not choose¹⁸⁶ and in a case about whether to remove that person's ability to conceive, noting that unlike terminating a pregnancy, conceiving need not involve a choice.¹⁸⁷ Chief Justice Bird focused instead on the right to

¹⁸¹ 707 P.2d 760 (Cal. 1985).

¹⁸² CAL. PROB. CODE § 2356(d) (West 2002).

¹⁸³ *Valerie N.*, 707 P.2d at 771.

¹⁸⁴ *Id.* at 772.

¹⁸⁵ *Id.* at 781.

¹⁸⁶ *Id.* at 788.

¹⁸⁷ *Id.* at 784-85.

procreate,¹⁸⁸ a right, she said, unrelated to choice.¹⁸⁹ Procreation is a “primal” right,¹⁹⁰ part of the “constitution”¹⁹¹ of a human being. While the state has important interests in protecting Valerie’s well-being, the state had not shown that protecting those interests required Valerie’s sterilization.¹⁹² Therefore, it could not allow her to be deprived of her right to procreate,¹⁹³ a right that is, if you will, part of her physical essence.

At the level of analysis Chief Justice Bird’s approach has much to recommend it. It avoids the necessity of fiction and dealing with a case about a person who cannot make the choice involved as if she could. In practical terms, however, Bird’s opinion is cruel. She would deny Valerie sterilization, thus dooming her to a life of supervision and restriction, much of it directed at assuring that Valerie would never be able to exercise the primal right that Chief Justice Bird would preserve for her.

What *Valerie N.* demonstrates is the inadequacy of a jurisprudence based on autonomy. The majority does the right thing for Valerie by torturing the concept of liberal individualism and resorting to fiction. The dissent avoids fiction and silliness and sacrifices Valerie’s well-being for Chief Justice Bird’s ideals. How much better it would have been to simply ask what Valerie’s condition was and what would be best for her, and then to do it. Alternatively, one might simply have yielded to the will of the legislature. Neither approach would have required discussion of free choice or the primal physical ability to procreate.

Autonomy, thus often ignores patients needs. This may suggest that the hard won defeat of medical paternalism is a Pyhrric victory.

III. ABUSING PATIENTS

The victory may be Pyhrric in more ways than one. A commitment to the rhetoric of autonomy not only ignores patient needs, it also provides a convenient opportunity to abuse incompetent patients in the name of doing what they would have chosen to have done for themselves.

¹⁸⁸ *Id.* at 784, citing *Skinner v. Oklahoma*, 316 U.S. 535, 536 (1942) (recognizing the “right to have offspring”).

¹⁸⁹ *Id.* at 785.

¹⁹⁰ *Id.*

¹⁹¹ *Id.* at 786.

¹⁹² *Id.* at 787.

¹⁹³ *Id.* at 787-88.

Of course, it need not be this way. One could simply say that autonomy means freedom of choice, and that it is inapplicable in cases involving persons who lack the ability to freely choose. Courts have been reluctant to do that, however. Autonomy has taken on such a mythic force that courts often try to apply it to cases in which patient autonomy cannot scientifically exist, as the majority did in *Valerie N.*

This tendency is exacerbated by an unthinking commitment to equality. In every case about whether to facilitate the death of an incompetent person decided before *Cruzan*, courts decided what the rights of a competent person would be and then said that the rights of incompetent persons must be the same as the rights of competent persons in order to avoid demeaning incompetent persons.¹⁹⁴ Thus, if competent persons are allowed autonomously to choose to have their deaths facilitated, incompetent persons must have the same right. Not only does this make no sense, perversely it also demeans persons with disabilities. For a person with a major disability, the disability may be the defining feature of his or her life. For those who care about individualism, the disability may be the most individual thing about the person. To insist that the person be treated like a person without a disability is to force the person to be accommodated to the majority's status, ignoring individualism in the name of forced conformity. To do that in the name of autonomy is ironic indeed.

The irony can have practical and devastating consequences. Take the case of Earl Spring.¹⁹⁵ Mr. Spring was a formerly competent elderly man who had never expressed an opinion about whether there were circumstances in which he would prefer to die than to continue to live. Mr. Spring had a wife of many years standing and an adult son. He also had two serious medical conditions, renal failure and chronic organic brain syndrome. The renal failure required Mr. Spring to receive hemodialysis three times a week at a dialysis center far from his home. Without the dialysis he would die. His wife transported him to the dialysis center and back. Mr. Spring's chronic organic brain syndrome made him difficult to be around. He cursed at and kicked his nurses, pulled out his dialysis tubing, and was generally unpleasant. Mrs. Spring suffered a stroke, which her son attributed to the strain of caring for her husband.

Mrs. Spring and her son petitioned a Massachusetts court for permission to stop Mr. Spring's dialysis treatments. They stated that Mr. Spring had been a vigorous man who surely would not want to

¹⁹⁴ See, e.g., *supra* notes 152, 154; see generally LIMITS, *supra* note 49, at 114-46 (discussing judicial reform of the right to die).

¹⁹⁵ *In re Spring*, 405 N.E.2d 115 (Mass. 1980).

live as he was.¹⁹⁶ The Supreme Judicial Court of Massachusetts reaffirmed a competent person's right to choose to have life prolonging treatment withdrawn.¹⁹⁷ It then applied a substituted judgment test to decide that Mr. Spring himself would choose to die if he could.¹⁹⁸ Therefore, in order to foster Mr. Spring's autonomy, the court authorized the wife and son to stop the dialysis treatments.¹⁹⁹ To put it simply, the court allowed a man who was unpleasant and a nuisance to be killed, and it did so in the name of serving his autonomy. It is a lot more comfortable to believe one is doing something noble, like respecting another person's autonomy, than to confront the stark question of whether old, annoying, dependent people should be killed. That comfort is horribly dangerous. No court would say that it is acceptable to kill the old, annoying, and dependent. We must not let courts achieve the same result in the name of patient autonomy.

IV. THE NEEDS OF OTHERS

The underlying premise of the autonomy focus is that one person is primarily affected by medical decisions, that it is possible to identify that person, and that his or her interests are so much more important than anybody (or everybody) else's that they must dominate completely, so that consideration of other person's interests is illegitimate. The dominant person is the patient. In the words of a popular play and television drama, "Whose Life Is It Anyway?"²⁰⁰ When other people's interests are considered, they are either considered surreptitiously as Mrs. Spring's interests apparently were,²⁰¹ or they are considered as possible candidates for creating an exception to the focus on the patient.²⁰²

In fact, while it is often easy to identify who the patient or the most affected person is, that is not always the case. Two obvious

¹⁹⁶ Yale Kamisar once noted in my presence that almost everybody was once vigorous. The wife's and son's argument if taken seriously would provide a basis for "allowing" almost everyone who has become incompetent to die.

¹⁹⁷ 405 N.E.2d at 119.

¹⁹⁸ *Id.* at 122-23.

¹⁹⁹ *Id.*

²⁰⁰ BRIAN CLARK, WHOSE LIFE IS IT ANYWAY? (Dodd, Mead & Company 1978) (1972).

²⁰¹ See 405 N.E.2d at 122 n. 3 (noting that the wife's opinion may have been compromised by financial considerations, but excusing it by implying that the patient's own opinion, if he were competent, might also have been skewed by financial considerations).

²⁰² *E.g.*, *Saikewicz*, 370 N.E.2d at 424-27 (discussing State and third-party interests that may trigger the exception to patient focus).

contexts in which it is difficult to identify the most affected person are genetic medicine and vaccinations for some communicable diseases.

Genetic medicine is family medicine. The *raison d'être* for most forms of genetic medical practice is to enable members of families to deal with diseases that run in families. When a married couple seeks genetic counseling to learn the carrier status of either the husband or the wife; or when that couple seeks prenatal diagnosis of their fetus; or when parents seek a diagnosis of their child's genetic condition, who is the patient? Whose autonomy is to be respected? If the couple is concerned about the possibility of transmitting an autosomal recessive disease, then each member of the couple needs to know the carrier status of both. Otherwise, neither will be able to make intelligent reproductive decisions. If the question is whether the husband is a carrier of the mutation for an autosomal dominant disease, the wife cannot make an informed decision about whether to conceive or bear a child unless she knows her husband's genetic condition. If prenatal diagnosis is involved, the genetic status of the wife, the husband, and the fetus are all relevant. The wife's status is important because she is pregnant and because she may learn about her own genetic condition from the diagnosis of the fetus. The husband's condition is relevant because he may learn about his condition from diagnosis of the fetus and because as father of the fetus he has some stake in the outcome of the pregnancy. The fetus itself obviously is important, especially if it is past the age of viability so that its interests enjoy some legal protection. If parents bring their child for diagnosis or treatment, all the usual ambiguities that attend the doctor-patient relationship when the patient is a child are exacerbated by the fact that the child's diagnosis reveals information about the parents.

