Taking Care of the Doctor-Patient Relationship (reviewing Robert Burt, Taking Care of Strangers)

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Review Article

Taking Care of the Doctor-Patient Relationship: A Review of Robert Burt's Taking Care of Strangers

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In Taking Care of Strangers, Robert Burt proposes basing legal regulation of the doctor-patient relationship on a psychoanalysis of that relationship. Currently, the law gives the patient the final say in decisions about his medical care. But Burt argues that such a rule is unsound on a psychological level. According to Burt, the doctor-patient interaction will be destructive if either the doctor or the patient believes he is the ultimate decision maker. Burt feels that it is impossible to believe any single individual—even the patient himself—who says he is speaking on the patient's behalf. Thus, says Burt, the law should not give the decision-making power to any one person. Burt says:

Whose claim of benevolence toward diseased people is to be believed? . . . [N]o 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.²

Since Burt uses a psychoanalytic basis for his legal recommendations, a complete review of his book must consider two issues. First, is his diagnosis correct—that is, does he substantiate sufficiently the psychological harm he is positing? And second, is his proposed treatment—the legal recommendations derived from his analysis—a practical and constitutional manner of reducing that risk of harm without causing its own serious side effects?


2. Id. at vi.
I. Legal Regulation Based on Psychoanalysis

A. The Psychoanalytic Basis

Mergers between psychoanalysis and law are not new. Generally, lawyers advocating such mergers accept the psychoanalytic literature at face value. Burt, however, constructs his own psychoanalytic theory, which conflicts with the traditional Freudian approach.

According to Burt there is in every individual a constant struggle between a desire for fusion with others (just as the infant sees himself as one with his mother) and the knowledge that one has a separate identity. This can be likened to the struggle postulated by Freud between the infantile id and more rational ego. Freud felt that the ego must triumph for an individual to be mentally healthy. In contrast, Burt says the mind is comfortable holding both the idea of fusion and a separate identity at the same time. He postulates that people, including both doctors and patients, will lash out violently if forced toward either pole. According to Burt,

Whenever anyone seeks to conceive himself as either a wholly choice-making or wholly choiceless individual regarding another person, that aspiration reflects the individual's uncertainty regarding the boundaries between his "self" and the other's and an unwillingness consciously to acknowledge his uncertainty. . . . Unless the attempt to maintain this univalent conception is interrupted, the individual is led toward action to destroy the physical existence of that other person and/or himself in order to keep his intrapsychic grasp on the constructed "self" which depends on the obliteration of the "other's" alien separateness.

Two case studies provide the foundation for Burt's analysis. The first case is that of Mr. G, who was severely maimed and burned over two-thirds of his body in an exploding car. He was blinded and skin was sewn over his eye sockets to prevent infection. He was completely immobile. The doctors had no cure for Mr. G; all they could offer were painful chemical immersions to stave off infections and the intention to operate on his hand so that he might have some control over his own environment.

Mr. G "clearly and eloquently" explained to the doctors why he wanted the painful immersion treatment discontinued so that he could die. He stated that initial surgery on his arm had actually decreased the

3. Sigmund Freud, An Outline of Psycho-Analysis, trans. and ed. James Strachey, 30, 38 (New York: W. W. Norton & Co., 1969). Freud stressed the importance of the patient's separate identity by warning the analyst not to try to remake the patient in his own image. "If he does," wrote Freud, "he will only be repeating a mistake of the parents who crushed their child's independence by their influence, and he will be replacing the patient's earlier dependence by a new one. In all his attempts at improving and educating the patient the analyst should respect his individuality." Id. at 32.


5. Id. at 3.
use of it, indicating that he realized how little medical science could do for him. He also implied that even with medical science doing its best, he would not be able to live the life he wanted. "[All] my life I have been active in sports. I have played golf, surfed and rodeo . . . ." he said. "And now, I think, at best, I could just be rehabilitated to the extent where I could make it alone rather than be able to do things I really enjoyed."

The doctors asked a psychiatrist to interview Mr. G, hoping to have him declared mentally incompetent so that Mr. G could be committed and forced to undergo treatment. However, the psychiatrist found that Mr. G was not mentally ill. Nevertheless, the immersions continued.

Mr. G was appalled that the law would allow him to be subjected to painful (and, in his assessment, useless) treatments against his will. He said:

What really . . . astounds me . . . is that in a country like this where freedom has been stressed so much and civil liberties, especially during the last few years, how a person can be made to stay under a doctor’s care and be subjected to the painful treatment, such as the tankings which are very painful, against this person’s wishes, especially if he has demonstrated the ability to reason. . . . The way I see it, who is a doctor to decide whether a person lives or dies?

Mr. G tried to hire an attorney to get him out of the hospital but had difficulty finding one to handle the case. "It’s something that I found out attorneys, at least ethical ones, don’t want to touch—probably for fear of getting bad publicity," he told the psychiatrist.

Despite Mr. G’s eloquence in explaining his wish to exercise a right of self-determination, Burt feels that it would be harmful for Mr. G to make the decision regarding what should be done to him since in acting as the decision maker he could not acknowledge his subconscious desire to fuse with others. Burt implies that this subconscious desire must be expressed and that since Mr. G is suppressing it, he will be forced to obliterate the offensive person (himself). But, Burt can point to nothing in Mr. G’s thinking that indicates an unmet desire to fuse. As evidence that dependency is being suppressed, Burt takes Mr. G’s statement "[I have] to rely on someone else to feed me, all my private functions I need help with." But this need does not necessarily indicate that any psychological dependency is being suppressed. Rather, it refers to objective environmental factors—Mr. G’s injuries now force him to depend on others for even his

6. Id.
7. Id. at 4.
8. Id. at 10. He did eventually hire an attorney. See text at note 73 infra.
9. This is despite the fact that the book contains extensive material that reveals Mr. G’s thoughts, including an appendix of the dialogue between Mr. G and the psychiatrist.
10. Burt, supra note 1 at 12, 179-80.
most basic needs. Thus, Burt’s finding that Mr. G is “palpably confused about whether he is able to conceive of himself as an individual—as a being who is separate from others” seems unreasonable. As indicated by Mr. G’s description of the type of activities and life he prefers, Mr. G can conceive of himself as an individual just fine. He is not confused; rather he is being completely realistic in noting that, despite his strong individual mental self and despite his preference for taking control of his life, it is physically (but there is no evidence that it is mentally) impossible for him to care for himself.

