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BOOK REVIEWS

TAKING CARE OF STRANGERS: The Rule of Law in Doctor-Patient Relations by R. A. Burt. The Free Press, Biblio. Index. 1979, Pp. x 200. \$16.95 hardcover.

Natalie L. C. Stason*

"Power tends to corrupt; absolute power corrupts absolutely."¹ Dr. Burt, in *Taking Care of Strangers*, agrees and adds new insights. Powerlessness, he believes, corrupts as well; and he explains, in terms of modern psychology, why both he and Lord Acton are right.

The style is sometimes turgid, but the book is saved and made interesting by the use of difficult and compelling case histories which force the reader to give attention to Dr. Burt's claims, his fears and his proposed changes in the law. His logic is sound, and his hypothesis appears to be supported, not only by the evidence he has amassed but by one's own awareness and experience. Certainly those who are interested in issues of informed consent in doctor-patient relationships or the abuses of power which we see when the law or medicine intervenes in the lives of the helpless, confused, or sick would do well to read Dr. Burt's book. It is both personal and scholarly, profound and simple, and it casts serious doubts on society's present methods for conflict resolution in these areas. Further work and proposals for reform are urgently needed, and I hope the book provokes much response and additional thought directed to the problems left unresolved.

Dr. Burt's hypothesis can best be stated in his own words:

This solution [that others are authorized to make decisions for the confused and incompetent], in common with civil commitment statutes for mental illness generally, rests on the premise that it is possible for two people conclusively to resolve the question between themselves that one is "confused" and the other is not regarding the capacity of both to define themselves as sepa-

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1. Lord Acton, Letter to Bishop Mandell Creighton (1887).

rate and choice-making individuals. I believe this attempt is ultimately fallacious no matter who the two people may be—whether psychiatrist and patient, judge and litigant, parent and child, or, indeed, conscious person and comatose person . . . In claiming that these judgements are fallacious I have a very particular meaning that no one (whether psychiatrist, parent or judge) can conclusively characterize himself as a separate and choice-making individual regarding another person when he is perceiving that person as lacking those very attributes; that is, the very act of judgment inevitably evokes the same confusions in the judge.²

There are “destructive psychological forces for everyone”³ when the law looks to anyone—the patient, child, or other dependent person; the experts or authorities, such as doctors and parents; or judges, who will insist upon seeing themselves as neutral, even though no one can be truly so—to be *the* decision-maker on matters of treatment for a dependent person. “The law can offer effective protection only if it can ensure that no one in the transaction—whether a judge, the doctors or [the patient]—is able clearly to identify himself as *the* choice-maker among them.”⁴

The reason for our inability to act altruistically in making choices for the choiceless, according to Dr. Burt, is that when we see someone who has lost or not developed a sense of self-delimitation—of having a place and a role and being a separate person—our own “ordinary conceptual demarcations between self and other,”⁵ are threatened. This disturbs us and makes us want to get rid of the threat; therefore, whoever is called upon to be the choice-maker for such a person will be motivated in part by a desire to get rid of the problem and, therefore, the person. This tendency has led to unnecessarily cruel treatment of people in many contexts.

If we classify the person who is claimed to be choiceless as being adequately competent and capable, we accept an undermining of our own sense of coherent selfhood. If we repair and restore our own sense of self, labeling the other person incompetent, helpless, and without the capacity to choose, we also, if the law gives us power to do so—as it does parents and judges, for example—, assure that that person will indeed be choiceless and accept our own

2. R. A. BURT, *TAKING CARE OF STRANGERS: The Rule of Law in Doctor-Patient Relations* (1979), 13-14.

3. *Id.* at 20.

4. *Id.* at 20-21.

5. *Id.* at 29.

power to make all decisions for her. Since we continue to fear the threat she poses to our own sense of self, these choices will not be made in the best interests of the incompetent person, but in our own best interests to protect us from harm. The danger is made greater by our failure to recognize that we are not impartial and altruistic when we face making such decisions. When we do not see the threat of harm and do not see the focus on what is best for us, rather than for the other person, we fail entirely to guard against the harm we may do them. When a person is viewed as incompetent and treated as being without any choice or self-governance, this in turn affects the incompetent and ultimately prevents her from wanting or believing in her own capacity to make any kinds of choices. Thus, the decision that a patient or child is incompetent causes, if we persist in acting upon it, the very incompetence which we claim we are seeking to ameliorate. "[P]eople will only see themselves as separate and choice-making individuals if they mutually force one another to such self-conceptions . . . The idea of 'self' [is] a product of mutual interactions among people rather than . . . fixed presentations of *a priori* separate self-delinations"⁶

In short, we tend to seek treatment for troubled people not because they need it but because we find their lack of self-governance threatening. In treating them, we want to remove, and perhaps to punish for, this threat rather than primarily wanting to do what is best for the person "in trouble." This hypothesis does much to explain apparently senseless intervention in the lives of those who, while not living "normally," seem to be doing no harm to anyone including themselves.