Similarly, it is sometimes difficult to know who the person most affected by a vaccination decision is. For example, rubella is a benign disease with symptoms similar to those of a common cold. However, if a pregnant woman contracts rubella, its effects on her fetus will be devastating. Who is the person most affected by decisions – including governmental decisions about mandatory vaccination programs – about whether to vaccinate little boys for rubella? If the focus were on the little boy's well-being or his parents' autonomy, vaccination would seem a poor idea. It costs something, exposes the child to a very small risk (as every needle puncture does), and gives him an unwanted needle stick all to avoid the possibility of getting something like a cold. Obviously, few little boys or their parents would make this choice. If however, the primary "person" involved is the unborn child of the little boy's mother, baby sitter, school teacher, or day care worker, the calculus looks very different. We vaccinate boys against

rubella because we know that just asking whose body is involved is too simplistic a way to make health care decisions.

Even when it is possible to identify the person who is most involved in a medical decision, that does not mean that person is the only person involved. It does not follow from one person's primary involvement, that other involved persons are to be ignored. Examples abound.

Family members and other persons who may come into contact with a person with a communicable disease obviously have interests worth considering as old quarantine laws²⁰³ and modern decisions about duties to warn²⁰⁴ recognize. Many family members and potential family members have interests in learning about genetic diseases in the family. For example, a person whose parent, grandparent, sibling, or more distant relative has familial adenomatous polyposis of the colon (FAP), a dominant disease that causes some cases of colon cancer, has a strong interest in learning that the disease runs in the family.²⁰⁵ Persons who know they are at risk can be

²⁰³ E.g., GEN. LAWS OF CAL., ACT 6238, §§ 12-17 (Deering 1937); CONSOLIDATED LAWS OF N.Y. ANN, PUBLIC HEALTH LAW §§ 101-145 (Birdseye, Cumming, & Gilbert 1918).

²⁰⁴ See Michelle R. King, *Physician Duty to Warn a Patient's Offspring of Hereditary Genetic Defects: Balancing the Patient's Right to Confidentiality Against the Family Member's Right to Know – Can or Should Tarasoff Apply*, 4 QUINNIPIAC HEALTH L.J. 1, 14-15 (2000-01) (applying the duty to warn to contagious diseases in recent court decisions) (citing *Bolicu v. Sisters of Providence*, 953 P.2d 1233, 1241 (Alaska 1998) as holding "health care facility owed a duty to spouses of nursing assistants to warn them of the risks of exposure to staph infection"); *DiMarco v. Lynch Homes-Chester County, Inc.*, 583 A.2d 422, 424 (Pa. 1990) (finding a duty to warn anyone who may be physically intimate with a patient who had hepatitis B)). Debate still rages in courts about the duty to warn when there is a risk of HIV transmission. Compare *Reisner v. Regents of Univ. of Cal.*, 37 Cal Rptr. 2d 518 (1995) (holding that a duty to warn considers the foreseeability of the potential victim, not simply whether the victim is "readily identifiable", but physician's duty will be discharged by warning the patient of the risks associated with the disease, as well as by giving advice about how to prevent the spread of disease) with *N.O.L. v. District of Columbia*, 674 A.2d 498 (D.C. 1995) (holding that there is no duty to warn plaintiff of his wife's HIV status). For a more complete discussion of the HIV, see King, *supra*, at 16-22.

²⁰⁵ King, *supra* note 204, at 22-37. See EARLY WARNING, *supra* note 176, at 15, 84-86. Common law is still developing its duty to warn doctrine in the genetics context: compare *Pate v. Threlkel*, 661 So.2d 278 (Fla. 1995) (holding that physician had a duty to patient's children to warn *patient* that a genetically heritable disease existed and that patient's children should be tested; physician's duty is discharged by warning the patient) with *Safer v. Estate of Pack*, 677 A.2d 1188, 1192 (N.J. Super. Ct. App. Div. 1996) (finding a duty to warn of heritable genetic disease and that the duty is satisfied when reasonable steps are taken to assure that the information reaches those likely to be affected or is made available for their benefit). Some legislatures

screened and avoid the ravages of the disease. Without the knowledge, they are less likely to seek screening, especially at a relatively early age.

Medical resources are limited, some are scarce. Whenever a decision is made to expend a scarce resource by using it for one person, every other competitor for the resource is affected by the decision. Obvious examples include shortages of beds in intensive care units and the serious shortage of transplantable organs. This problem has long been recognized. Thirty years ago, when chronic renal dialysis became possible, grand social experiments were designed and implemented to attempt to allocate scarce dialysis machines fairly.²⁰⁶ The efforts failed,²⁰⁷ and the problem was eventually solved by making enough resources available so that the shortage was corrected,²⁰⁸ but nobody doubted then or now that more than just the interests of the patient who happened to show up first for dialysis had to be considered.

Another setting in which somebody's interests in addition to the patient's have to be considered is the situation in which the patient poses a danger to others, not by exposing them to disease, but by the patient's conduct. The most frequently discussed example is the situation typified by the *Tarasoff*²⁰⁹ case in which a psychotherapist's patient told the psychotherapist that he planned to kill his girlfriend. In a decision that has been widely followed²¹⁰ the California Supreme Court imposed an obligation on the psychotherapist to make a

have taken it upon themselves to enact statutes specifically protecting the confidentiality of genetic information. *E.g.*, CAL. CIV. CODE § 56.17 (West 2003).

²⁰⁶ See generally RENEE C. FOX & JUDITH P. SWAZEY, *THE COURAGE TO FAIL: A SOCIAL VIEW OF ORGAN TRANSPLANTS AND DIALYSIS* 215-315 (2d ed. 1978) (noting inherent difficulties, especially with selection criteria, when short supply treatments are available).

²⁰⁷ *Id.*

²⁰⁸ *Id.*

²⁰⁹ *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334 (Cal. 1976).

²¹⁰ *E.g.*, *Emerich v. Philadelphia Ctr. for Human Dev.*, 720 A.2d 1032 (Pa. 1998) *rearg. denied* (Jan. 13, 1999); *Limon v. Gonzaba*, 940 S.W.2d 236 (Tex. App. 1997); *Almonte v. New York Med. College*, 851 F. Supp. 34 (D. Conn. 1994) (including duty to warn a class of victims). Additionally, the majority in *Currie v. United States*, 644 F. Supp. 1074, 1078 (M.D.N.C. 1986), not only applied *Tarasoff* to North Carolina, but also noted that "the vast majority of courts that have considered the issue have accepted the *Tarasoff* analysis." *Currie* at 1078. As of March 2003, there were 571 combined state and federal cases citing *Tarasoff*. See Keycite References for 551 P.2d 334: limited to cases, at www.westlaw.com (last visited Mar. 12, 2003). Although many of the cases listed are within California, 532 of the total number of citing cases treated *Tarasoff* positively. *Id.*

reasonable effort to warn the intended victim.²¹¹ Similarly, a few cases have held doctors liable for failing to take reasonable steps to protect motorists from bad driving caused by the doctor's prescription of a drug to his or her patient.²¹² My colleagues and I have discussed the case of a commercial airline pilot who has been diagnosed as carrying the mutation that will lead to Huntington's Disease.²¹³ Can anyone believe that the fate of the pilot's passengers is irrelevant to deciding what the physician's obligations are?

The exclusive, fiduciary nature of the doctor-patient relationship exacerbates the problem of ignoring the interests of relevant others or of deciding how to advert to them. This is especially unfortunate, given that who the patient is often is a matter of luck that turns on who got to the doctor first, rather than on desert, and the obvious possibility that a doctor may owe duties to more than one patient.

V. CHANGING FOCUS

The autonomy focus and the exclusive, fiduciary nature of the doctor-patient relationship fail to deliver on their promise of patient-centered decision making and freedom of patient choice while depriving patients of some of the benefits professionals can offer, exposing some patients to abuse, and undervaluing the interests of

²¹¹ *Tarasoff*, 551 P.2d at 346. The *Tarasoff* court proclaimed that although there was generally no duty to "control the conduct of another" or to "warn those endangered by such conduct," there was an exception when the person who knew of the threat had a special relationship with either the potential perpetrator of the harm or the foreseeable victim. *Id.* at 343. The court arrived at a duty to warn through reasoning that "by entering into a doctor-patient relationship the therapist becomes sufficiently involved to assume some responsibility for the safety, not only of the patient himself, but also of any third person whom the doctor knows to be threatened by the patient." *Id.* at 344. *Tarasoff* was revisited and subsequently narrowed in *Thompson v. County of Alameda*, 614 P.2d 728 (Cal. 1980), where the Supreme Court of California found no duty to warn about "nonspecific threats of harm at nonspecific victims", but rather to victims that are "readily identifiable." *Id.* at 734.