The second case that Burt uses to develop his theory is that of Catherine Lake. Mrs. Lake, a 60-year-old woman, was stopped by a policewoman on a Washington, D.C., street because the officer thought Mrs. Lake looked confused. When Mrs. Lake could not recall her home address, the policewoman divined over Mrs. Lake’s protests that Mrs. Lake was not capable of taking care of herself and thus could be a danger to herself. On the basis of this exchange, Mrs. Lake was committed to St. Elizabeth’s Hospital, even though at the hearing she said, “I feel I am thoroughly competent. . . . I always took care of myself.” Apparently, no one bothered to check to see whether, despite the fact that she could not recite her address, she could have found her way home. After being confined to St. Elizabeth’s on the basis of her “aimless wandering,” Mrs. Lake was forced to stay against her will at the institution for the next nine years, until her death.

Burt feels that Mrs. Lake’s lengthy institutionalization was unwarranted. He seems to agree with the D.C. court of appeals, which heard the case, that she might have been adequately protected in a community facility or wearing an identification bracelet so that she could be helped home if lost on the streets. Yet Burt does not see the problem as one of the standards for institutionalization or the lack of appropriate facilities or programs for dealing with the elderly. Burt says the problem is that Mrs. Lake, like Mr. G, erroneously saw herself as “wholly and legitimately self-commanding.” According to Burt, “The unwillingness of either the surgeons and officials on their side, or of Mr. G and Mrs. Lake on their side of the transactions, to shift back and forth in their own self-representations between these two diametrically opposite conceptions was the key that unleashed the destructive abuse in these transactions.” Burt assumes that a patient’s assertion of the right to make decisions (and the current legal authority of the patient to do so) pushes doctors toward

11. Id. at 11–12.
12. Id. at 26.
13. Id.
15. Burt, supra note 1, at 66.
16. Id. at 61.
either rigid authoritarianism or a posture of impotence. But his proof for that point is a quote from a single physician asserting that doctors are frightened and hostile due to their fear of suit.\textsuperscript{17} His arguments about patients also lack substantiation. He says that if you give a patient decision-making power, the patient may reject the recommended treatment so as not to feel impotent.\textsuperscript{18} "[P]atients reject the cure that their physicians propose precisely because that is the physicians' proposal,"\textsuperscript{19} says Burt. He cites as evidence of that point studies that show that patients fail to follow doctors' prescriptions. But there are explanations other than a doctor-patient power play for why some patients do not take the type or amount of drugs their physicians recommend. A patient's symptoms may go into remission, and he may then feel he doesn't need the drugs.\textsuperscript{20} A patient may have gone to the doctor merely to find out whether the malady was a serious one, and when the doctor confirmed that it was not, decided it wasn't worth treating. Or a patient may not understand what the drug is for or how it is to be administered. He may think the doctor does not have the patient's best interest at heart. Or the patient may decide he can't afford the treatment.

Based on the cases of Mr. G and Mrs. Lake, Burt says that both self-determination (in which the patient makes treatment decisions) and paternalism (in which the doctor makes treatment decisions) are so psychologically destructive that they can even lead to the patient's death. The ideal doctor-patient relationship, according to Burt, is one in which both parties "shift back and forth" between viewing themselves as fused and as separate. But the case studies of Mr. G and Mrs. Lake fail to establish why such mental shifts are necessary or how they can be accomplished. Nevertheless, Burt makes legal recommendations that he believes will foster shifts in power and thus encourage dialogue.

B. Legal Recommendations

Under current law, competent adult patients have the right to decide what treatments they will undergo, and they can use the courts to pro-

\textsuperscript{17} The full quote is as follows:

"As a physician I live in an aura of fear—fear of suit. . . .

"It may be hard to believe but we are a frightened profession. The doctor feels put upon. He feels nude on the corner of the Main Street of life. He often tries to cover himself with pride, and even occasionally arrogance, only to find himself being castrated. He really doesn't want to believe the hostility he feels. . . .

The faith of the patient is important to the patient and to his physician. Faith is a power, and the physician continually feels it being eroded by sometimes justified and frequently unjustified attacks."

\textit{Id.} at 193 n.23.

\textsuperscript{18} \textit{Id.} at 94.

\textsuperscript{19} \textit{Id.}

\textsuperscript{20} Mechanic points out that a patient may fail to take drugs because he feels well (even though the disease process may still be active in his body). "From the patient's commonsense perspective," says Mechanic, "to stop medication or cancel a follow-up visit when he is feeling well, is logical." David Mechanic, Response Factors in Illness: The Study of Illness Behavior, in Theodore Millon, ed., Medical Behavioral Science 354, 362 (Philadelphia: W.B. Saunders Co., 1975).
hibit doctors from treating them against their will. Doctors can go to the courts for guidance in treatment decisions in some cases, such as where the patient’s ability to consent is at issue.

Burt, however, rejects the idea that patients and physicians should have access to courts for declaratory judgments. He feels that going into court at an early stage will stop the dialogue cold, forcing the parties to situate themselves at destructive poles. The law must refuse to take control, he says. Yet Burt recognizes the philosophical difficulty of holding a legally competent patient like Mr. G indefinitely against his will merely in the interests of conversation.

Burt’s solution is the following. Physicians would be able to declare any patient, not just psychiatric patients, “mentaly ill” for a limited period (he suggests a month) to engage in a dialogue about treatment decisions. Burt makes no reference to the literature warning of the problems of labeling someone mentally ill, although he does say that the label of “temporary incapacity” might be preferable. Perhaps he feels that since the label would be lifted after 30 days, the patient’s reputation and psychological well-being would not be harmed. During the 30-day period, the doctor could use any means necessary to foster a dialogue, including physically restraining or drugging the patient. Burt naively suggests that “drugs or physical restraints could be used to calm [a patient] in conjunction with attempts to talk to [the patient] but drugs or constraints for confinement alone would be proscribed.” Yet he does not face the question of how to test the veracity of an institution’s claim that it was restraining a patient for conversational purposes.