Dr. Burt next tackles the question of why we should be this way. Why is it that we are threatened when someone else appears to be powerless or to have lost or not yet developed a sense of self? Dr. Burt's answer lies in the early stages of our psychological development. Each of us is born a helpless infant. We are indeed powerless and choiceless and totally dependent on someone else for the things needed to sustain our lives. At this stage of an infant's life, she has no concept of self. The experts tell us that, when she begins to be aware of her own existence, she considers herself part of the primary caretaker, usually mother. During the time when mother and self are seen as one, the child's wants and needs and pains are fulfilled and removed by this other self, mother. The

6. *Id.* at 44.

child comes to believe that to feel a want is to have it gratified, that to be aware of a need is to have it met, and that to feel pain is to have it removed. Later, the child begins to differentiate between self and mother. She also learns that she herself has power. She can get mother to do things. She can cause mother to act or to change her emotional state. Unfortunately—oh painful discovery!—, she also learns that mother has power. Mother can delay or withhold things that she wants or needs. The power struggle between parent and child is on. Her sense of power and self-delimitation is hard-won, and she is proud of it. She will defend it with all that is in her. It was easier to be powerless, to be dependent, part of mother, and that state has an appeal for her. However, returns to infancy, in most families, are forcefully resisted by mother and usually rejected by the child herself as an unacceptable surrender of her own power. She is rewarded internally and externally for maintaining her sense of self. Throughout her life, whenever she sees powerlessness in another person, it threatens her own sense of self. It reminds her of the temptation to return to that powerlessness when she had no sense of self. It triggers an assertion of her own sense of power, which she will then exercise over the other person.

This is the radical implication of Freud's discoveries: that each critical organizing principle in rational and irrational thinking—*distinguishing between or confounding self and other, reality and fantasy, cause and effect, and the like—rests on the implicit premise that the diametrically opposed principle is more desirable, more satisfying.* [emphasis added] If neither mode can or should dominate the other, and yet each claims to be mutually exclusive, the individual cannot avoid always reasoning in circles. Each attempt to stop the circle at one pole paradoxically enhances the individual's perception of the attractiveness of the other pole.

This paradoxical vision now gives us a way to understand why each polar belief in its starkest form—as the rigidly clear-cut distinction between or the utter confounding of self and other, for example—has fearful, even violent, implications for all adults

...⁷

The apparent powerlessness or choicelessness of another person arises from our perception that that person is incapable, at least for the moment, of being a self-defining and self-protecting en-

7. *Id.* at 55.

tity—as being without self—, and this sets up the polarity described by Dr. Burt in the quotation above.

Dr. Burt uses the example of incest to demonstrate this polarity. When the very young child sees herself fused with the caretaker-parent, the beginnings for the wish for incest are readily understandable, since that parent, presumably, has a sexual relationship with the other parent. When the concept of separate selfhood begins to grow and develop later on, with its rights of power and decision-making, the incest wish becomes a forbidden idea because the new self, the child, would be in competition with the caretaker-parent for the sexual relationship with the other parent. Therefore, incest returns us to the stage of our development when we had no power, no choice, and the taboo is our reaction, individually and collectively, to the threat posed by any thought of returning to that selfless, powerless, choiceless state. This same threat comes when we are confronted with someone who appears to be selfless, powerless, and choiceless. We react self-protectively and from our emotional foundations, which not only cloud, but obliterate concern for the other person and reasonable response to the situation as it is.⁸

Dr. Burt draws an example from the well known Milgram experiments,⁹ in which, in one experimental group, 25 of 40 subjects ignored the protests of a learner, to whom they believed they were administering a painful and dangerous electric shock, simply because the experimenter urged them forward with the suggestion that the experiment required that they continue. Several of these subjects actually believed, when the learning sequence which they thought was the point of the experiment ended, that the learner was dead. Yet, they had continued to administer what they believed to be electric shock of increasing voltage for each wrong answer. Dr. Burt explains these results in terms of his hypothesis: "The compliant subject thus first conceptually obliterated the learner by defining him as utterly impotent and without legitimate choice-making authority. The learner's actual obliteration, his [apparent] death, followed from this conceptual obliteration."¹⁰

The compliant subjects defined themselves as choiceless also

8. I find the implications of the incest analogy for gender differences in emotional reactions and self-concept intriguing, but they are beyond the scope of Dr. Burt's book or my review of it. Dr. Burt does explore, in a useful analysis at 61-65, the implications of his theory for child abuse by parents.