²¹² See, e.g., *Wilschinsky v. Medina*, 775 P.2d 713 (N.M. 1989) (holding that a doctor owes a duty to third parties from treatment of an outpatient when the doctor has given the patient an injection of drugs that could clearly impair the patient's ability to reason and to operate an automobile). *But cf.* *Lester ex rel. Mavrogenis v. Hall*, 970 P.2d 590, 591, 598 (N.M. 1998) (declining to extend the *Wilschinsky* holding to a scenario where the plaintiff was injured by defendant physician's patient when the defendant had prescribed medication that allegedly caused the accident five days prior to the accident). See also, e.g., *Welke v. Kuzilla*, 375 N.W.2d 403 (Mich. App. 1985) (holding that physician does have a duty to protect innocent third parties on the road when the physician determines or should determine that his patient poses serious threat of danger to a third party).

²¹³ EARLY WARNING, *supra* note 176, at 62-67.

persons who have important stakes in the patient's medical condition and treatment. Correcting these problems without returning to unbridled medical paternalism or giving doctors authority that exceeds their expertise requires rethinking the commitment to autonomy and traditional notions of the doctor-patient relationship. Much can be accomplished by changing the doctor's obligation from one of acting with exclusive loyalty to the patient and fostering patient autonomy to one of acting with respect to all significantly affected individuals.²¹⁴ The critical changes of focus are from autonomy to respect and from the patient to all significantly affected individuals.

Under this approach the doctor's obligation is to act with respect. Commentators often treat respect as synonymous with commitment to autonomy.²¹⁵ Under this conception of respect, we respect a person most when we do the least for him; the way to respect a person is to abandon him in his hour of need.²¹⁶ Thus, a doctor shows a person respect when he or she refuses to tell the patient what the doctor would do in the patient's situation or allows the patient to make a short-sighted or even stupid decision about accepting or rejecting treatment or about choosing between treatment alternatives without attempting to dissuade him. This is a very impoverished notion of respect.

A better conception of respect would be rooted in the idea that we are all members of the human community and that we owe each other obligations of mutuality and concern. This is hardly a radical idea. It is, in essence, the golden rule. Under this view saying that the doctor's job is to act with respect toward the patient means that the doctor's job is to do what is best for the patient within the limits of the doctor's expertise, valuing *all* the patient's interests, including the patient's interest in autonomy. Granting heavy, but not dispositive weight to autonomy is what distinguishes this part of the suggested approach from mere paternalism.

Under this conception of respect the doctor's role (in addition to performing medical tasks competently) is to give advice to try to steer the patient to the best decision. When the patient asks what he should do or what the doctor would do if he were in the patient's situation, the doctor should tell the patient. The doctor should, when necessary, argue with the patient to try to convince the patient to do the right

²¹⁴ For a discussion of the term "respect", see Sarah Buss, *Appearing Respectful: The Moral Significance of Manners*, 109 *ETHICS* 795 (1999).

²¹⁵ See generally, e.g., *id.* at 797 (citing Immanuel Kant, *The Metaphysics of Morals, Part II*, in *ETHICAL PHILOSOPHY* 127 (James W. Ellington trans., 1983)).

²¹⁶ See Buss, *supra* note 214, at 817-26 (defining "respect").

thing. Ultimately, however, the patient must remain free to reject the doctor's advice.

This view of respect is similar to Mill's view of autonomy, which, as noted before, imposes an obligation on others to attempt to *get* a person to do the right thing, even while denying those others the authority to *require* the person to do the right thing.²¹⁷ Adopting this approach will increase the benefit that individual patients receive from their physicians. It will retain at least as much autonomy as patients now enjoy while reducing patients' sense of abandonment and decision making inadequacy, and it should improve the quality of medical decisions that are made.

However, focusing on respect for the patient alone will not solve the other problems with the autonomy focus and the exclusive, fiduciary doctor-patient relationship. In order to provide adequate attention to the needs of others, the doctor's obligation to act with respect should be extended to all significantly affected individuals. This means that doctors should be obligated to consider the interests of reasonably identifiable other persons who may be significantly affected by the patient's health and the doctor's treatment of it. Taking this position will impose a number of specific duties on doctors.

First, doctors should routinely breach confidence to warn of contagious diseases, genetic diseases and other dangers. As we have seen, a few examples of this obligation already exist, as for example in the case of a psychotherapist with a homicidal patient.²¹⁸ I suggest that rather than being an exception to a presumed rule of confidentiality, the obligation to make reasonable efforts to warn should be clearly established as one of a doctor's routine obligations.

Three obvious objections to such a rule exist. One might think that imposing an obligation to make a reasonable effort to warn will reduce the quality of patient care, will injure patients, and/or will impose an excessive burden on doctors. None of these concerns is meritorious.

When *Tarasoff* was decided critics feared that it would reduce both the quantity and quality of psychiatric care.²¹⁹ Some potential

²¹⁷ See MILL, *supra* note 172, at 93 (observing that people may offer, but not force, their opinions on others).

²¹⁸ See *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 346 (Cal. 1976) (stating that entering into the doctor-patient relationship is sufficient to assume responsibility for the safety of the patient or third persons whom the doctor knows to be threatened by the patient).

²¹⁹ See, e.g., Vanessa Merton, *Confidentiality and the "Dangerous" Patient: Implications of Tarasoff for Psychiatrists and Lawyers*, 31 EMORY L.J. 263 (1982).

patients would refrain from consulting psychiatrists if they knew that some of their confidences would not be honored. Others might seek psychiatric help but refuse to be forthcoming with their therapists, thereby reducing the likelihood that their therapy would be effective. However, in the quarter century since *Tarasoff* its rule has been adopted in many states,²²⁰ and there is no evidence that it has injured the practice of psychiatry in any way.²²¹ Given that many mental illnesses are widely stigmatized in our society, it seems unlikely that extending the *Tarasoff* obligation beyond psychotherapy will have a negative effect on other aspects of medicine either.

Of course, breaches of confidentiality will upset many patients. However, avoiding individual upset is no reason to allow innocent third parties to suffer the avoidable ravages of communicable or genetic diseases or to be exposed to physical danger. To the extent that more than upset is involved, for example if a particular breach of confidentiality exposes a patient to the risk of losing a job or insurance benefits, some statutory protections already exist.²²² If they are insufficient, then perhaps they should be strengthened. We can protect patients from the harms associated with a loss of confidentiality without foisting worse harms onto others.

The concern that doctors will be overburdened is mistaken. It proceeds from forgetting that duties are obligations to make reasonable efforts to achieve certain ends, not obligations to achieve them.²²³ The duty on the psychotherapist in *Tarasoff* was not a duty to warn the intended victim. It was a duty to make a reasonable effort to warn her.²²⁴ That is a very different and less burdensome thing.

For a comprehensive listing of articles discussing *Tarasoff's* implications for mental health professionals, see Peter F. Lake, *Revisiting Tarasoff*, 58 ALB. L. REV. 97, 101 & n.14 (1994).

²²⁰ E.g., *Davis v. Lhim*, 335 N.W.2d 481, 489 (Mich. Ct. App. 1983); *Lake, supra* note 219, at 100 nn. 12-13

²²¹ See Daniel J. Givelber et al., *Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action*, 1984 WIS. L. REV. 443 (1984) (finding that *Tarasoff* is consistent with therapists' ethical obligations).

²²² E.g., IND. CODE ANN. § 27-8-6-5 (Burns 2002). See also 42 U.S.C. §§ 1320d-1320d-8 (Supp. 2002) (setting forth elaborate federal protections for privacy of health care information); 45 C.F.R. §§ 164.101-164.534 (2002).

²²³ See RESTATEMENT (SECOND) OF TORTS § 4 (1965) (noting that an individual must merely conform to conduct of a particular nature to avoid liability for breach of duty).

²²⁴ *Tarasoff*, 551 P.2d at 347 (“[i]f the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we see no sufficient societal interest that would protect and justify concealment”).

Similarly, in the genetic and communicable disease contexts recognizing that doctors owe duties to persons in addition to their patients means only that they must treat such persons reasonably. This means three things: (1) Doctors only have to try to warn third parties if the third party can take some meaningful action based on the warning to protect himself or someone close to him. (2) Doctors only have to make *reasonable* efforts to warn third parties. (3) The reasonableness of a breach of confidence and attempt to warn includes consideration of the patient's interests in maintaining confidentiality.

