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Bernard L. Diamond

University of California, Berkeley

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RESOLVING DOCTOR-PATIENT CONFLICTS

*Bernard L. Diamond**

TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS. By *Robert A. Burt*. New York: The Free Press. 1979. Pp. vii, 200. \$15.95.

Professor Burt of the Yale Law School has written a book that is concerned with a single problem, and he proposes a specific solution to that problem. This narrow theme makes the book very difficult to review fairly. If one agrees with the proposed solution, one may overvalue the book and not perceive whether the author reaches that solution through sound reasoning. If one disagrees with the author's conclusions, one may lose objectivity and overlook the broader implications of the analysis that precedes the conclusion.

I disagree with most of Professor Burt's analysis of the problem and I strongly disagree with his proposed solution. This disagreement is despite my feelings of harmony with Professor Burt's interest and approach toward a difficult subject. Burt is a legal scholar who has a very considerable knowledge of psychoanalytic theory. I am a psychoanalyst who has some knowledge of legal theory, so we share much intellectual territory. Perhaps that is why we don't agree. Or is it because the medical mind and the legal mind can never agree, no matter how much they share?

The problem posed by the author is a profound one: Who has, or should have, the power to make critical decisions in the doctor-patient relationship? Does the doctor know best? Perhaps doctors should make all final decisions. Does the patient's right of self-determination override all other considerations? Perhaps we should never tolerate anything short of fully informed consent by the patient. Or should the law intervene in certain difficult situations, making a judge decide what is to be done?

Burt introduces the problem by vividly describing two cases. The first is that of a young man who is horribly mutilated and blinded by an automobile fire and explosion. His treatment is slow, excruciatingly painful and he will never be restored to a normal condition. The other case is that of an elderly woman who was confined in a mental hospital because of her tendency to wander about the streets. Her case is well known, for she is the subject of a leading "least

* Professor of Law, University of California, Berkeley. Clinical Professor of Psychiatry, University of California, San Francisco. A.B. 1935, University of California, Berkeley; M.D. 1939, University of California, San Francisco.—Ed.

restrictive alternative" appellate decision.¹ Burt uses these two cases to develop "the proposition that assigning exclusive choice-making authority in one party (whether patient, physician, or judge) and complementary choiceless status to another in an interpersonal transaction readily leads to paradoxically destructive results for all participants" (p. 134). For reasons I will develop below, I am impelled to reply, "Not necessarily!"

Relying almost entirely upon psychoanalytic theories concerning unconscious motives, attitudes and feelings, the author pursues his theme with vigor and consistency. He states:

Whose claim of benevolence toward diseased people is to be believed? That is the underlying question of this work. My answer can be quickly summarized: no one's claim should be wholly believed or disbelieved, whether the claimant is physician or law reformer, judge or the diseased person himself. Rules governing doctor-patient relations must rest on the premise that anyone's wish to help a desperately pained, apparently helpless person is intertwined with a wish to hurt that person, to obliterate him from sight. It is not accidental that the injunction to "take care of" someone has a two-edged meaning in popular speech [p. vi].

To mitigate the dangers of unconscious ambivalence and destructive aggressive impulses, Burt proposes that all consent between doctor and patient, for treatment of both physical and mental conditions, be reached only by what he calls "conversation" between them. By "conversation," he really seems to mean a psychotherapeutic interchange, as prolonged as necessary, to resolve completely all unconscious ambivalence, in both the patient and the physician. If such conversation does not spontaneously resolve all ambivalence, Burt would allow no appeal to the law to make the decision, for the judge, who necessarily suffers from the same ambivalence, will inflict his own brand of unconscious aggression upon the patient and doctor.

The law cannot interrupt this dynamic by purporting to take control of relations between doctor and patient. It can only hope to accomplish this by refusing to take control, by forcing both doctors and patients to acknowledge that neither has unquestioned power over the other in order to prod both toward confronting the ultimate reality that neither has unquestioned power over the issues of disease, mortality, and dis-eased [*sic*] thinking that have brought them into relation. The law will only fuel rather than interrupt this destructive dynamic by providing a mechanism for advance review, for declaratory judgments, to decide all specific treatment issues in dispute between patients and physicians [p. 137].

Thus, Burt would use the authority of the court not to make a decision, but rather to force doctor and patient into "conversation."

1. See *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966).

Essential to Professor Burt's proposal is the element of uncertainty. The physician must know in advance the penalty for violating his patient's expressed wishes. Such penalty may be stringent or it may only be symbolic, but

[t]he principle should remain clear that physicians are obliged to obtain patients' consent in all matters; thus motivation will be established for conversation, for negotiation. But by keeping uncertain the precise consequences of any breach of this principle, the law establishes the motives for intense negotiation, for sustained face-to-face conversation in which each party feels himself personally engaged because each believes in the unavailability of his own pain and the other's power to inflict pain on him [p. 140].