9. S. MILGRAM, *OBEDIENCE TO AUTHORITY* (1974).

10. BURT, *supra*, at 80.

and ascribed all power, choice, and responsibility to the experimenter. Dr. Burt suggests that this result came about because of the initial stress caused in the subjects by the juxtaposition of the learner's agonized screams and protests on the one hand and, on the other, the experimenter's calm direction that the experiment continue. The subject's sense of self was threatened by the highly non-standard cues from the other two people involved. The choice-making power was abdicated in favor of the experimenter because of "the social plausibility and even seductiveness of the self-conception that [the experimenter] could offer the experimental subjects because he could cloak himself in the mantle of science."¹¹

Indeed, Dr. Burt suggests that Dr. Milgram succumbed to this force himself when he continued his experiments to their conclusion regardless of the very real suffering on the part of the nearly two-thirds of his subjects who believed, during the time they were serving as subjects, that they were inflicting severe pain, and perhaps death, upon other people. Dr. Milgram continued the experiments out of a respect for science and its needs which, according to Dr. Burt, is the same value which caused the subjects themselves to resign choice-making and powerful selfhood in order to avoid the confusion set up by the actions of the learners on the one hand and the experimenter on the other.

The same value—the needs, rights and inherent power of science itself—influences, of course, decision-making in which the law engages when it faces doctor-patient decision-making or other situations in which scientific expert testimony suggests one course of action and an apparently powerless person or her spokeswoman desires a different one. The confused but harmless old lady threatens those with whom she comes in contact because her "abnormality" raises confusion about the sense of self in those who encounter her, and no one takes responsibility for her ultimate commitment to an institution where she does not wish to go.¹² Her relatives are not responsible; they are acting on the advice of doctors and the decision of a judge. The judge is not responsible; she is acting in response to the needs of the family and the expert advice of the doctors. The doctors are not responsible; they are acting only as providers of data to the judge who has final decision-making authority. Since no one is responsible for the decision, no one needs

11. *Id.* at 81.

12. *See, e.g.,* Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966) This case provides one of Dr. Burt's primary examples.

to defend it in terms of what the confused little old lady really needs or what society really needs. Instead, each actor responds with panic to the threats posed to her by the abnormal and conflicting stimuli and avoids the threat by defining herself as powerless and choiceless. Since no one has to defend the decision, except in terms of her reliance on other actors involved in the situation, the consequences for the person acted upon are most unlikely to be desirable or reasonable.

This may appear to lead us to the conclusion that the originally confused person—in the example above, the little old lady—should have the legal power to make her own decisions, that the patient should always decide whether or not treatment is warranted, that the troubled teenager should determine the disposition of her own case by the juvenile court. However, Dr. Burt rejects this solution as well, for it cuts off interaction cues needed by the patient or other troubled person. Usually, when legal-medical-psychiatric questions arise, the originally powerless person is also confused, and putting her at the opposite pole of being all-powerful and the only choice-maker in the situation is not the best solution either.

Dr. Burt believes that on-going negotiation and a continuing relationship, with responsibility on all participants, is the best way to arrive at the proper choices. He suggests that the role of the law should be to encourage the first-line participants to resolve their problem. Dr. Burt's solution is that "the law [ought to] force the parties to resolve [the] question initially for themselves with only tentative, generalized guidance regarding the law's willingness subsequently to approve or to penalize those resolutions."¹³

If the doctor faces the possibility of criminal prosecution for discontinuing treatment or civil liability for giving treatment against a patient's wishes, she has an incentive to continue her dialogue with the patient in hopes that the two of them can arrive at a mutually acceptable course of conduct. Also, the patient's refusal to consent to treatment, or insistence upon treatment, will not be frozen in time the moment a lawsuit is brought, but will continue to be tested against the assault of the doctor's contrary opinion in this continuing dialogue. It is of course, exactly such dialogue that one wishes to avoid when confronted with a self-threatening, non-normal other person who fails to assist her in her on-going self-definition and thus poses a threat to it. If the law tells the parties

13. *Id.* at 132.

that it will not assume the responsibility of choice-making, and not allow them to be powerless, and gives them some countervailing value which provides a reason to undertake the threatening discussion, perhaps we can avoid the brutality which is a potential part of the process in which everyone avoids taking, or admitting that she is taking, any responsibility for the decision made.