For example, if a patient has Huntington's Disease a duty to behave reasonably to that patient's relatives would not require a doctor to make any effort to seek out and warn the patient's unmarried, childless, 60-year-old sibling. The sibling could not do anything with the information, and so there is no need to give it to him or her. In addition, the likelihood that the sibling would develop HD if he or she were asymptomatic at age 60 is very small.

A doctor may be obligated to make reasonable efforts to warn close relatives of a person with FAP. That may require the doctor to ask the patient for names and addresses and even to look for distinctive names in a small town's telephone directory if that is where the patient lives. It will not require the doctor to try to find every person named Jones in Manhattan to ascertain whether they are related to patient Jones. Similarly, it is likely that sending the relative a letter or leaving a message on the relative's answering machine will be enough to satisfy the doctor's duty to make a reasonable effort to warn. The doctor will not have to drag the relative kicking and screaming into the clinic.

Finally, if the patient has special confidentiality needs that exceed the privacy concerns everyone has, then behaving reasonably may relieve the doctor of an obligation to make any effort at all to warn others. For example, if the patient's fear of losing a job is based on specific facts like the patient's employer saying he will fire anyone who is HIV positive, that is a special circumstance that reduces the likelihood that the doctor will be obligated to inform third parties about the patient's condition.

A second obligation that flows from an obligation to act respectfully toward all significantly affected individuals is the obligation to take other people's interests into account when advising the patient. The doctor should try to get the patient to do the right thing. For example, consanguineous twins have identical genetic make-ups. Thus, if one twin has a genetic disease, the other twin will also have the disease. If a patient seeks presymptomatic testing for a genetic disease, but the patient's consanguineous twin does not want to learn his genetic status, the doctor should work with the patient to

protect the twin's preference. One twin's preference to remain uninformed about his genetic condition cannot justify refusing to test the other twin, but it does suggest that the doctor should explain to his patient the consequences of the diagnosis to the other twin and should emphasize the importance of the patient not divulging his diagnosis to his twin.²²⁵ Similarly, a physician deciding whether to do prenatal diagnosis of a fetus to discover whether it will inherit an autosomal dominant disease for which its father is at risk, should counsel the mother about the risks to her husband involved in learning unwanted information about himself and should become satisfied that the husband's as well as the wife's and fetuses interests have been taken into consideration.²²⁶

A third setting in which it is appropriate to consider interests in addition to the patient's is the allocation of scarce medical resources. Everybody understands that triage decisions in emergencies necessarily involve comparing the competing interests of different individuals. The same reasoning that leads to that conclusion leads also to the conclusion that multiple persons' interests must be considered when deciding how to allocate scarce resources in other situations as well. We already have systems that compare potential organ recipients in order to decide how to allocate one scarce resource.²²⁷ Similar mechanisms are appropriate for allocating intensive care beds and any other medical resource that may be in short supply. There is plenty of room to argue about which allocation system – degree of illness, likelihood of success, age, social worth, etc. – is the best, but some allocation system there must be, and any system except the most arbitrary must take more than one person's interests into account.

²²⁵ EARLY WARNING, *supra* note 176, at 24; *Reisner v. Regents of the Univ. of California*, 37 Cal. Rptr. 2d 518 (1995), was an HIV duty to warn case, where the court held that a physician's duty to warn is discharged by warning the *patient* of the risks associated with the disease, as well as by giving advice on how to prevent the spread of the disease. That a doctor must give advice on "how to avoid the spread of the disease" necessarily includes taking potential sexual partners', family, and health care providers' interests in not contracting HIV into account – essentially, the California court demanded that physicians advise their patients with others' interests in mind. *Id.*

²²⁶ EARLY WARNING, *supra* note 176, at 42-45.

²²⁷ The United Network for Organ Sharing (UNOS) manages the national transplant waiting list, matches donors to recipients, develops policy to maximize organ supply, sets professional standards for efficiency and quality of patient care, and maintains the national database that contains all clinical transplant data. For more information on UNOS and transplant management efforts, see <http://www.unos.org> (last visited Oct. 25, 2001).

Finally, the law should recognize that no person is an island. Every significant decision about a patient's health may have an impact on that person's relatives, dependents, and others. At least some attention should be paid to those interests. To facilitate the death of a 35-year-old married parent of four children who has a good chance of recovering from his or her disease or injuries without considering the needs of the spouse and children would be to abstract the patient from his or her entire social context and to make a decision out of keeping with that patient's life plan and obligations. The problem with the *Spring* case²²⁸ is not that Mrs. Spring's interests were considered. The problems are that her interests were weighed too heavily against those of Mr. Spring, who could not speak for himself; that they were considered surreptitiously; and that the court used the language of patient autonomy to run roughshod over Mr. Spring's autonomy and his life.

Thus, it is clear that medical decision making that focuses exclusively on the patient is shortsighted and inadequate. However, it is possible to go too far in considering the interests of others. Proper consideration should be given to the interests of reasonably identifiable, significantly affected individuals. Consideration should not be given to the interests of society as a whole.

While one might argue that the interests of society as a whole are best served by creating a concerned and loving environment in which each person can be secure in the knowledge that he or she will be treated with respect and without abuse, that is not a realistic picture of what attention to the public interest would mean. The public interest inevitably descends to concern about fostering those who are best able to "contribute" to the common welfare and to concern about protecting the taxpayers. Both of those concerns lead to imposition on the sick and the poor. The sick, especially the seriously or fatally ill, are unlikely to make much contribution to the common welfare. They will cost more than they will produce. Spending money on them will increase the cost of medical care for those who buy insurance and for the taxpayers who support the medicare and medicaid systems. Thus, consideration of the needs of society as a whole will lead to decisions to withhold treatment from low contributors, very sick people, and people whose medical bills are paid by the rest of us. That is, it will lead to lack of respect, lack of protection for autonomy, bad medical care, and invidious discrimination against the poorest and most

²²⁸ *In re Spring*, 405 N.E.2d 115 (Mass. 1980); for a discussion see text accompanying notes 195-99, *supra*.

desperate members of society. The balance between the needs of individuals and the needs of the community is best struck by adopting a system that adverts to the interests of significantly affected individuals, ignoring the interests of those who are affected only in the sense that everything that is done to one person necessarily has an effect on all others.

VI. THE LAW

Changing focus from patient autonomy to respect for all significantly affected individuals should rid the law of fiction; reduce opportunities for abuse of patients (although, abuse cannot be eliminated altogether); promote people's actual desires; foster good medical care; give society the benefits it deserves in exchange for the support it provides to professionals; and lead to decisions that do not arbitrarily ignore the needs of obviously relevant persons. What steps can the law take to accomplish these goals?

First, the law should eliminate the cause of action for lack of informed consent. As I have already shown, the informed consent cause of action does nothing to promote or protect patient autonomy.²²⁹ That is not surprising. Many features of the cause of action lead to its lack of utility.

First, its basic premise is unsound. There is no reason to believe that doctors can successfully explain highly complicated scientific matters to lay persons under the best of circumstances.²³⁰ Medical decision making requires an ability to understand some scientific concepts and to engage in probabilistic reasoning. Most Americans cannot do that.²³¹ Moreover, every teacher knows that the gap between what a teacher says and what a student learns is enormous despite the fact that at least at the higher levels of education students are intelligent, previously educated, and largely self-selected and, therefore, interested in learning.

²²⁹ Text accompanying notes 67-83, *supra*.

²³⁰ See Caroline L. Kaufmann, *Medical Education and Physician-Patient Communication*, in 3 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, vol. 3, app. 1 (1982) (discussing whether the criteria for selecting students or the curriculum itself is to blame for physicians' inability to communicate well with patients).

²³¹ William C. Thompson, *Psychological Issues in Informed Consent*, PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS, VOLUME THREE: APPENDICES STUDIES ON THE FOUNDATIONS OF INFORMED CONSENT 83, at 86-87 (1982).

Doctor-patient communication, of course, does not take place under the best of circumstances. Typically, it involves a patient who is frightened or suffering or both, listening to an authority figure upon whom the patient depends for relief of the fear and/or suffering, in a conversation that takes place on hostile turf (a hospital or doctor's office) and with the doctor decked out in garb (white coat with stethoscope around neck) that reinforces the distance and power relationship between the doctor and the patient. Moreover, doctors receive little or no training in communication skills, especially the skills required to communicate with suffering, frightened laypersons. Who could expect these discussions to lead to informed decision-making by patients. Compliant (and smart) patients do what the doctor recommends (if the doctor is willing to make a recommendation); others resist. But the likelihood that either the acceptors or the resisters are making meaningfully informed choices is small indeed.

