Uncertainty and Medical Authority in the World of Jay Katz

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In *The Silent World of Doctor and Patient*, Jay Katz painted a portrait of medical practice in which physicians' voices dominate and drown out others with at least equal and often superior claims to be heard. Many physicians today, however, complain that their voices are no longer sufficiently heard in the provision of medical care. Some are angry at this perceived turn of events; they see intrusions by unscrupulous lawyers, by unsympathetic judges and lay jurors, by greedy malpractice insurance companies and by ham-handed bureaucratic regulators. These angry physicians mimic Rodney Dangerfield's comic complaint that they "don't get no respect." And many of these angry physicians regard the influential work of Jay Katz as part of their problem.

Another contemporary group of physicians evaluate Jay's work in a different mood. These physicians, typically younger members of the profession, are intrigued by Jay's analysis and often seem eager to implement it—to solicit patients' "informed consent," to invite (sensible) judicial or legislative regulation, to eschew the old model of the infallible father-physician. These physicians view Jay's influence as a welcome contribution to the solution of their problem.

For both the traditional and the newer breed of physicians, therefore, Jay's descriptive portrait of medical practice may seem no longer accurate. Notwithstanding these contemporary appearances, however, there are powerful reasons to doubt whether any significant change has occurred in interactions between doctor and patient. Many contemporary physicians do solicit patient's consent more self-consciously than in earlier days. But this solicitation often appears to be merely a formalistic recitation of risks and benefits of the proposed procedure that both physicians and patients routinely expect will be followed by patient acquiescence in

the physician's recommendation. If nothing more transpired than this ritualized response of "amen" from the patient, if nothing more were changed in the interaction between doctor and patient, then there would be little reason to doubt the continued accuracy of Jay's portrait of this "silent world."

There is, however, another voice in the physician-patient interaction that has noticeably arisen only in the past decade or so: the voice of the judge. For many decades, of course, judges have issued authoritative-seeming pronouncements about medical practice. These pronouncements have come in the course of legal challenges to specific actions by physicians where dissatisfied patients (or their surviving families) sued and judges enunciated standards of negligence or criteria for adequate informed consent by which the physicians' liability should be assessed. As Jay's work has acutely demonstrated, the novelty or efficacy of these judicial pronouncements has often been less than their surface appearances portended. He has shown the many ways in which these seemingly new doctrines, while purporting to buttress patients' authority to control their medical treatment, have in fact only (and often surreptitiously) reinforced physician control.¹ Even with this cacophonous explosion of malpractice litigation, therefore, Jay has shown good reason to believe that silence—that is, reflexive deference to physician's claims for unquestioned authority—still reigned in ordinary interactions between doctor and patient.

During the last decade or so, however, a new phenomenon in judicial interventions has arisen in medical practice. This new phenomenon is the increased reliance on declaratory proceedings where judges resolve physicians' uncertainty about their authority either to provide or to withhold specific treatments. I cannot provide ex-

act statistical accounts of the prevalence of this new phenomenon. It is my impression, however, that these declaratory actions are much more frequent today than ten years ago. When I wrote about these actions then,² there were a few recent and notorious cases: the *Karen Quinlan* case in New Jersey,³ the *Saikewicz* case in Massachusetts.⁴ Since that time the law reports, and the popular press, have burgeoned with accounts of such proceedings.⁵ Even if such proceedings are still a rare occurrence in ordinary medical practice, all of the potential participants in such proceedings—physicians, patients, families, lawyers, and judges—no longer view them as unimaginable, or even as novelties. If in 1979, such proceedings appeared on the metaphorical legal horizon as “clouds no bigger than a man’s hand,” they have now grown to thunderstorm proportions.

These declaratory proceedings have potentially transformative implications for the legal regulation of medical practice. In particular, such proceedings appear to promise a new regime of diminished judicial deference to physicians’ authority. The traditional format of malpractice litigation is, of course, an “after-the-fact” review of physicians’ conduct. This format may in itself explain what Jay has observed about the tendency of judges to buttress physicians’ challenged authority; in an “after-the-fact” review, that is, judges are likely to be enticed into an unspoken alliance with their fellow-professionals against the complaining laity. In a declaratory proceeding, where the physician has not yet taken any action, this intraprofessional alliance does not arise so swiftly. To be sure, the physician may offer an opinion about the best course for future action and the judge may be inclined to give excessive weight to this opinion. But because the physicians have not yet acted, less is at stake for them in securing judicial ratification of their opinions; and, even more significantly, in the new breed of declaratory proceedings that have recently appeared, physicians are openly uncertain about the proper course of treatment and explicitly acknowledge that they have turned to judges not because they want judicial ratification of their own prior determinations but rather because they want the judge to decide what should be done.