In some instances, a doctor, possibly one more concerned about the mental illness label than Burt is, might choose not to use it as a conversation starter, or a doctor might want to continue to talk to a patient or treat him beyond the 30-day period. If the patient in that situation went to court to say he was being detained against his will, possibly obtaining a habeas corpus writ, the second phase of Burt’s proposal would come into

22. Id.
23. Id. at 129.
24. Id. at 13.
25. But even a temporary label can be injurious. The stigmatizing effect of suspending children from school for ten days was found by the U.S. Supreme Court to be sufficiently injurious to the children’s reputations (and thus to “the students’ standing with their fellow pupils and their teachers as well as . . . later opportunities for higher education and employment”) to require that schools provide notice and a hearing before suspension. Goss v. Lopez, 419 U.S. 565, 575, 581 (1975).
26. Burt, supra note 1, at 141. But, elsewhere, Burt says that Mr. G could be forced to continue the painful chemical immersions that he was trying to avoid. Burt tries to justify this seeming departure from his proposal that only therapies to aid conversation be used by saying that the immersions should be allowed since they “were not central to and did not end the dispute between him and his physicians” and thus were “an inducement toward, rather than the end of, conversation.” Id. at 129. An inducement for whom? Maybe a pressure for Mr. G, but certainly not for the doctor.
27. Id. at 141.
TAKING CARE OF THE DOCTOR-PATIENT RELATIONSHIP

play. Adjudicating remedies would be postponed "until the physicians have decided their course for themselves and acted on that decision."28 Since Burt feels that uncertainty is beneficial, he proposes that the potential punishment for the breach of a patient's rights should remain a mystery to the doctors. The law should require that patient consent be obtained, but it should keep "uncertain" the precise consequences of any breach of this principle.29

II. PSYCHOLOGICAL GOALS AND LIKELY EFFECTS OF BURT'S PROPOSAL

A. Underlying Goals of the Dialogue

Burt views increased dialogue as a panacea, but he gives very little indication of what goal (besides the mental cha-cha between fusion and choice making) the dialogue should have and, consequently, how it can be discerned that the dialogue should be ended. What would Burt view as a successful dialogue? One in which the patient agreed to undergo the most "medically sound" treatment (the treatment that most doctors recommended)? Or one in which the decision reached most closely reflected the patient's real desires?

The goal of current laws regarding the doctor-patient relationship is generally to reach a treatment decision based on the patient's true desires. In order to protect patients from making a careless decision because of inadequate knowledge, the informed consent doctrine requires doctors to give patients certain information about proposed treatments and alternatives.30 Cases have upheld the patient's right to refuse treatment recommended by medical professionals, even if the treatment would undoubtedly help the patient's condition.31 On the surface, Burt's 30-day commitment option and his uncertainty alternative might appear to be aimed at eliciting the patient's desires and thus to be in keeping with the present law. Burt sees the "patient, upon confronting illness, as inevitably uncertain about his customary grasp on both his social identity and his reason-

28. Id. at 132.
29. Id. at 140. Burt sees his legal solutions as working in this manner: "by withholding that [judicial] 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 comfortably indestructible, dimension." Id. at 138. But it's hard to fathom that the patient would be comforted to know that a doctor could operate on him against his will (or in Burt's more gentle terms "act on a disputed conclusion") with the courts refusing to intervene until after that action occurred. And nowhere does Burt tackle the question of whether a person has a right not to engage in conversation.
ing capacity.” He feels that lengthening the process of doctor-patient negotiation is the “only way that a coherent identity can emerge for the patient.” But it is equally plausible that the patient will have a better grasp of his identity earlier (rather than later) in the negotiations. Burt himself points out that psychiatric patients who are hospitalized for over a year are less likely to recover—perhaps in part because they have drifted so far away from the separate identity they had before entering the institution. With medical patients, too, there is evidence that the longer a patient remains hospitalized, the more the patient loses the ability to make decisions and tends to bow to the staff’s wishes. In addition, if the goal of Burt’s system is to learn what the patient really thinks, there is considerable doubt whether a physician untrained in psychiatry is competent to help the patient discover those repressed thoughts.

Hospitalization and the use of tranquilizers and restraints, while of questionable value in eliciting the patient’s true desires, would be of great value in getting patients to accept the doctor’s recommendations. There are indications that Burt values the doctors’ suggestions over the patients’ preferences. He feels that “the stress of physical illness inevitably induces distortions in anyone’s conventional sense of self and that the diagnosis of mental illness is itself only a shorthand depiction of such psychic distortion away from the conventional norm.” He also says that Mr. G’s and Mrs. Lake’s thinking was perceived as “alien” by everyone around them. The bias toward deference to doctors’ decisions in Burt’s system is emphasized by the fact that presumably no inquiry is made regarding false positives. If a patient agreed with the doctor, it is unlikely that he or she would be asked whether that agreement reflected the patient’s true desires. Only if a patient disagreed would his or her “true desires” be sought. Is this really a system to help patients overcome the distortion in thinking that Burt believes is caused by illness—or is it merely a system to coerce patients to accept doctors’ viewpoints?

32. Burt, supra note 1, at 97.
33. Id.
34. Id. at 40.
35. See text at notes 65–72 infra.
36. Burt, supra note 1, at 142.
37. Id. at 47.
38. Allowing a physician to declare a patient mentally ill when they disagree on a treatment implies that a patient who disagrees with his doctor is crazy. If that is how Burt feels, though, his arguments would be more palatable if framed in terms of protecting the patient from the potential physical harm of choosing an option not advocated by his physician as medically sound. Courts have already had experience in dealing with that matter in situations where, for example, a Jehovah’s Witness refused a blood transfusion. Perhaps Burt focuses on psychological well-being rather than physical well-being because discussing the latter would force him to deal with the sticky issues already faced by the courts concerning self-determination, the right to refuse treatment, and the balance of an individual’s values against society’s.
39. If the goal is to assure acceptance of the medical model, there are more straightforward and efficacious methods for assuring patient compliance than Burt’s legal system. The law could stop
B. How the Dialogue Would Work