In addition, tort law is ill suited to enforce the informed consent ideal for several reasons: First the law is forced to go at the entire inquiry backwards. The question the law wants to answer is whether the patient had adequate information to autonomously exercise his will. In other words, what was in the patient's mind? However, the law does not ask what was in the patient's mind. Instead, it asks what the doctor did. Did the doctor tell the patient enough?²³² There are two good reasons for the law to do that: First the legal issue is whether to impose liability on the doctor. The doctor can control what he tells the patient. He cannot control what the patient hears, thinks, knows, or understands. It would be unfair to impose liability on the doctor for something he cannot control. Therefore, the law asks what the doctor did, rather than what the patient knew. Second, there is no reliable way for the law to ascertain what the patient knew at the time he gave his consent. It is much easier to find out what the doctor said. Therefore, courts do what is doable. They ask what the doctor told the patient. This is all perfectly sensible in terms of the limitations of law, but it does mean that the inquiry is backwards. It is easy to predict that law that must be done backwards is not going to work out very well.²³³

²³² For a general overview of modern informed consent, see generally Paula Walter, *The Doctrine of Informed Consent: To Inform or Not to Inform?*, 71 ST. JOHN'S L. REV. 543 (1997).

²³³ Compare, for example, the well known examples of rape and confessions law. In rape prosecutions focusing on the victim's resistance or lack of consent may be the only practical way to prove the defendant's mens rea, but doing so has the undesirable result of turning prosecutions into trials of victims. In confessions cases,

Another reason that tort law is ill equipped to deal with informed consent is that tort law is primarily common law. Common law decides cases after the events the law is dealing with have already happened, and it focuses on the highly specific facts of each case to reach its decisions.²³⁴ This approach has many virtues. However, it is not good for obtaining conduct control in specific cases.²³⁵ One of the main goals of informed consent law is to make doctors behave a certain way. To be effective the law has to tell doctors clearly and in advance what they have to tell their patients. Common law does not do that, and so it is ineffective in achieving its aims. Left to guess what to say to a patient a doctor will either over inform to try to avoid all risk of liability or under inform to take advantage of the fact that without a highly unlikely injury occurring, he will be safe from liability. Neither of those strategies fosters patient autonomy. Of course, the existence of malpractice insurance, which makes the doctor's cost of liability much less than the cost of the patient's injury, reduces the deterrent efficacy of the law even further.

However, this does not mean the law of informed consent is without impact. Doctors know that failing to obtain a patient's informed consent can lead to liability. Therefore, rather than thinking of informed consent as an ethical obligation to engage in meaningful conversation with the patient, many doctors see informed consent as one more legal hoop to jump through. This attitude is captured in the common medical use of the word, "consent," as a transitive verb, as in "Who is going to consent the patient?" Whoever "consents" the patient is unlikely to have done much to advance the patient's understanding or the cause of patient autonomy. To the extent that informed consent is a good idea, the way to foster its goals is to educate doctors about informed consent as an ethical goal and to train them in the art of communicating highly complex technical information to frightened, suffering, dependent laypersons. The mere fact that informed consent is an attractive aspiration does not mean that failure to attain it should give rise to a cause of action in tort.

focusing on whether the police have complied with formal requirements makes cases turn on technicalities rather than whether the defendant was acting voluntarily when he confessed. This results in inadequate protections for defendants and frustration for law enforcers.

²³⁴ For a brief primer on common law adjudication, see *LIMITS*, *supra* note 49, at 7-10.

²³⁵ It may achieve vague, general conduct control, for example, by making product manufacturers as a group internalize more of the costs associated with their products, but it is incapable of directing specific actions.

If the truth about informed consent is that the doctrine provides a useful way for patients to recover for malpractice when they are unable to prove physician negligence,²³⁶ then that suggests that something is fundamentally wrong with the law of malpractice. Either patients should be allowed to recover despite the absence of provable negligence, or they shouldn't. It is not appropriate to allow some patients to avoid the requirements of malpractice law by resort to a fiction that is not available to other similarly situated patients. The only function the cause of action for lack of informed consent serves is to arbitrarily and occasionally mitigate the harshness of the malpractice system. If mitigation is needed, it should be achieved more directly. This is especially true because, as suggested above, the tort cause of action distorts and reduces meaningful doctor-patient communication.

The second change in the law suggested by the respect-for-all-significantly-affected-individuals focus is the elimination of the substituted judgment test and its replacement by the best interests of the patient test.²³⁷ A substituted judgment test purports to have a surrogate decision maker ascertain what a patient would choose for himself if he were competent to make a choice and then to effectuate that presumed choice. As our discussion of the *Spring* case has already demonstrated, it is easy to abuse the substituted judgment test and to run roughshod over an incompetent person in the name of serving his autonomy.²³⁸ The same phenomenon is present in cases about whether children or incompetent persons may be used as organ donors.²³⁹ A parent with a mentally retarded or just a young child with two healthy kidneys and another child in need of a kidney transplant will naturally be eager to transplant a kidney from the healthy child to the sibling. Obviously, the parent's conflict of interest precludes the parent's consent to the transplant from being

²³⁶ Meisel, *supra* note 1, at 1399.

²³⁷ See *supra* note 156 for an explanation of these two different standards.

²³⁸ See text accompanying notes 195-99, *infra*.

²³⁹ See Bryan Shartle, *Proposed Legislation for Safely Regulating the Increasing Number of Living Organ and Tissue Donations by Minors*, 61 LA. L. REV. 433 (2001) (discussing proposed legislation and the need for minor organ donors). See also Robert W. Griner, *Live Organ Donations between Siblings and the Best Interest Standard: Time for Stricter Judicial Intervention*, 10 GA. ST. U.L. REV. 589, 589-91 (1994) ("[t]he possibility of organ transplants from a living donor adds numerous complicating factors"); Hal Daniel Friedman, Note, *The Greatest Gift, But At What Cost? – Objections to Court-Compelled Organ Donation in Aid of a Family Member*, 30 J. FAM. L. (1991-92) (noting that courts have refused to order minors to donate organs if there is no parental consent or the relationship between the donor and donee is not sufficiently close that there will be no psychological benefit to the child).

enough to authorize it. A court order is required. Courts, however, do little to protect potential donor children. Applying a substituted judgment test, they routinely authorize the transplants, attributing to the potential donor altruism²⁴⁰ or a desire to have a sibling to care for him after his parents die.²⁴¹ Maybe taking healthy kidneys from children and giving them to their siblings is sound social policy, but let us not deceive ourselves into believing that in pursuing that policy we are promoting the autonomy and honoring the decisions of donor children.

Not only is the substituted judgment test susceptible to abuse, it is also impossible to apply. Even in the case of previously competent patients there is little hope of applying the test sensibly. Most people have never thought about, much less expressed an opinion about what they would choose if presented with one of life's innumerable health crises.²⁴² Not only have they not addressed each specific situation, they have provided no basis from which to extrapolate a choice. Even if they have said something relevant, there is little reason to believe that their abstract past expression reflects their desire when they are actually presented with the previously hypothetical situation.²⁴³

If the substituted judgment test is nearly impossible to apply to formerly competent patients, it is completely impossible to use with patients who have never been competent. By definition such persons cannot have expressed a meaningful view about health care options. As one wag noted in a now famous attack on the use of the substituted

²⁴⁰ See, e.g., *Little v. Little*, 576 S.W.2d 493 (Tex. Civ. App. 1979) (resolving that the record demonstrated that the incompetent donor would experience psychological benefits from donating a kidney to her brother, but limiting the holding to situations where the donee is a parent or sibling).

²⁴¹ But see *In re Richardson*, 284 So.2d 185, 187 (La. Ct. App. 1973) (holding that such an argument is highly speculative). See also *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969) (discussing the doctrine of substituted judgment).

²⁴² According to the U.S. Living Will Registry, a privately funded organization that electronically stores "advance directives" (living wills or health care proxies) and makes them available to health care providers, although 75% of Americans are in favor of advance directives, only 25-30% have actually prepared an advance directive. U.S. Living Will Registry, at <http://uslivingwillregistry.com/factsheet.shtm> (last visited Mar. 12, 2003) (on file with author).

