

Benumbed

by Carl E. Schneider

I originally intended to write a column on tort liability and research ethics, and I still plan to do so. But this column is a *cri de coeur* as I finish another semester teaching law and bioethics. This year, I asked with growing frequency, urgency, and exasperation, “Must law’s reverence for autonomy squeeze out the impulse to kindness? Where is the beneficence in bioethics?” These questions assail me every term. Why?

Consider *Steele v. Hamilton County Community Mental Health Board*.¹ Mr. Steele was involuntarily “hospitalized after his family reported that he was ‘seeing things and trying to fight imaginary foes.’” Concluding that Mr. Steele was paranoid schizophrenic, the hospital sought judicial permission to give Mr. Steele antipsychotic drugs without his “informed consent.” Eventually the case reached the Ohio Supreme Court. It began its analysis by intoning a hymn to “the right to refuse medical treatment,” which it called “a fundamental right in our country, where personal security, bodily integrity, and autonomy are cherished liberties.” The court concluded that the state could not administer the drugs unless it showed by “clear and convincing evidence” that (1) a patient “lacks the capacity to give or withhold informed consent,” (2) “the benefits of the antipsychotic medication outweigh the side effects,” and (3) “there is no less intrusive treatment . . . as effective in treating the illness.” Piling Ossa on Pelion, the court imposed elaborate proce-

dural requirements for issuing and maintaining such a judicial order.

Perhaps this is the right result. It is not, as opinions in this area go, extreme, which is one reason I’ve selected it to discuss. Certainly the history of civil commitment and hospitalization of the mentally ill has sometimes been ugly. Surely infringing autonomy can be cruel in its own ways, as Jay Katz’s famous story of Iphigenia reminds us.² But the court’s opinion in *Steele* does not justify its holding, and the omissions in it make it heartless. Painfully absent is any sense that poor Mr. Steele lay bound on the rack of a disease that was destroying his life and devastating his family and that ameliorating this wretchedness was even desirable. The court nodded briefly to “the state’s *parens patriae* power,” but its attention and concern went not to the savagery of the disease, but to the menace of the state. The court’s anxiety was overwhelmingly that “[t]his type of intrusion clearly compromises one’s liberty interests in personal security, bodily integrity, and autonomy.” When the court mentioned treatment, it lingered lovingly on the side effects of antipsychotic drugs, since “[t]he seriousness of the possible side effects of these types of drugs cannot be overstated.” The court went on to overstate that seriousness, not least because its information was indolently drawn from legal, not medical, sources and out of date.

Hence the court strewed barriers between Mr. Steele and treatment. It repeatedly imposed the highest civil stan-

dard of proof—“clear and convincing evidence” rather than “a preponderance of the evidence”—and it devised procedures that were forbiddingly burdensome. If all this inspired better decisions about treatment, it might be justifiable. But the court never bothered to assess the effects of its requirements, and in other contexts we would call them “bureaucratic red tape.” The court seemed more influenced by *One Flew Over the Cuckoo’s Nest* than evidence about paranoid schizophrenia, commitment proceedings, or due process.

Yet the court’s apparent indifference to Mr. Steele’s illness was not forced upon it. The law of procedural due process, while it interprets an express constitutional text, is in all else a judicial creation. And the law of substantive due process (the wellspring of “the right to refuse medical treatment”) is *fons et origo* judicially created. What is more, why was the right attributed to Mr. Steele the right to refuse treatment (and not, say, a right to *have* treatment)? Did he choose this argument? If he was seeing things and fighting imaginary foes, how lucidly, how autonomously, was he thinking? If he did not assert the right to refuse treatment, who chose for him, and why did the court accept the choice so uncritically? More broadly, what can be said of a legal system that develops so zealously, so sanctimoniously, the right to refuse medical treatment while ignoring the tens of millions who cannot get it?

I was not heartened when I turned from the court’s opinion to my class’s reaction. Law is taught through “casebooks” that comprise cases, statutes, administrative regulations, commentary, text, and questions. My co-author wrote the section of our casebook that considers decisions for incompetent patients and thus *Steele*. She realized that many students would know little about mental illness and wanted to give them some sense of what a paranoid schizophrenic must endure. She did a masterly job, not just through medical and social data, but also through excerpts from a paranoid schizophrenic’s moving account of his torment in the throes of the disease

and his partial but blessed release when he was finally treated.

Nevertheless, the class's first and virtually only reaction to *Steele* was that the opinion was dangerously tolerant of the state's invasion of Mr. Steele's rights: Everyone has a right to autonomy and therefore to refuse medical treatment, and schizophrenics do not lose their rights just because they are ill. Mr. Steele and his family might be suffering, but forced medication would be an intolerable step down the slippery slope toward the end of personal autonomy. End of Story.