In addition to not indicating whether the goal of the dialogue is to achieve the most medically sound or the most personally sound treatment decision, Burt does not describe how the communication process could meet a particular goal.40 Burt argues for equality in decision making, which he believes is accomplished by shifting back and forth between inequalities.41 But the 30-day commitment option might actually impede dialogue because the patient perceived the means of achieving it as so consistently unequal. Already, patients are suspicious of legal developments purported to be for their own good but that appear mainly to benefit physicians. One study, for example, found that more patients see consent forms as legal documents to protect the physicians than view them as the means to give patients information needed for decision making.42 Is it likely that patients would trust and confide in a doctor who said, “I really want us to be joint decision makers. Let me just tie you up and tranquilize you to make our collaboration easier”? Burt optimistically states that by limiting the time and treatment modalities available to physicians “we may induce them and their patients to talk to one another.”43 But how would that work? Tough medical issues are sometimes extremely difficult to talk about. It is a rare doctor, for example, who feels comfortable talking to his terminally ill patient about “pulling the plug.”44 In addition, some doctors feel put upon in spending even a few minutes with the patient to describe, as is required under the informed consent doctrine, the risks of a treatment they are proposing. In a nationwide survey of doctors, 46 percent of the respondents reported that they spent ten minutes or less “informing” each patient.45 It is hard to imagine that a lengthier dialogue would ensue under Burt’s system, which offers no incentives to increase the amount of time doctors actually spend talking to patients.

recognizing the patient’s right to refuse treatment (much as it currently does not allow people to refuse vaccinations). I will not attempt to explore the constitutionality of such a proposal.

40. Burt says that many physicians and their legal advisers seek to reduce informed consent conversations to “stylized monologues in which they recite a litany of the statistics on risks and benefits of the proposed medical intervention and then offer the prospective patient a document for his signature ‘on the dotted line.’” Supra note 1, at 124. But he does not explain how his system would avoid that same result.

41. Id. at 99–100.


43. Burt, supra note 1, at 142.

44. Many doctors won’t even take the first step and tell the patient he is terminally ill. For example, studies have shown that 60–90 percent of doctors will not disclose to patients that they have a terminal illness. Barney G. Glaser, Disclosure of Terminal Illness, in Milion, supra note 20 (citing H. Feifel, Death, in N. L. Farberow, ed., Taboo Topics 17 (New York: Atherton Press, 1963)).

Nor does Burt inquire about the quality of communication that would be achieved. Poor doctor-patient communication is widespread. In one study, only 22 percent of the patients were judged to have effectively communicated their needs to the hospital staff.\textsuperscript{46} And other studies have shown that medical students and licensed doctors communicate no better than do patients. Even senior medical students who knew their skills at taking a patient's history were being studied performed inefficiently. These deficiencies included an inability to clarify the real nature of patients' complaints, a reluctance to ask about relevant psychological aspects of their histories, and a failure to pick up important verbal and nonverbal cues.\textsuperscript{47} According to Maguire and Rutter, the authors of such a study, "[I]t was particularly worrying to find that 24% of the students failed to discover their patients' main problems."\textsuperscript{48} About one-quarter of the students "made their questions so complicated and lengthy that it was impossible for the patients to recall the separate elements or give appropriate answers."\textsuperscript{49} Nor do added training and years of experience seem to help medical professionals overcome these communication deficiencies. In fact, in some respects, they may get worse. One study found that senior medical students performed more poorly than freshmen medical students at obtaining information on the interpersonal aspects of a health problem.\textsuperscript{50} Studies by other researchers have discovered that physicians,\textsuperscript{51} surgeons,\textsuperscript{52} and pediatricians\textsuperscript{53} have difficulty communicating.

Thus, Burt's suggestion for a better dialogue between the parties is certainly warranted. But his implication that increasing the potential time for dialogue (even against the parties' own wishes) will actually enhance the quality of dialogue overlooks two important factors: (1) Doctors and patients do not come to the dialogue as equals; and (2) The medical system does not foster communication.

Classic communication theory tells us that communication is enhanced by similarity between the two parties.\textsuperscript{54} But with doctors and patients

\textsuperscript{46} Ruth G. Elder, What Is the Patient Saying? in Millon, supra note 20, at 413.
\textsuperscript{48} Id.
\textsuperscript{49} Id. at 557.
\textsuperscript{50} Ray E. Helfer, An Objective Comparison of the Pediatric Interviewing Skills of Freshman and Senior Medical Students, 45 Pediatrics 623, 625 (1970).
\textsuperscript{53} Barbara M. Korsch \textit{et al.}, Gaps in Doctor-Patient Communication, 42 Pediatrics 855 (1968).
\textsuperscript{54} A dialogue between doctor and patient cannot be achieved unless each party has the power to persuade the other. Yet there is a considerable body of evidence that the power of persuasion is operative only to the extent that the source of the communication is similar to the receiver. See, e.g., William J. McGuire, The Nature of Attitudes and Attitude Change, in 3 Gardner Lindzey & Elliot
there are many important dissimilarities that can hamper communication. After all, the doctor and the patient are not on equal footing as far as a feeling of control is concerned. The patient is the one who risks physical harm. Burt's proposal might foster a dialogue between two doctors who treated each other, because in that case equality through shifting inequalities could be attained since whoever is the treating physician at a given moment would realize that he might be a patient the next time. But in the normal course of events, doctors and patients cannot draw straws to see who plays what role. Each comes to the encounter with the feeling of a certain level of "control."

Burt may be suffering from shortsightedness in assuming that if courts were prevented from getting involved too early in the process an effective dialogue between doctors and patients would inevitably ensue. Perhaps if the patient were a Yale Law School professor like Burt, who is probably similar in ethnocultural background, class, and self-image to the doctors who treat him, the patient would not mind giving up the absolute right to self-determination, precisely because the shared values would both enhance communication and lead physicians to make treatment suggestions according to criteria the patient would use.