²⁴³ See, e.g., Rebecca Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373, 379 (1986) (arguing that past and present expressions of goals and desires cannot be adequately determined without the input of the patient); Harvey Max Chochinov et al., *Will to Live in the Terminally Ill*, 354 LANCET 816, 818-19 (1999) (finding that desires for death and the will to live were highly unstable among terminally ill cancer patients, indicating that a request to die or a "DNR" order may vary often in that population).

judgment test to ascertain the desires of a never competent leukemia patient in his sixties, who had a mental age of two, asking what the patient would choose if he were competent is like asking, "If it snowed all summer, would it then be winter?"²⁴⁴

This impossible and easily abused test, which does not actually protect patient autonomy, ignores all values other than autonomy.²⁴⁵ A better way to decide what should be done for incompetent patients is to ask what would be best for them (subject to appropriate consideration of the interests of other significantly affected individuals). That approach requires focus on reality, rather than fiction and it considers many relevant interests, not just one: What chance of recovery does the patient have? How full will the recovery be? How much pain and other suffering will the procedure and its aftermath entail? What will the patient's life be like after the procedure? What will the procedure do to the patient's place in his family and community?²⁴⁶ Etc., etc., and, if there is any meaningful evidence of the patient's desires, what does that evidence show? This kind of a multi-faceted, reality based test forces the decision maker to focus on what the real interests of the patient are. It makes it harder (of course, not impossible) to make things up. It reduces the chance of riding roughshod over the patient. No legal test can guarantee that future Mr. Springs will not be abused, but the best interests test at least will force courts to look at what they are doing and to come to grips with the fact that if they allow the Earl Springs of the world to die, they are deciding that such people are better off dead than alive. They are not just respecting the patient's wishes.

Third, courts should restrict the patient's cause of action for breach of confidence in order to permit doctors to consider and act on the needs of others as well as those of the patient. I have already demonstrated the importance of considering the important interests of reasonably identifiable third parties.²⁴⁷ In cases where those interests are more important than the patient's interest in confidentiality, doctors should be freed of the concern that they will be liable to their

²⁴⁴ *In re Storar*, 420 N.E.2d 64, 72-73 (N.Y. 1981). See also LIMITS, *supra* note 49, at 119 (discussing the problem with the substituted judgment approach relating to incompetent persons).

²⁴⁵ This is the case except in instances in which courts treat substituted judgment as synonymous with the best interests of the patient, evidently assuming that a patient will always choose what is best for himself.

²⁴⁶ This is especially relevant in cases in which the patient is a member of a close-knit community with deeply held views, like the Jehovah's Witnesses antipathy to blood transfusions.

²⁴⁷ *Infra* at text accompanying notes 200-13.

patients if they breach confidentiality to serve more important interests.

The cause of action for breach of confidentiality is not very well established,²⁴⁸ and it lacks a sound theoretical grounding.²⁴⁹ Despite the common assumption that doctors owe an obligation to maintain their patients' confidences, few cases actually enforce that obligation by awarding damages for its breach.²⁵⁰ Perhaps that is because the obligation is sufficiently enshrined in medical ethics that few breaches occur, or perhaps it is because few breaches cause significant damage. In any event, the paucity of cases suggests that eliminating the cause of action will not do much harm.

It is difficult to find legal underpinning for a cause of action for breach of confidentiality. The demise of the *prima facie* tort doctrine,²⁵¹ which would have made a tort out of almost any intentional infliction of harm, suggests that one must find a more specific justification for a cause of action than simply wanting to compensate all harm.

Some states purport to find a basis for the cause of action in the doctor-patient testimonial privilege.²⁵² However, that privilege, which

²⁴⁸ See generally, e.g., Susan M. Gilles, *Promises Betrayed: Breach of Confidence as a Remedy for Invasions of Privacy*, 43 BUFF. L. REV. 1 (1995) (discussing the viability of breach of confidence as a remedy for those injured by unwanted publication of private facts).

²⁴⁹ *Id.* at 4-13. But see, for an early, generally positive, background of the rise of the breach of confidence tort, Alan B. Vickery, Note, *Breach of Confidence: An Emerging Tort*, 82 COLUM. L. REV. 1426 (1982).

²⁵⁰ See, e.g., *McCormick v. England*, 494 S.E.2d 431, 437 (S.C. Ct. App. 1997) (building on the recognition of a physician's duty of confidentiality in *S. Carolina State Bd. Of Med. Exam'rs v. Hedgepath*, 480 S.E.2d 724 (S.C. 1997), "recogniz[ing] a cause of action for a physician's breach of a duty of confidentiality"). *McCormick* at 432.

²⁵¹ Justice Holmes stated that "prima facie, the intentional infliction of temporal damage is a cause of action, which, as a matter of substantive law whatever may be the form of pleading, requires a justification if the defendant is to escape." *Aikins v. Wisconsin*, 195 U.S. 194, 204 (1904). Prima facie tort was later defined as the infliction of intentional harms, resulting in damage, without excuse or justification, by an act or series of acts which would otherwise be lawful. *Firester v. Lipson*, 270 N.Y.S.2d 844, 850 (1966). The problem with this rule is that if prima facie tort really made actionable any intentional infliction of damage, it would abolish all other forms and theories of action. E.g., *Fieger v. Glen Oaks Vill.*, 132 N.E.2d 492, 496 (N.Y. 1956).

²⁵² Although at common law neither the physician nor the patient may refuse to disclose communication between the two, many states have enacted statutes specifically creating this privilege. E.g., *Quarles v. Sutherland*, 389 S.W.2d 249, 251 (1965). For a very fully developed statutory treatment of the privilege, see Cal. Evid. Code §§ 990-1007 (West, 1995). For an example of where the physician-patient privilege was used to find a basis for the breach of confidentiality, see *Schaffer v.*

applies in the litigation setting, tells us nothing about whether a patient whose doctor divulges a confidence in a different setting should incur liability to the patient. The balance of interests in resolving litigation and in creating causes of action bear almost no relationship to each other. Moreover, the doctor-patient testimonial privilege itself is sufficiently hard to justify that it seems ill advised to attempt to expand it beyond its limited sphere.

The tort of invasion of privacy does not seem to provide a sound basis for a breach of confidentiality cause of action.²⁵³ If one accepts Prosser's²⁵⁴ and the Restatement's²⁵⁵ categories of invasion of privacy cases, breach of confidence seems most likely to be a public exposure of embarrassing private facts.²⁵⁶ However, the elements of that cause of action will seldom be met in the breach of confidence setting. The tort claim requires a public disclosure,²⁵⁷ not just a "publication" to one third party like defamation requires.²⁵⁸ Therefore, very few breach of confidentiality cases will fit. Moreover, the invasion of privacy claim also requires that the information disclosed not be of legitimate interest to the public.²⁵⁹ In the cases we are considering here, disclosure will be important at least to the segment of the public to whom disclosure is made.

Similarly, breach of confidentiality does not seem to constitute a highly offensive intrusion into the solitude or private affairs of the plaintiff. This is not like spying or eavesdropping on the patient.²⁶⁰

Moreover, as Justice Linde of the Oregon Supreme Court has pointed out, if a person has an invasion of privacy cause of action for disclosure of medical information, that cause of action would exist against anyone, not simply a doctor.²⁶¹ Persons trying to find a valid

Spicer, 215 N.W.2d 134, 136, 138 (S.D. 1974)

²⁵³ See Gilles, *supra* note 248, at 4-13.

²⁵⁴ William L. Prosser, *Privacy*, 48 CAL. L. REV. 383 (1960).

²⁵⁵ RESTATEMENT (SECOND) OF TORTS §§ 652B-652E (1977). The Restatement recognizes for distinct branches of privacy torts: 1) intrusion upon seclusion; 2) appropriation of name or likeness; 3) publicity given to private life; and 4) publicity placing person in false light. §§ 652B-652E (1977). Also, see *Vickery*, *supra* note 248, at 1437-48, for a discussion of these causes of action in relation to a breach of confidence.

²⁵⁶ See RESTATEMENT (SECOND) OF TORTS § 652D (prohibiting publicity, that is either "highly offensive" and "not of legitimate concern to the public").

²⁵⁷ See *id.*, at cmt. A (defining "[p]ublicity").

²⁵⁸ *Id.*

²⁵⁹ *Id.* § 652D(b).

²⁶⁰ *E.g.*, *Nader v. General Motors Corp.*, 255 N.E.2d 765, 770-71 (N.Y. 1970) (holding that unauthorized wiretapping and eavesdropping are activities that constitute an invasion of privacy).

²⁶¹ *Humphers v. First Interstate Bank of Oregon*, 696 P.2d 527, 530 (Or.

claim that is restricted to physicians, or at least to health care professionals, must look for something specific in the doctor-patient relationship that gives rise to such a case.

Two possible bases for the patient's claim would be that the expectation of confidentiality arises out of the contract that creates the doctor-patient relationship²⁶² or the expectation that doctors will behave ethically. These suggestions, however, beg the essential question: What are the terms of the doctor-patient contract, and what are the dictates of medical ethics? Obviously, if the law rejects the cause of action, a reasonable expectation of a legally enforceable claim to confidentiality will not exist.