If the patient and doctor fail to resolve their conflict, the legal system should tread lightly.

By promising that some subsequent judicial review of the doctor-patient conversation is available, but by withholding that review until the immediate participants have acted on their own disputed or agreed conclusions from that conversation, the law gives both participants a concrete demonstration that their conversation has an interminable, and comfortingly indestructable, dimension [p. 138].

Burt's judicial review will not produce a decision as to the correct action in giving or withholding the treatment. Rather, it will only review the adequacy of the conversation, assessing whether the conversation has ended properly or should be carried further. If the physician has acted improperly after an inadequate conversation with the patient, the court will impose a punishment that is appropriate to the wrongdoing but that the physician could not have accurately foretold. The goal is to avoid shifting the responsibility for decision upon the law, and instead to use the authority of the law to force upon the doctor and patient as extensive a negotiation conversation (therapy?) as is necessary.

The final chapter discusses the issues raised by what the author terms "silent patients." These are patients who, because of severe mental illness, incapacity, or unconsciousness, are unable to engage in the conversation required for informed consent. Here, two other cases are introduced and their dilemmas analyzed: Karen Quinlan and the less well-known Saikewicz. Saikewicz was a sixty-six year-old man, severely mentally retarded, incapable of any meaningful verbal communication, who suffered from a fatal leukemia. People with such leukemia are normally given chemotherapy, which prolongs their lives but does not cure the disease. The treatment requires cooperation from the patient, and it is often painful and distressing. Saikewicz's doctors petitioned a Massachusetts court to decide whether they should withhold chemotherapy because of his inability to consent, to cooperate, or to understand the reason for the suffering he might undergo as a result of the treatment. The court

authorized withholding chemotherapy, and Saikewicz soon died (p. 145).

For the complex problems aroused by such silent patients, the author prescribes the same conversational remedy, but in more complex form. Neither physician, relative, friend, nor judge must speak for the patient. Especially, no one must presume to assert what the patient, if he could speak and understand, might desire. The solution must still be a conversation but of such extent that all who could possibly have any involvement or interest must participate. Because the physician and family are granted no advance legal immunity,

[t]hese actors could withhold treatment and minimize these risks [of criminal prosecution] only by the most intense collaboration with one another, and with intense individualized attention to the uncommunicative patient, in order to build a defensible record that every treatment effort has been made and that the futility and painfulness of these efforts appeared so palpable to so many different people involved in the decision that all were prepared to take the risk of prosecution for criminal conspiracy rather than continue heartless compliance with the apparent letter of the law [p. 166].

Burt does not explain how to select the "many different people involved in the decision." In some situations, one might anticipate great difficulty in getting anyone involved. In other situations, all sorts of persons might claim involvement and decisional rights to which they are not entitled. One can foresee endless difficulties. Throughout the book, the author is annoyingly vague about how his proposed procedures should be implemented.

Many of the inferences and psychoanalytic interpretations that Burt presents as established facts could be disputed: he gives no credit to alternative interpretations of psychological phenomena. His basic writing style expresses an unjustified attitude of certainty, conviction, and enthusiasm. If perceived as a highly speculative, somewhat one-sided, proposal for the solution of very difficult medico-legal problems based upon disputable psychoanalytic interpretations of unconscious motivation, *Taking Care of Strangers* is a fascinating and instructive book. But if considered as a practical and realistic proposal to cope with existing conflicts of medical informed consent, its usefulness is questionable. I fear the author had the latter rather than the former mission.

Rather than go through the volume and nit-pick about all the points where I would prefer a different interpretation from Professor Burt's, I will limit myself to discussing a few of the broad and mistaken assumptions that, in my opinion, pervade the entire book. A relevant (apocryphal?) anecdote is told about Sigmund Freud. Freud was an inveterate cigar smoker, and one day a friend asked him, "Doctor Freud, how is it possible that you, who discovered that cigars and similar objects are actually phallic symbols, go around all

day with a penis in your mouth?" Freud replied, "Yes, it is true that a cigar is a penis symbol. But do not forget that a good cigar is also a good cigar."