But communication becomes increasingly poorer the more dissimilar the patient is from the doctor. In many instances, there is even a basic difference in the language that the parties use. As a striking example, one study asked 125 patients to define 50 medical terms. All terms had been used frequently in a series of doctor-patient interviews studied by the investigators. The terms were used in simple sentences in the experiment to give contextual clues about their meaning. Even though responding patients gave definitions for most of the terms, never admitting (or maybe never ever realizing) that they didn't know the meaning, many gave incorrect definitions. For example, "abdomen" was identified variously as


55. Even if they are not professionally equal, Burt sees some psychological equality. He says there are "important parallels" between the doctor-patient relationship and the parent-child relationship. Burt, supra note 1, at 65. He assumes that because the good parent finds "comfort in seeing himself alternating in control of, and under control of, his child" (id. at 67), the doctor and patient, too, will be able to accomplish the shifts between fusion and self-identity. But the two types of relationships are not interchangeable. The doctor is, after all, taking care of strangers, without the same emotional and social pressures that force parents to continue to work at their relationships with their children. Laws—such as laws against doctors abandoning patients and laws requiring that doctors get patients' consent—are necessary for the very reason that these emotional and social constraints do not exist. A parent, even the parent of an infant, may be more willing than a doctor to view himself as both the controller and the controlled since such a shift in decision-making authority does occur over time. Parents perceive that their children will ultimately care for them in their old age. But the patient never assumes the role of doctor.

the sides, buttocks, back, uterus, heart, bladder, and the entire area below the waist; an “appendectomy” was defined as a cut rectum, sickness, the stomach, rupture of the appendix, a pain or disease, taking off an arm or leg, something contagious, and something to do with the bowels. Thus, communication difficulties can be caused by the medical terminology used in the dialogue.

Several researchers have also found differences in how people of different sexes, ethnic groups, and social classes communicate about illness. David Mechanic has summarized this research by noting that “different patterns of responses to illness are culturally conditioned and functionally relevant.” Other researchers found that members of different ethnic groups have different reactions to pain. Likewise, men and women differ in the way they communicate about illness. Thus a physician who classifies patients' responses according to their similarity to his or her own may erroneously view as a hypochondriac the patient who has been socialized to demonstrate his feelings and ignore as trivial the problems of the patient who has been taught to suffer in silence. In addition, the physician's values may influence how seriously he or she takes the patients' articulated desires. For example, the possibility of disfigurement may seem trivial to the physician (who has been socialized by medical school to emphasize the risks of physical injury that a procedure will present) but may be important to the patient. This may prevent the doctor and patient from coming to the consensus necessary for treatments to begin.

Burt himself points out that doctors and patients have different viewpoints. He says that what Mr. G considered to be “self-determination” his physician considered to be “self-destruction” and what Mrs. Lake thought of as “freedom,” the policewoman who stopped her (and presumably the doctors who advocated committing her) thought of as “aimless wandering.” Yet, there is nothing in Burt's system to assure that the two sides find a common vocabulary so that they can even begin to

57. Id. at 298.
58. Mechanic, supra note 20, at 356.
60. The differences between men and women in their willingness to communicate about illness may be one of the causes of the greater use of medical facilities among women as compared with men. See, e.g., O. Anderson, The Utilization of Health Services, in Harold E. Freeman, Sol Levine, & Leo G. Reeder, eds., Handbook of Medical Sociology (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1963).
61. Zborowski found that Anglo (or in his words, “Americanized”) doctors tend to distrust Jewish and Italian patients' reaction to pain. According to Zborowski, “The material suggests that [Americanized doctors] do tend to minimize the actual pain experiences of the Italian and Jewish patient regardless of whether they have the objective criteria for evaluating the actual amount of pain which the patient experiences.” Zborowski, supra note 59, at 23.
62. Burt, supra note 1, at 128.
ask the right questions. That is the precise reason why, under current law, judges are involved in the process—not to stop the conversation, as Burt thinks, but to attempt to provide the language in which it can be undertaken and to try to assure that all voices are heard and understood.

Just as Burt ignores the differences in perspectives that doctors and patients bring to the dialogue, he also ignores those hindrances to communication caused by hospitalization itself. The attitudes of many health care professionals and the hospital structure impede communication. In one study, the doctors and nurses interviewed said they expected patients “to be quiet,” “not to ask,” and “not to complain.” In the Maguire and Rutter study of how medical students took patients’ histories, “32 per cent [of the senior medical students] gave little or no indication that they wanted their patients to continue talking. Instead, they often buried their heads in their notes and rarely, if ever, looked at their patients.”

Some patients may not talk about their problems and preferences because they feel they are bothering the doctor.

The chances of achieving a dialogue could very well be lessened rather than increased under Burt’s 30-day commitment plan precisely because illness and hospitalization wear away at a patient’s sense of autonomy. Hospitalization can cause patients to feel insecure about their identities and ability to influence their environment. Patients in a hospital may be stripped of their identities and referred to by their conditions (e.g., “the gall bladder in 408”). One medical report is illustrative: it said “The body awoke approximately 18 hours later and complained of hunger and depression.” The lab technicians who performed Mr. G’s immersion treated him like an object, not even soothing him in his pain. Howard Leventhal notes that health care institutions foster such dehumanization, leading patients to feel it is neither useful nor possible to communicate with others. Philip Zimbardo writes about the similar process of “dein-

63. Rose Laub Coser, A Home Away from Home, in Millon, supra note 20, at 381. Coser found that the pressures on patients not to give their own opinions were like those pressures on servicemen. She says that both servicemen and patients “unlearned” to make choices. Id. at 386. Coser cites an earlier work which says that the army and other such institutions robbed the individual of his sense of self-direction and ultimately damage the capacity for it. Virtue in such institutions consists in having no preference about many things; in eating whatever is put on the table, in wearing what one is told to wear, in going to bed and rising again according to instructions, in making the best of things. The good institution member does not make choices or decisions. He submits and permits himself to be carried along, as it were, in a “moral automobile.” When he returns to civilian life, his suddenly uncensored soul seems flabby and incapable of standing alone.

Id. at 387 (citing Willard Waller, The Veteran Comes Back [119] (New York: Dryden Press, 1944)).