Of course, it is possible to adapt existing law to recognize a cause of action for breach of medical confidentiality. Some courts have done so.²⁶³ The question is whether doing so is worthwhile, given the important interests that are often served by breaches. Patients can retain existing causes of action that cover specific injurious situations without creating an all-purpose breach of confidentiality tort. For example, an unjustified disclosure to an employer that causes the patient to lose a job may give rise to a cause of action for interference with a beneficial contractual relationship.²⁶⁴

Suppose, though, that a doctor breaches a patient's confidence for an invalid reason, perhaps because the physician just likes to gossip. Now the case may come closer to fitting into an existing doctrinal pigeon hole. For example, it may be sufficiently widespread and serve so little purpose that it will give rise to a claim for public disclosure of embarrassing private facts.²⁶⁵ Even in the cases in which recognizing the claim is worthwhile, however, a major problem exists. How will the plaintiff prove damages, and what damages will be recoverable? In cases in which plaintiffs suffer real losses, like the

1985).

²⁶² *E.g., id.* at 528-29; *Horne v. Patton*, 287 So.2d 824 (Ala. 1973) (holding that an implied contract arises in the ordinary course of dealing between a doctor and patient that information disclosed to the doctor concerning the patient's condition will be held in confidence by the doctor).

²⁶³ *E.g., Biddle v. Warren Gen. Hosp.*, 715 N.E.2d 518, 523 (Ohio 1999); *McCormick v. England*, 494 S.E.2d 431, 435-37 (S.C. Ct. App. 1997). *See Humphers*, 696 P.2d at 527 (permitting a claim against a physician for breach of confidentiality when the physician identified a mother's identity to the daughter she had given up for adoption).

²⁶⁴ *See generally, e.g., French v. U.S. Dep't of Health and Human Servs.*, 55 F. Supp. 2d 379, 381 (W.D.N.C. 1999) (stating that an unauthorized and intentional disclosure of medical records which prevent employment may create a claim based on interference with contractual rights or intentional infliction of emotional distress).

²⁶⁵ Even if it does create such a claim, Justice Linde's argument about the inability to limit the claim to cases against doctors will have to be confronted.

loss of a job, recovery may be justified, and damages will be easy to prove and measure. In cases where the plaintiff's only loss is the unhappiness that comes from other persons learning his business, it is hard to see why the legal system should devote its time and the public should devote its resources in the form of increased medical costs to compensate for that unhappiness. Not everything that makes people unhappy is or should be a tort.

The fourth, related legal adjustment suggested by our recommended approach is to provide a cause of action for reasonably identifiable persons whose demonstrable interests a doctor has negligently ignored. I have already explained the importance of those persons' interests.²⁶⁶ Recognizing their claims requires no bold new steps. Since *Tarasoff*²⁶⁷ the law has moved significantly toward recognizing such claims.²⁶⁸ All that is required is to continue that development and to adopt a new mind set that recognizes that duties to third parties are the rule, rather than the exception.

Restricting the patient's breach of confidentiality cause of action while expanding the claims of significantly affected third parties is consistent with actions the law already takes even if it seems inconsistent with common assertions about what the law requires. Black letter law states that there is no duty to take affirmative steps to help other persons. There is no duty to be a Good Samaritan.²⁶⁹ Also, as noted some courts hold and most people assume that doctors do have a duty to maintain their patients' confidences.²⁷⁰ However, both of these rules are often honored in the breach.

The reasons for the Good Samaritan rule are (1) that imposing duties to render aid would create impossible line drawing problems; which of the 500 motorists who passed a traffic accident without stopping would be liable for damages his intervention could have prevented? (2) that imposing liability would not achieve significant loss spreading because of the absence of failure-to-rescue insurance; and (3) that imposing a duty would not increase rescues because people who fail to try to help others in peril are likely to be paralyzed

²⁶⁶ See text accompanying notes 203-13, *supra*.

²⁶⁷ *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334 (Cal. 1976).

²⁶⁸ *Lake*, *supra* note 219, at 100 nn. 12-13.

²⁶⁹ See RESTATEMENT (SECOND) OF TORTS § 314 (1965) (noting that an individual is not required to aid another individual in distress on that basis alone).

²⁷⁰ *Cf. Humphers*, 696 P.2d at 534-36, (discussing physicians' duties of confidentiality); *Horne v. Patton*, 287 So.2d 824, 829-30 (Ala. 1973) (concluding that a medical doctor has a duty to refrain from making extra-judicial disclosures of information obtained in the course of the doctor-patient relationship); *Hague v. Williams*, 181 A.2d 345, 349 (N.J. 1962) (holding that generally physicians should not reveal confidential patient information).

by fear or horror and, therefore, beyond the deterrent force of the law.²⁷¹ Exceptions to the widely criticized rule are made whenever the reasons for it, or at least some of them, are not present.

The reasons for the Good Samaritan rule do not apply in the context of deciding whether a doctor should act reasonably toward persons in addition to the doctor's patients. Line drawing is easy. The doctor is readily identifiable, and at most a few other health professionals may be in a similar position to act. Malpractice insurance is available, and there seems no reason to deny coverage in this context. And the doctor is making a considered judgment about what is the right thing to do, not a snap decision while he is terrified by the sight of an emergency.

The duty to maintain patient confidences yields to the supervening public good. In addition to duties to report child abuse,²⁷² gunshot wounds,²⁷³ etc., doctors are often held liable for failing to make reasonable efforts to warn or otherwise protect intended victims of their psychiatric patients,²⁷⁴ family members at risk for genetic diseases,²⁷⁵ persons exposed to contagious diseases,²⁷⁶ and even unknown future drivers on the highway.²⁷⁷ Thus, recognizing a general duty toward relevant third parties is consistent with the reality, if not the rhetoric, of American law.

²⁷¹ Don M. Reckseen, Note, *The Duty to Rescue*, 47 IND. L.J. 321, 329 (1972). But see Viola C. Brady, Note, *The Duty to Rescue in Tort Law: Implications of Research on Altruism*, 55 IND. L.J. 551, 556 (1980) (arguing that based on theories of altruism, the "imposition of an expanded legal duty to aid would cause more persons to render aid").

²⁷² E.g., IND. CODE ANN. § 31-33-5-2 (West 2001).

²⁷³ E.g., IND. CODE ANN. § 35-47-7-1 (West 1998) (requiring reporting of injuries caused by firearms).

²⁷⁴ The *Tarasoff* case, 551 P.2d 334 (Cal. 1976) discussed earlier in this article, and the jurisprudence following it are excellent, straightforward examples of the public good trumping individual confidences in the American legal system. See text accompanying notes 209-13, *supra*.

²⁷⁵ See, e.g., *Pate v. Threlkel*, 661 So.2d 278, 282 (Fla. 1995) (holding that a physician owed a duty to a patient's family member to warn her of a hereditary disease because the prevailing standard of care was developed for the benefit of certain third parties and the physician knew of the existence of such third parties).

²⁷⁶ See King, *supra* note 204, at 14-16 (discussing the key cases establishing a physician's duty to warn in the context of contagious diseases).

²⁷⁷ See *supra* note 212.

VII. ESTABLISHING THE BOUNDS OF PROFESSIONALISM

Eliminating the cause of action for lack of informed consent, abandoning the substituted judgment test, restricting patients' claims for breach of confidentiality, and expanding third parties' claims for failing to behave reasonably toward them should go a long way toward solving the problems caused by the focus on autonomy and the exclusive doctor-patient relationship. However, the new approach carries a potential danger that must be guarded against. Encouraging doctors to consider all of a patient's interests, not just the interest in autonomy, and encouraging doctors to consider persons in addition to the patient raise the possibility that doctors may exceed the bounds of professionalism. They may think the change of emphasis gives them new power to impose their preferences in areas beyond their professional expertise. This possibility must be prevented.

The insistence that only significantly affected individuals, not society as a whole, be considered in determining doctors' obligations is one step toward reining doctors in and preventing them from foisting their political philosophies off onto the rest of us. But it is not enough. Urging doctors to consider a wide range of interests of a large number of persons does seem to invite them to act out their own social preferences. In the absence of any reason to believe that physicians' social preferences deserve privileged status, this apparent invitation must be revoked.

I have argued that the present autonomy focus deprives us of much of the potential benefit of having professionals. Obtaining that full benefit does not require or suggest that we should privilege nonprofessional views of physicians. The tricks are deciding what is within the area of professional expertise and how to restrict physicians to action within that area.

The most obvious foci for deciding what is within the professional expertise of any group of professionals are their education and experience. In addition, one can learn something about what the society expects from professionals by studying the statutes that define their scope of practice and provide for their licensure. However, none of these tools is easy to use or without problems.

First, medical education is largely within the control of branches of the medical profession – medical schools and medical residency programs. In addition, what doctors experience depends on what they choose to do. Therefore, medical educators could infinitely expand medical education, and hence what counts as part of professional expertise, simply by expanding medical curricula and the content of

training programs. Doctors could expand the bounds of their profession by doing, *i.e.*, experiencing more things.