The judge's role in Mr. Burt's suggested reform is to send the parties back to their conversation until, eventually, some action is taken by the doctor or the patient, or the possibility of action has ended. At this time, the judge will review the results and evaluate the decisions made. This after-the-fact review is less threatening to the judge because she is evaluating an accomplished fact, rather than choosing between alternatives in the dispute between the doctor and the patient. Where one person is incapable of any dialogue—for example, that infant who cannot yet speak or a comatose hospital patient—, the refusal of the courts to decide the issue presented by family or doctors until after action has been taken will force the actor to consider the incapable person's views and interests. The responsibility that will be imposed upon her if she makes a wrong choice will inhibit her from succumbing to the temptation to look away from the powerless person or to insist that she is not responsible and is also powerless in this threatening and confusing interaction.

The dangers of continuing a system in which no one admits responsibility are well stated by Dr. Burt:

Imprisonment in mammoth, socially isolated institutions in the name of "treatment" emerged as the characteristic modality from the last century. More direct physical obliteration of unconventional people in the name of "individual liberty" may be emerging as the contemporary modality The current reformist intentions to take care of helpless, abnormal people by removing them from brutal institutions can readily become translated into an intention to fill up gravesites with them.¹⁴

If we insist upon the individual's right to refuse treatment which is necessary to prolong life, either at the moment that treatment is explained to her or at an earlier moment by signing a living will, we allow her to be the exclusive choice-maker in her own postponable death. The attraction of this free-choice solution may be the comfort it affords those of us who are relieved of any responsibility by the other person's all-powerful choice. That is, we may exalt

14. *Id.* at 169.

this particular individual freedom not because we think it is good for the person who has it, but because it makes it easier for us to turn away from the threat to us implicit in her powerless situation and allows us to disclaim responsibility in her postponable death.

Dr. Burt's solution may well be a vast improvement over present law on the issue of doctor-patient relations, which is the primary focus of the book, in that the doctor is made responsible by the threat of judicial review and prevented from assuming an all-powerful stance by that same threat. If the doctor turns away and allows the patient or the patient's family to be the sole choice-maker, she may face penalties when the court later decides that the patient's request or the family's request was not the proper action to take. On the other hand, if the doctor disregards the family and the patient and decides on the basis of her own preferences, she will be held accountable for the resulting action unless the judge can be persuaded to share those preferences. The judge will not share the doctor's need to avoid interaction with, or responsibility for, the patient, since the issue is already decided in fact and the judge's task is only to evaluate that action with what is commonly called the "benefit of hindsight."

However, the title of the book, *Taking Care of Strangers*, suggests a broader implication for the principles Dr. Burt recognizes, and I am troubled by the lack of apparent solution where the court is called upon, not to determine when a doctor or some other third party should intervene, but to determine whether or not the court itself should intervene in the life of the powerless person. If a child is before the court on a neglect petition with allegations of child abuse by the parents, sending the parents and the children home to continue their interaction until some decision is made and then holding them responsible for that decision would be patently unsuccessful. On the other hand, if the judge does intervene and remove the child from the home, then she is in the position in which the doctor found herself vis-à-vis the patient. That is, she is the one threatened by the situation of the powerless child and the one called upon to decide what is to be done. She is threatened by the situation and has all the motivations we have seen to disclaim responsibility. Sending the family home to work it out may be worse than allowing the patient a final choice to refuse treatment and die. Removing the child from the home may be like hospitalizing the mental incompetent who poses no threat of physical harm to herself or to society. The judge must do something or nothing; there is no one else to decide.

It is perhaps unfair to ask more of a book than its author proposed or attempted, and the subtitle makes clear the limitation to doctor-patient relations. However, it is certainly the judge herself, and not a doctor, who is taking care of strangers in most family and juvenile cases, and some improvement is sorely needed to avoid the growing toll of children who die because they are left in the home with abusing parents and children who suffer irreparable psychological damage because they are unnecessarily removed from their homes.

Who is to second-guess the judges? In our system, that function is given to appellate judges, but, unlike the after-the-fact evaluation proposed by Dr. Burt, the appellate judge is compelled by our system of jurisprudence to confine herself to precisely the situation which was before the trial judge, and she is thus in exactly the same position with exactly the same threats and confusions that the trial judge faced. This is not an after-the-fact, Monday-morning-quarterback evaluation but another opportunity for disclaiming responsibility. The trial judge can say, "If I was wrong, the appellate judge will fix it." The appellate judge can say, "The trial judge was there and heard the evidence, and her decision is more likely to be right than mine. I will abide by her decision." There is nothing in this system which holds either judge accountable for harmful consequences of her decision for the person before the court. Not all strangers are patients; how do we take care of threatened children, battered spouses, other crime victims, and all the powerless strangers who turn to police or courts for help?