If I thought my students were particularly callous, I would not be disturbed by their reaction to *Steele*. But they are, if anything, exceptionally decent. I know quite a lot about law students: I was one, I teach them, and I am writing a book about how our graduates have made decisions about their careers. I always emerge from my interviews with an enlivened respect for our students and for their seriousness and goodness. The interviews make me glad to be their teacher.

So what leads good people like my students (and, presumably, the judges in *Steele*) to respond so indifferently to the misery of Mr. Steele and his family? That is too big a question for so small a space. But law has its own imperatives. Law's "idioms rule us in ways we do not always grasp or desire, and they have limits growing out of the ends for which they were created."³ Law is about minimums, not maximums; rules, not compassion; deterring wrong, not inspiring right. It is driven by distrust. It can be satisfied by forms, by outward signs without inward grace. All this is often unavoidable. But then law should proceed—as it did not in *Steele*—with delicacy, discretion, prudence, modesty, and insight into and sympathy for the lives of those it traps.

In particular, the law's moral clumsiness should make us cautious when legal reasoning colonizes other institutions and should make us zealous to preserve the extra-legal virtues that those institutions should nurture. It is easy to understand the resort to law: It always looks like the cheapest way to change behav-

ior. And the grand principles that we hope animate law are so near to our hearts and so embedded in our culture that we carelessly embrace the legal rules, forms, and procedures that attend them. But when legal thinking infiltrates social behavior, the bad in legal reasoning drives out the good in social life. The legal principle of autonomy is so "greedy" a principle, a principle so determined to extend itself to its limits, that it crowds out what patients themselves may think are more important matters, matters of decency and compassion unmoored to ideas about autonomy. And so homely virtues like solicitude and kindness get lost in the struggle.

But law should not shoulder all the blame; "bioethics" shares these faults without the law's excuse of special imperatives. As Renée Fox gently puts it, even the "benefiting of others advocated in bioethical thought is circumscribed by respectful deference to individual rights, interests, and autonomy; and minimizing the harm done to individuals is more greatly accentuated than the maximization of either personal or collective good."⁴

Consider an example at the intersection of law and bioethics. I have been reading articles on "advance care planning" by eminent bioethicists and doctors. Often I can barely tell that they are instructing physicians on how to help human beings face decay and death. The articles march straight to the point—patients have a right to make medical decisions, doctors should transcribe their wishes in legally binding form. Hardly a word about the sustenance and comfort—physical, moral, emotional—that dying people might crave. Hardly a hint that sympathy, understanding, reassurance, and support might be as dear to patients as legal rights. No sense that patients' troubles can be eased by costless kindness, by the simple empathy—or even good manners—that would make stories like Reynolds Price's inconceivable: "The presiding radiation oncologist had begun our first meeting by telling me, with all the visible concern of a steel cheese-grater, that my tumor was of a size that was likely unprecedented in the annals of Duke Hospital."⁵ And

what is gained when the law's forms so overwhelm the doctor's thoughts? Too often, too little. For example, evidence now proliferates that the law's gift to the dying—the living will—rarely serves its intended purpose.⁶

Law speaks of "balancing" individual rights and state interests. Bioethics speaks of serving both autonomy and beneficence. These are impoverished endeavors at best. But if law and bioethics could at least treat these pairs of concerns with the even-handedness their formulas seem to imply, they might achieve a richer morality and a wiser policy. From the start, however, "individual rights" and "autonomy" exude the odor of sanctity, while "state interests" and "beneficence" trail the stench of paternalism, even tyranny.

So as I prepared for class by reviewing the cases and statutes on law at the end of life and reading articles on planning for death, I could not repress the memory of one visit to a hospital palliative care unit. A patient had arrived from another hospital. He had only hours to live, and he was in apparently untreated pain. He had tried to tear out his IV, and blood smeared his sheets. He had writhed to find a painless position, and his gown hardly covered his nakedness. As he lay dying he cried out, "Don't let your children die like this in pain. Don't let your children die like this in pain."

1. 736 NE2d 10 (Ohio 2000).

2. J. Katz, *The Silent World of Doctor and Patient* (The Free Press, 1984).

3. I suggest some of the ways in "Bioethics in the Language of the Law," HCR 24, no. 4 (1994), 16.

4. R.C. Fox, The Evolution of American Bioethics: A Sociological Perspective, in George Weisz, *Social Science Perspectives on Medical Ethics* (Philadelphia: University of Pennsylvania Press, 1990), 206-207.]

5. R. Price, *A Whole New Life* (New York: Atheneum, 1994), 40-41.

6. A. Fagerlin and C.E. Schneider, "Enough: The Failure of the Living Will," HCR, forthcoming.