These are not substantial concerns. It is appropriate to expand medical education to keep up with new developments. That medical education now pays attention to genetics and nutrition is not a ground for concern about overreaching. In addition, fears about an ever-expanding field of medical power are unrealistic. The effect of moving a new area into the sphere of medical expertise is to impose more obligations on doctors. That fact plus the financial and time constraints on medical education make unwarranted expansion unlikely. As to experience, that too should pose no problem as long as one remembers that the relevant experience is the experience of the profession, not of an individual practitioner.

More troubling is the difficulty of defining what is meant by education and experience. For example, medical education increasingly includes some exposure to medical ethics. Sometimes it even includes exposure to medical law. Does that mean that doctors have been educated in ethics or law so that they are acting within the realm of professionalism when they offer ethical guidance or give legal advice? Clearly not. One could try to define ethics and law out of medical practice by attempting to devise a "substantial education" test or something of the sort, but any such effort would be exceedingly difficult and doomed to failure. It would even be dangerous if, for example, a medical school provided the same or a greater number of contact hours in medical ethics that it provided in the anatomy of the kidney.

At this point the medical practice acts come to our rescue. Medical practice acts differ from state to state. They all attempt to define the practice of medicine and to require licensure for those who would engage in the practice.²⁷⁸ Typical medical practice acts define the practice of medicine to include certain important things that are not relevant to the present inquiry, like holding oneself out as qualified to diagnose or treat,²⁷⁹ or using certain titles like "M.D."²⁸⁰

²⁷⁸ *E.g.*, CAL. BUS. & PROF. CODE §§ 2050-2076 (West 1990) (explaining licensing requirements and exemptions); 225 ILL. COMP. STAT. ANN. 60/1-63 (West 2002) (defining the practice of medicine to include the treatment or diagnosis of any physical or mental ailments and requiring a license to practice medicine); N.Y. EDUC. LAW § 6520 et seq. (McKinney 2001) (describing requirements for becoming a licensed physician).

²⁷⁹ *E.g.*, CAL. BUS. & PROF. CODE § 2054 (West 2003) (requiring that a person who is not a physician to not hold himself or herself as one); 225 ILL. COMP. STAT. ANN. 60/3.5 (West 2002) (defining the practice of medicine to include holding oneself able to practice as a physicians).

²⁸⁰ *E.g.*, CAL. BUS. & PROF. CODE § 2055 (West 1990) (limiting use of initials

Some require payment before one can be found to be practicing medicine.²⁸¹ Importantly, however, they all address the actual activity of medical practice as well. In different terms they include diagnosis, treatment, prescription, healing, and surgery for human illnesses and injuries as the activities of medical practice.²⁸² No medical practice act mentions providing ethical or legal analysis or advice, much less advice about how to maximize one's insurance benefits, structure one's finances, etc. Even doctors who have had a course or two in medical ethics, medical law, health care financing, or whatever should be understood to be exceeding the scope of their professional practice when they discuss such matters with their patients. A course in medical law no more qualifies a doctor to give legal advice than a course in forensic medicine turns a lawyer into a pathologist.

Doctors should be discouraged from acting beyond the scope of their professional expertise. A doctor may (and should) make decisions about his or her own conduct based on a refined and informed sense of ethics and law. A doctor should not impose those views on patients or act as if they are part of the doctor's professional armamentarium.

For example, suppose a 60-year-old woman seeks fertility services from a gynecologist who provides such services. It would be perfectly appropriate for the gynecologist to decide that she will not provide the services because she thinks it is unethical to render otherwise infertile women in their 60's pregnant. Two things would not be appropriate. First it would be wrong for the gynecologist to reach this conclusion out of prejudice or based on a knee-jerk reaction. A conscientious ethical position must be thought through and tested against opposing opinions. However, assuming that we are discussing ethics, rather than bias, no one would contend that professionals may not act on the basis of their sincere ethical commitments. Second, it would be inappropriate for the gynecologist to attempt to dissuade the patient from seeking fertility services unless

"M.D." to persons with a physician's or surgeons certificate); 225 ILL. COMP. STAT. ANN. 60/28 (West 2002) (defining the practice of medicine to include the use of the titles "Doctor of Medicine" or "M.D."); N.Y. EDUC. LAW § 6522 (McKinney 2001) (noting use of title of "physician").

²⁸¹ *E.g.*, 225 ILL. COMP. STAT. ANN. 60/9(D) (West 2002) (requiring a person to pay a licensing fee before he or she can practice medicine); N.Y. EDUC. LAW § 6524(8) (McKinney 2001) (noting fees required to practice as a physician).

²⁸² *E.g.*, N.Y. EDUC. LAW § 6521 (McKinney 2001) (listing the activities of a physician); CAL. BUS. & PROF. CODE § 2051 (West 1990) (including prescription of drugs and surgeries to treat human conditions). *See also, e.g.*, 225 ILL. COMP. STAT. ANN. 60/50(D) (West 2002) (defining the practice of medicine to include the treatment of diagnosis of any physical or mental ailments or conditions).

the advice is based on medical reasons. The gynecologist should explain the risks to both mother and child of late pregnancy and motherhood. She should alert the patient to relevant findings in the medical literature about the adverse impact, if any, on children of having their mother be ill or die during the child's childhood. She should even advise the patient about whether it is a good idea, given the patient's medical situation and all that is known about late, assisted pregnancy, to seek the services. She should not tell the patient whether she thinks it is ethically or socially desirable for her to attempt to become pregnant with medical assistance. Once the doctor has decided whether to refuse services for medical reasons, she has made her own ethical decision. Her ethical views are no part of what society has licensed her to transmit to the patient. In a social setting, of course, a doctor is as free to state and argue her views as anybody else. However, it is inappropriate to try to pass the views off as part of her professional expertise.

Perhaps a more legally relevant example would involve a doctor trying to outfox an insurance company. Suppose a person at risk for Huntington's Disease seeks presymptomatic diagnosis. It is inappropriate for a physician to tell the patient that he may have trouble getting health insurance if his test is positive so that he should either eschew testing or buy insurance first. This perfectly understandable preference for a patient over an insurance company is an effort to "game the system," in essence to practice a form of fraud on the insurance company. It ignores the fact that causing the company to insure a person it would have preferred not to insure has an effect on real people, not just the bloodless company. The hypothesized practice will increase other people's health insurance costs, and at the margin will prevent some people from being able to afford insurance. It represents the doctor's effort to make social policy in the office, something the doctor has neither the expertise nor the moral sanction to do.

As a practical matter, preventing the inappropriate imposition of physicians' ethical, legal, political, and financial views is unlikely to become a major task for the law. As medical practice becomes ever more impersonal, the opportunities even for desirable doctor-patient conversation become all too infrequent. The likelihood that many doctors in a capitulated world will be eager to spend time advising their patients about nonmedical matters seems small. To the extent that a problem exists, it can be attacked first through medical education as doctors are taught to distinguish professional from nonprofessional expertise.

Residual problems can be dealt with in two ways by the law. First, if a doctor's behavior intrudes on the domain of another licensed

profession, the doctor can be prosecuted for practicing that profession without a license.²⁸³ The clearest case is the one in which a doctor gives a patient legal advice. The use of the criminal sanction is draconian, and it is hard to imagine that there will be many occasions for this approach, especially once law-averse physicians have been informed of the risk.

A more realistic response to nonprofessional behavior by doctors is to recognize that acting beyond the scope of one's expertise is negligent and should subject the negligent actor to damages for any injury the negligent behavior caused. Thus, as I have suggested before, if a doctor advises a patient to try to avoid insurance company rules, and the insurance company discovers the ruse and denies coverage to the patient, the physician should be liable to the patient for the damage caused.²⁸⁴ These situations too will arise infrequently. Education plus the threat of liability in an area where most doctors are already loath to tread should suffice to keep litigation low.

Excessive concern with autonomy and with the exclusive doctor-patient relationship are much more likely to do harm than is doctor overreaching into areas beyond their professional expertise. Some use of unauthorized practice statutes and tort liability should be enough to keep physicians within the bounds of professionalism. Striving to make them act in the full interests of patients and all significantly affected individuals is the more important and the more difficult task.

²⁸³ See, e.g., CAL. BUS. & PROF. CODE §§ 6125-27 (West 1990) (limiting the practice of law to only those who are active members of the State Bar); 705 ILL. COMP. STAT. ANN. 205/1 (West 2001); N.Y. JUDICIARY LAW §§ 476a-c (McKinney 2001) (prohibiting the practice of law by unlicensed individuals); TEX. GOV'T CODE ANN. §81.101 et seq. (Vernon 2001) (stating that it is illegal to conduct the unauthorized practice of law).

²⁸⁴ *The Human Genome Project*, *supra* note 5, at 135.