By concentrating on the unconscious dynamics of the participants in the medical-legal-patient relationship and neglecting their conscious and intentional motivations, the author is misled into impractical and perhaps erroneous conclusions. Much of what he says concerning the unconscious destructive dynamics of doctor, patient, and judge may well be true. But it is not the whole story. The unconscious is an important determinant of human behavior, but it is not the sole determinant. Burt seems to give no credence to the possibility that experience, knowledge and insight might confer sufficient power over one's destructive drives to permit rational actions and relationships, even without prolonged conversations. Professor Burt derives his hypotheses and his solutions from extraordinary and exceptional cases. They well fit what Judge David Bazelon of the District of Columbia Circuit Court of Appeals calls "chamber of horrors cases." Laws and procedures based on such horror cases are not likely to be good. They are the hard cases that can make bad law. It may be that such cases evoke the malicious power of the unconscious. But the rules that govern the millions of everyday interactions of doctors and patients must be responsive to the conscious egos, and give credibility to the will and intent of the participants. Burt seems to have overlooked the fact that ambivalent feelings do not necessarily give rise to ambivalent decisions and actions. To the contrary, I think that in most ordinary interpersonal situations, one side of the ambivalence is suppressed, for good or bad reasons, and the resultant action is unambivalent. Thus both patient and physician may suppress their mutual hostility and interact with trust and confidence. In the vast majority of simple, direct interchanges between doctor and patient (or between any two persons), it may be best, as Freud says, to pay attention to the cigars and leave the phallic symbols to the psychoanalytic couch.

Thus, I believe, for most surgical and medical procedures, patients can give rational, informed consent in an atmosphere of trust, and the physician can suppress any sadistic motivations and respond to the patients' needs. However, I do agree with Burt that in special cases and special circumstances, this is not likely to be true. These include the chamber of horrors cases of pain, mutilation, and disability² as well as the cases of uncooperative incompetent patients

2. I am very familiar with the monstrous problems associated with such tragedies. During World War II, I had the major responsibility during one year of attempting to cope with the emotional problems of hundreds of blinded soldiers. In addition to their blindness, most of them had severe head injuries, and many had one or more mutilated arms or legs. See Diamond & Ross, *Emotional Adjustment of Newly Blinded Soldiers*, 102 AM. J. OF PSYCH. 367 (1945).

who are involuntarily confined and treated. For some such cases, Burt's extended and extensive conversations motivated by the threat of judicial review may work. But for many of these exceptional problems it cannot be assumed that there is a rational, correct solution. Unfortunately, we cannot assume that every human problem has a proper answer. Sometimes every possible response to a problem will have significant detrimental consequences. Yet to take no action may be much more detrimental. Sometimes the knowledge required for a rational decision does not exist and will not magically appear, no matter how extensive and protracted the conversations between the participants. And in many cases an incorrect decision is better than no decision.

These are the human problems where the issue is not, "Who knows the right answer?" Rather, it is, "Who is accepted by society and the participants as having the *authority* to prescribe an answer?" Such authority may not necessarily be founded upon superior knowledge or special insights into the human condition. Nor is the responsibility inherent in that authority necessarily a quality of the decision maker. It may well be simply attributed to him by social institutions or customs. Nevertheless, a sort of consensus cloaks the decision with an aura of wisdom and power, action is taken, and everyone can then go about their daily business. Certainly it is possible to demonstrate that the need for such authorities has its roots in the unconscious need for the omnipotent and omniscient father of infancy. But the decision is also a decision that needs to be made, roots or no roots.

Different cultures at different times have used a variety of persons to decide impossible problems. In our society, I believe, judges are admirably suited for this role. They are designated by society as authority figures; their decisions are translated into action. They are surrounded with sufficient mystique and symbols of wisdom and fairness that their decisions can be respected by all concerned. Behind them is the *Law*, supposedly the distillation of the moral wisdom of the ages. That all this may be illusory is beside the point. Some illusions are worth retaining. When there is no right answer, when there is no existing wisdom to determine the correct response, when the truth is elusive, yet action must be taken, judges seem to do quite well (unless they suffer from excessive scrupulousness or blind arrogance). When there has been a breakdown in the normal communication between doctor and patient, or when, as with "silent patients," communication is impossible, Professor Burt would have us avoid the one decision maker in our society peculiarly suited to the task — the judge. Rather than limit his authority, I would extend it. I would reinforce his decisional respectability by establishing, insofar as possible, guidelines (laws?) and precedents that take some of the burden off his shoulders.

I know only too well from my experience as a forensic psychiatrist that judges are not always wise, rational, free from prejudice, or responsible in their decisions. Sometimes I have thought that others would have made better decisions, or that I, personally, could have done better. But neither I nor the others possessed the necessary authority and social ascription of power and respectability to have our decisions accepted. Some judges never make any decisions, let alone difficult or impossible decisions. They pass the problem on to someone else, or they procrastinate, or they rubber-stamp, or they blindly follow what they believe to be precedent. They may do exactly as Burt says — wreak havoc by inflicting their own unconscious aggression on others. But I have more faith than Professor Burt that the law and its representatives, the judges, are the proper instruments for resolving conflict and dispute and for making decisions in all those human situations where no one else has the proper combination of knowledge, experience, wisdom, power, authority, and respectability to do as well.