64. Maguire & Rutter, supra note 47, at 557.


66. Burt, supra note 1, at 8.


68. Id. at 156.
dividuation," in which people have difficulty viewing themselves as individuals and consequently lose their sense of themselves as autonomous persons. According to Zimbardo, arousal, sensory overload, a novel situation, physical involvement, an emphasis on the present, and altered states of consciousness foster deindividuation. Most or all of these conditions are experienced by any patient as a result of the combined influences of his illness or injury and the alien hospital environment. And the sense of dehumanization or deindividuation could be worsened by the drugs and restraints that Burt's legal scheme allows. In such a situation, seeming communication might be mere obedience to the doctors' suggestions. Psychological studies have pointed out that when a person loses his bearing, the behavior of people around him has an important influence on helping the person find an explanation of his subjective state. The doctor and other hospital staff members thus have an inordinate influence on the patient who has lost his or her customary moorings. In addition, the social authority of the physician may cause the patient to feel that the physician's opinion is better than the patient's own—even about matters such as the patient's own desires.

If Burt's goal is to equalize the doctor-patient relationship, perhaps he should not dismiss so casually the doctrine of patient self-determination. If, as the whole thrust of the book suggests, Burt's interest is in both parties' psychological well-being, surely he can see that the patient is starting off at a psychological disadvantage. Perhaps giving the patient the legal


70. In one experiment, people in a general unexplained state of arousal attributed the arousal to either euphoria or anger depending on whether the person they were with was happy or angry. Stanley Schachter & Jerome E. Singer, Cognitive, Social, and Physiological Determinants of Emotional State, 69 Psychological Rev. 379 (1962).

71. Mechanic, supra note 20, at 365, points out that patients often seek care when they are distressed and "there is a large amount of evidence that distressed persons are highly suggestible and open to influence."

72. Burt describes the influence of authority brought to light in the Milgram experiment. Burt, supra note 1, at 72-91. Stanley Milgram, a Yale psychologist, conducted an experiment to assess the level of people's obedience to authority. The experimental subjects were told that the purpose of the experiment was to test individuals' ability to memorize random word associations. Each subject was introduced to the "learner," who while appearing to be another subject, was actually a cohort of the experimenter. The subject was told to press levers to give the learner increasingly severe shocks for each wrong answer. Throughout the process, the subject did not realize that the learner was actually receiving no shocks, but convincingly acting as if he were, crying out in pain, and, if the shocks got high enough, even feigning a heart attack. When an experimenter dressed in a scientific technician's jacket told the subjects to proceed with shocking the learner despite his protests, two-thirds of the subjects complied and kept shocking to the deadliest, highest voltage. Id. at 74, 81. However, when not the scientist, but another man dressed in ordinary clothes told the subjects to go ahead, only 20 percent kept shocking to that dangerously high level. Id. at 81. This implies that the influence of a man of science is greater than that of an ordinary man in getting people to obey even a malevolent request. It is possible that this is also in effect in the medical care situation, with the patient being influenced to think that his doctor's desires (or the doctor's perception of the patient's desires) should be given more weight than his own. Burt himself notes that "The experimenter's invocation of the scientific ethos contained the same promise that physicians have traditionally offered patients to assist them in ceding their self-definitions to physicians." Id. at 82.
right to determine what should be done to his body is necessary to balance the extreme psychological advantage the doctor has. Support for the proposition that giving patients the ultimate say actually fosters the dialogue that Burt is trying to achieve can be found in the case of Mr. G. Mr. G initially did not want to "negotiate" with his doctors but rather maintained the steadfast position that they should not subject him to treatment. When Mr. G found a lawyer to represent his interests, however, he decided to undertake the recommended treatments. Perhaps knowing that he could initiate litigation balanced the power equities sufficiently so that Mr. G could give careful consideration to what the doctors were proposing.

C. Alternatives to Burt's Psychological Theory

A major flaw in Burt's book is that he presents sketchy and disputable psychoanalytic interpretations as absolutes. Burt drops ideas onto the page without support. In that regard, his analysis resembles his writing style. He is prone to use hyphens in unusual ways—in words such as "dis-eased," and "con-fusing." With this hiccup of Mr. Burt's typewriter, the reader presumably is to infer that a patient who is dis-eased and con-fused is neither at ease nor at one with his doctor. These are ideas worth exploring, but semantic tricks are not necessarily probative, and the use of an unusually placed hyphen without a concurrent explanation neither describes nor proves the ideas. In using this technique, Burt has slipped too far into a pseudopsychiatric approach, where the use of a single word (often the psychiatrist's knowing "Ah") is thought to reveal a world of meaning.

Burt takes the position that the intrapsychic struggle between fusion and self-identity is constantly present in a destructive form. But even a traditional psychoanalytic approach would allow that in many situations the ego can keep this struggle in check and doctors and patients can decide on a course of treatment without attempting mutual or self-ob-

73. Id. at 121.
74. Id.
75. For example, an important premise in Burt's system is that each individual has difficulty knowing and evaluating his own desires. However, Burt does not provide adequate support for that idea. He refers to the work of Kenneth Arrow, who demonstrated that the intensity of desires among people cannot be used to order social allocations because these desires are incommensurable. Kenneth J. Arrow, Social Choice and Individual Values (2d ed. New York: John Wiley & Sons, 1963). Burt then says "I think it [the incommensurability of desires] is equally a problem for each individual in knowing and evaluating his own desires." Burt, supra note 1, at 55. But the analogy is imperfect. Arrow's theory presumed that individuals could order their own desires, and there is a great difference between the problems of social and personal ordering. While society might have difficulty evaluating which is the more pressing need—putting a man on the moon or providing heat in the winter to a section of the city—an individual (particularly one in a cold home) probably would be able to order these in importance.
76. Burt, supra note 1, at 137.
77. Id. at 118. Burt does the same thing with "re-cognition." Id. at 129.
literation. 78 This would be particularly true in instances of relatively simple treatments where the parties are not confronted with the psychologically jarring issues faced in the cases of Mrs. Lake or Mr. G of drawing the line between deviance and acceptable social behavior or between the value of human life and individual choice.

Even in the complex cases, Burt’s analysis is far from convincing. In focusing on fusion and self-identity, Burt fails to take into account other psychological influences that may affect the doctor-patient relationship. Throughout the discussion of his recommendations, Burt confuses two ideas—power and responsibility. He feels that giving any of the parties the right to decide leads to destructive consequences. But he does not give sufficient thought to whether the destruction is caused by having someone make a decision or by allowing someone to decide without being held responsible for that decision.