Returning to the confines of the book itself, I see a much greater problem. Dr. Burt's solution of leaving the intervention decision to resolution by doctors and patients acting concurrently, or by a doctor who is forced by the threat of subsequent review to consider the well-being of her silent patient, will strongly tempt doctors faced with this threat of review to protect themselves by keeping the patient alive even when the patient, her friends and relatives, and most other people would agree that a dignified death is the better solution. It is unlikely that a court will attach any serious sanction to such a decision, while very serious sanctions may attach to the decision to allow a dignified death. *Per contra*, there will be a tendency to give minimum treatment in situations that are not life-threatening because nonintervention will be less severely sanctioned than intervention which is later deemed to be improper or not best for the patient.

After-the-fact consideration by judges and reluctance to im-

pose sanctions against doctors who face hard decisions and act in good faith will predispose judges to ratify whatever the doctor and patient have, in fact, done, unless it is sufficiently outrageous, perhaps, to shock the conscience of the judge. These dangers are particularly great if the legal system holds to its present rules in evaluating the doctor's conduct. Failure to act, particularly when life is not endangered, is not sanctionable, but taking, without the patient's consent, an action which is later found to have been improper does carry with it legal sanctions. Allowing a patient to die by withholding treatment, at least where treatment had begun and was discontinued, has been labeled murder, but there are no sanctions for keeping a patient alive when treatment should, in the opinion of second-guessers, have been stopped. I am not concerned with the likelihood of non-intervention where no serious harm threatens, but the bias to preserve the comatose presents its own dangers. It may enhance a value we want in our system, but, before Dr. Burt's solution is adopted, it should be very carefully examined. The fact that we allow the individual to decide in order to avoid responsibility and power, does not automatically mean that her decision—for example, to die with dignity as expressed in a living will—is not also the best choice for her. Do we want to make that solution as unattractive to doctors as Dr. Burt's reform would do?

One of Dr. Burt's primary examples, referred to as Mr. G., is a victim of severe burns suffered in an accident. Mr. G, from the time the ambulance came to pick him up immediately after the accident until, apparently, his hospitalization ended, consistently refused to consent to his own treatment. His view was that the pain he suffered from his injuries and, later, from the treatment itself was too high a price to pay for the prolonging of his life. He lacked the physical capacity for suicide, as he was immobile and could not grasp with his hands. The doctors continued to treat Mr. G, not only to prevent infection and assist the healing of his burns but also surgically to correct his hands and feet. Dr. Burt does not tell us why the treatment was continued despite the lack of consent, but it does appear that Mr. G's case never went to court. Eventually, Mr. G recovered and, having been amazed throughout his hospitalization that the doctors could and would ignore his repeated attempts to refuse treatment, he attended law school. Dr. Burt seems to assume that the present success and usefulness of Mr. G justifies the decision to continue his treatment. Nowhere, however, does Dr. Burt relate to us Mr. G's current opinion. Is Mr.

G grateful that his treatment, with its excruciating pain, was completed? Should the legal system join Dr. Burt in assuming that postponing Mr. G's death for another cause and another time is the best choice?¹⁵

A system in which the doctor and judge usually act to protect the doctor is less fraught with danger to the patient than our present system. However, no one is representing the interest of family and friends and the pain it brings to see a loved one kept alive unnecessarily. Nor is anyone considering what may become, with increased technology, astronomically expensive and utterly valueless prolonging of life. For example, where extreme pain and irreversible brain damage might justify for a doctor and a judge today a decision to end life, perhaps an electronic brain implant in the pain center can prevent such pain and thus obliterate the reason for stopping treatment. Perhaps no one need die at all in such a system. Indeed, under Dr. Burt's formulation, what *would* justify, for the doctor, unplugging the respirator when she faces the risk of criminal responsibility if a judge later thinks she shouldn't have? There could be hospitals full of those who are all but legally dead and no resources of facilities, expertise, machinery, technology, or money to care for those who are merely ill.

With Dr. Burt's reform, no one represents the interest of the larger society, of those individuals who are not involved in a particular transaction at all. While the judge may be said to represent the people, she can more easily set aside her responsibility to them than she can her responsibility for the penalty suffered by the doctor if the doctor's decision is set aside by the court. As the doctor's temptation will be to opt for keeping the patient alive, no matter what, the judge's easier route will be to ratify what the doctor has done, no matter what. The consequences may be even less attractive than Dr. Burt's spectre of our filling the graveyards with those who bring us confusion and problems for self-delimitation. Death comes to us all, and later is not always better.

15. *Id.* Mr. G's case is discussed off and on throughout the book, but see particularly Chapter 1.