In Mrs. Lake’s case, the police officers, the commitment officials, the psychiatrist, and the judge could, according to Burt, “assign responsibility elsewhere.” 79 And in a case of livesaving treatment, the judge can feel that he is merely acting on the medical expert’s recommendations, while the medical expert can take comfort in the fact that the judge makes the final decision. 80 Maybe the problem is, therefore, not that people are making decisions but that they are making decisions without feeling responsible for them. The legal issue then becomes one with which Burt has not dealt—whether the law should be directed against the potentially dangerous outcomes of the exercise of choice without responsibility.

One approach to curbing abuses of the decision-making power would be to “provide a code of principles that purports to answer every question of power in doctor-patient relations and to provide an institutional mechanism to produce that answer immediately upon request of a doctor or patient who doubts his power.” 81 But Burt says the law should refrain from doing that, despite the fact that the parties want such a system. He reverts to his narrow psychoanalytic approach and says the doctors’ and patients’ intense wishes to have a mechanism for resolving these difficulties “reflect their unwillingness to admit their separate and mutual powerlessness in confronting disabling illness.” 82 Here, Burt is playing a

78. This is precisely the role of the ego in a mentally healthy individual. Freud, supra note 3, at 56.
79. Burt, supra note 1, at 32.
80. Id. at 157–58. Likewise, in the Milgram experiment (described in note 72 supra), the subjects had to make a decision (whether or not to deliver an apparently painful shock to another person), but they could do so without accepting responsibility since, when they hesitated, the experimenter told them, “The experiment requires that you continue”; “It is absolutely essential that you continue”; and “You have no other choice, you must go on.” Id. at 74. In fact, many compliant subjects continued shocking only after the experimenter agreed to take complete responsibility. Id. at 80–81.
81. Id. at 136.
82. Id.
psychoanalytic shell game. He takes behavior inconsistent with his theory and says that such behavior reflects the doctors' and patients' unwillingness to admit the truth of his theory. With this type of interpretation of conflicting data, it is impossible to conceive of any behavior that would not support Burt's theory, since everyone is either doing what Burt hypothesizes they will do or, under Burt's schema, denying their desire to do what Burt hypothesizes they will do.

D. Psychological Problems Burt's System Might Create

Burt's concern for doctors' and patients' psychological well-being stops short of an inquiry into the potential side effects of his legal prescription. He does not consider the psychological damage a 30-day commitment for conversation or the uncertainty alternative might cause. Burt at no point explores whether participants in the medical system (doctors, nurses, etc.) who disobey the patient's express wishes (by drugging or restraining him against his will or treating him against his will because they believe the uncertain potential penalties would be slight) will suffer psychological harm from having acted aggressively against the patient's stated wishes. Such a psychological pressure on the participants would not exist if the patients were given the final say in the decision. Burt also neglects to explore whether the uncertainty he tries to promote with his legal plan would itself cause stress and psychological harm to doctors and patients.

In addition to the potential psychological disadvantages of Burt's system, an unacknowledged physical risk is present as well. The proposed one-month delay may seem reasonable in Mr. G's case, where the delay will prolong life but, in many serious medical matters, delay will endanger the life or health of the patient. Take the case of a woman with breast cancer whose doctor tells her that she should have a radical mastectomy, yet she would prefer a partial mastectomy. 83 Since the doctor could not treat the cancer but only use modalities to foster conversation during the 30-day period, the cancer could conceivably worsen. The potential for harm is increased by the fact that people with serious health problems might be dissuaded from seeking treatment in the first place by the possibility that they would then be subjected to drugs and restraints against their will. 84

83. This, particularly, is a situation where it cannot be argued that delay will save a patient from a wrong choice, since there is controversy among respected physicians as to which treatment—partial or radical mastectomy—is preferable. See, e.g., Thomas Anglem, Management of Cancer: Radical Mastectomy, 230 J.A.M.A. 99 (1974), and George Crile, Jr., Management of Breast Cancer: Limited Mastectomy, 230 J.A.M.A. 95 (1974).

III. Legal Ramifications of Burt's System

A. How Burt's System Fits into Existing Law

Since he is a lawyer and not a health professional, Burt could perhaps be forgiven for lack of appreciation of the practical effect of his recommendations if they represented advances in legal theory. Unfortunately, there, too, Burt disappoints the readers. Burt tries to find historical legal support for his idea that patients should not make decisions about their own bodies, but, in the attempt, he plays fast and free with the precedents in some respects. He says it may seem "rationally irrefutable" that the patient should be the prime decision maker "since his body, after all, is the subject of dispute. But it is nonetheless striking that doctors' obligations to obtain specific consent from a patient for any medical intervention has [sic] only recently been promulgated either by the medical profession or the courts." This statement is incorrect. At common law, an unconsented touching (even by a physician) was a battery. As early as 1649, Massachusetts had a statute requiring consent. Elsewhere in the book, Burt himself refers to consent cases holding for the patient as early as 1767. And as to the medical profession itself not promulgating consent guidelines, perhaps by the time that medical societies were generally being formed after the Revolutionary War, consent was already such a well-established legal doctrine that it need not have been referred to in an ethics code.

Maybe Burt meant to say that informed consent is a recent requirement. That is certainly true. But an understanding of medical science sufficient to make predictions is a rather recent phenomenon. Until the latter part of the nineteenth century, physicians did not understand disease etiology. Their prime means of therapy were a small number of treatments with drastic effects and no scientific basis—most commonly, bloodletting,

85. Burt, supra note 1, at 102.
86. Id.
87. See, e.g., Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905).
89. Slater v. Baker and Stapleton, 95 Eng. Rep. 860 (K.B. 1767), cited in Burt, supra note 1, at 191 n.7. Burt tries to explain away the relevance of the early cases by saying that since the behavior of the physicians in them were remote from that of reputable professionals, the cases did not really deal with consent between physician and patient, but with a relationship between ordinary citizens. Burt, supra note 1, at 103. This is akin to saying that once a physician does something drastically wrong, he should be viewed as never having been a physician at all. This would certainly eliminate the existence of a doctors' malpractice problem (since anyone who malpracticed would not be considered a doctor), but such a semantic switch is just not valid.
91. Moreover, the early medical codes of ethics were quite self-serving. The early AMA code had a section on "Obligations of Patients to Their Physicians," saying that patients should not second-guess doctors and should be grateful. Id. at 173.
92. Id. at 41.
cathartics, and blistering.\textsuperscript{93} It is no wonder that informing patients was not a legal requirement at least until there was some information that doctors could reliably pass on.

Burt cannot claim tradition, because he overlooks important common law principles in promulgating his recommendations. He says that the use of the doctrine of self-determination leads to "stereotyping."\textsuperscript{94} He feels that we should not let a person feel in command of himself since this is "a false assurance," a "psychological fiction."\textsuperscript{95} Perhaps self-determination as a concept does not provide all the solutions, but it is a principle underlying all areas of Anglo-American law—tort law, contract law, criminal law, and so forth. Moreover, self-determination can be seen as having a constitutional basis.\textsuperscript{96} Yet Burt rejects the idea that people can and should make their own health care decisions, without postulating the effect of such a stance on other areas of law or other potential individual decisions. If Burt is correct that a person does not know his own desires, presumably that confusion occurs with respect to other decisions in his life as well. Yet we do not try to psychoanalyze a person who makes other decisions that might have consequences equally potent as those of health decisions—such as writing a living will, drinking alcohol, joining the army, taking a dangerous job, climbing mountains, getting married, or bearing children. In all these situations we are theoretically confronted by two different expressions of a person’s will—what he says he wants and, presumably, if we probed more deeply, what he “really” wants. Society has chosen to believe the individual’s stated wishes. Burt does not give a convincing enough explanation why, in the medical area, we should probe more deeply.

Burt also overlooks important legal principles in the application of his proposed solutions to the problems of the doctor-patient relationship. For example, Burt’s uncertainty alternative allows doctors to take action but keeps secret the punishment they face for taking that action. This principle is a departure from a legal system that has found value in letting precedents be known.\textsuperscript{97} The uncertainty in Burt’s system could give rise

\textsuperscript{93} Id.
\textsuperscript{94} Burt, supra note 1, at 123.
\textsuperscript{95} Id. at 140.
\textsuperscript{96} Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417 (Mass. 1977). “As this constitutional guaranty [of privacy] reaches out to protect the freedom of a woman to terminate pregnancy under certain conditions, Roe v. Wade [410 U.S. 113, 153 (1973)], so it encompasses the right of a patient to preserve his or her right to privacy against unwanted infringements of bodily integrity in appropriate circumstances. In re Quinlan [70 N.J. 10, 38-39].” Id. at 424. The court goes on to state that “The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life.” Id. at 426.
to serious constitutional problems.\(^98\) In addition, it stretches credulity to think that the secrecy about outcomes that Burt proposes could be maintained within the present judicial system. The first time a case was decided, and a penalty imposed, the uncertainty would be shattered since that case would serve as a precedent for the judge in the next case. Doctors would begin adjusting their behavior in light of the precedent. And if judges, trying to implement Burt’s suggestion, did mete out wildly different punishments each time, the decisions would probably be reversed as an abuse of judicial discretion.

B. How Burt Justifies His Departure from Tradition

Burt’s legal recommendations depart from both the philosophy and the procedural safeguards of the traditional common law system. Burt rejects a system in which the courts get involved at an early stage to curb abuses because he views the judicial system as being as psychologically destructive to the parties as the medical system. Although the law claims to have special expertise in adjudicating power relations, says Burt, its delineated structure leads to “this same bureaucratizing structural impulse already evident in medical practice.”\(^99\) Judges, he implies, are as destructive to patients as are doctors. In Mr. G’s case, says Burt, there was no clear-cut assurance that “all those around him—now including not only his family and doctors but also the lawyers and judge—were not horrified and even repelled by his plight and by him, [and] did not wish that somehow he would go away.”\(^100\) In addition, Burt feels a judge’s attempt to help would fail because he would be drawn into the conversation, and the “judge’s mind is no more free from the alternating ideas of separateness and self-dissolution, rationality and madness, than anyone’s.”\(^101\)

But what Burt is describing here is an inherent part of the legal system and has nothing to do with the doctor-patient relationship. A middle-class judge may be “repelled” by a murderer from the ghetto, but he is still called upon to decide homicide cases. And as far as the parallels between the judicial system and the medical system are concerned, at least in the legal system an inarticulate patient would have someone to speak for him, and the conversation would take place in the open where society could listen to and learn to deal with the problems inherent in the doctor-patient relationship. Moreover, the medical dialogue is not a true alter-

\(^98\) The Supreme Court has noted the importance of specific standards for punishment, which Burt’s system does not provide. “A system could have standards so vague that they would fail adequately to channel the sentencing decision patterns of juries with the result that a pattern of arbitrary and capricious sentencing like that found unconstitutional in Furman [Furman v. Georgia, 408 U.S. 238 (1972)] could occur.” Gregg v. Georgia, 428 U.S. 153, 195 n.46 (1976).

\(^99\) Burt, supra note 1, at 136.

\(^100\) Id. at 15.

\(^101\) Id. at 137.
native to a legal one, since the parties generally seek access to the courts when the medical dialogue has broken down.\textsuperscript{102} If the breakdown is irreparable, there seems to be little point in postponing court involvement.

\section*{IV. Conclusion}

The original Hippocratic oath, governing the practice of medicine, had as its main tenet, "First, do no harm." If there is a contribution in Burt’s book, it is the suggestion that psychological forces (and not just negligence in technique or unauthorized treatment) may cause doctors to wrongfully harm patients. The shortcoming of the book is Burt’s refusal to consider the possible alternative diagnoses for the problem or to acknowledge the potential ill side effects of his legal prescription. As a result, Burt’s proposed solution is muddled and may aggravate, rather than alleviate, the very harm he is trying to avoid.

\textsuperscript{102} In addition, the legal dialogue is intricately structured so that it may resolve the issue and thus may be preferable to other types of dialogues. James B. White, The Legal Imagination: Studies in the Nature of Legal Thought and Expression 807 (Boston: Little, Brown & Co., 1973).