Moreover, in this new breed of proceedings, the typically stated reason for physicians’ uncertainty does not arise from scientific doubts about the best course of treatment. The typical professed basis for physicians’ doubt revolves directly around the issue at the heart of Jay Katz’s work—the issue of patient autonomy. The physician, that is, has doubts about the patient’s capacity to consent to treatment because, for example, the patient appears retarded or emotionally disturbed or the physician is uncertain about whether following the family’s directives regarding a comatose patient would adequately protect the patient’s legal rights. This new

trend for physicians to request advance judicial review may thus demonstrate the success of Jay’s underlying mission to secure enhanced respect for patient autonomy.

I am, however, quite skeptical about this. My skepticism, moreover, is based on a deeper aspect of Jay’s analysis in *The Silent World of Doctor and Patient*. In my view, the heart of Jay’s book, and the source of his lasting influence, is not in his descriptive portrait of physician dominance in medical care. The true force of Jay’s analysis is in his account of the psychological and social forces that lie beneath the tradition of physician dominance. To understand the continued relevance and importance of Jay’s work, it is necessary to separate his account of these underlying forces from his descriptive portrait of the expression of these forces in the traditional format of physician control.

In Jay’s account, uncertainty plays a critical role. In the penultimate chapter of his book, entitled “Acknowledging Uncertainty: the Confrontation of Knowledge and Ignorance,” Jay discusses the reluctance of physicians to admit three related kinds of uncertainty about medical practice: uncertainty about their personal command of the most current scientific medical practices, uncertainty about the verifiably scientific basis for large parts of medical practice, and uncertainty about their capacity to distinguish between personal and ultimate scientific shortfalls in understanding.⁶ Jay convincingly shows how these three related kinds of uncertainty regularly lead physicians to overstate their own certitude in dealing with patients—sometimes consciously deceiving patients purportedly to provide calming reassurance to them, and sometimes unconsciously deceiving themselves in order to bolster their own courage in their confrontations with disability and death.

In this chapter, Jay’s analysis focuses on physicians’ uncertainty about the technical aspects of medical practice—uncertainty about their own proficiency as healers and the reliability of their profession’s healing claims. In the ultimate chapter of his book, entitled “The Abandonment of Patients: A Final Argument Against Silence,” Jay appears to shift focus somewhat; in this chapter, he directly addresses the fear of death as a force driving medical practice and shows how the “denial of death” fuels claims for unquestioned medical authority at the same time that this denial leads physicians to turn away from, to abandon, their suffering and dying patients.⁷ I believe that this more elemental force is at work behind the new protestations of uncertainty that are leading physicians today to turn to judges in declaratory proceedings for answers to the “legal and moral questions” about patients’ competency and physicians’ authority. Though the rhetoric of these new proceedings is in the vocabulary of legal rights and patient autonomy—and in this guise the pathbreaking work of Jay

Katz is frequently cited—the underlying, though unarticulated, conversation is about death and fear: an existential uneasiness about personal incapacity to make sense of mortality, about the contemporary failure of cultural and religious norms to provide a comforting framework of meaning for these ultimate questions, and uncertainty about distinguishing between personal and general cultural shortcomings on these matters. In these declaratory proceedings, I believe, the courts are citing the wrong portions of Jay Katz's work: while purporting to implement his valuation of individual autonomy, they are missing the diagnostic significance of his account of the way that existential uncertainty leads to the conscious and unconscious falsehoods that buttress claims for medical authority.

In these declaratory proceedings, moreover, it is easy to miss this lesson because individual physicians are not claiming unquestioned deference; indeed, in these proceedings judges themselves are claiming such authority on behalf of the legal system. In the final analysis, however, I believe that the basic claim for authority in these proceedings is not with individual doctors or judges, and not with individual patients. The claim that I see repeatedly occurring at the heart of these proceedings is for the authority of Medicine, though not for individual doctors, and for the complementary impersonal image of the Law, though not for the autonomy of individual patients on whose behalf the judges purport to speak.

I want to spend some time discussing one recent case in order to illustrate these propositions. In part this particularized focus is necessary in order to counteract the impulse toward excessive abstraction, toward a dehumanizing avoidance of engagement with particular patients, that Jay has so eloquently warned against. The case arose in June 1987, when Angela Carder, then about twenty-five weeks pregnant, was admitted to the George Washington Hospital.

From the outset of her pregnancy, Ms. Carder had been regularly seen at the hospital's high-risk obstetrics clinic because of her history of cancer during the previous fourteen years. She and her physicians had been optimistic about the prospects for both her and her baby because her cancer had been in remission for more than three years. Unhappily, however, a new and quite virulent tumor appeared in June; and it was suddenly apparent that Angela Carder's life expectancy was now measured in months and perhaps even weeks. As her life ebbed away, the hospital administrator decided to ask a judge of the District of Columbia Superior Court whether a Cesarean operation should be performed to save the twenty-six week old fetus notwithstanding the apparent refusal of Ms. Carder and the clear objections of her husband and her mother. After an emergency hearing at the hospital, the judge ordered the operation.

Two hours after delivery the baby died; two days later, Angela Carder herself died.⁸

This case is not typical in all respects of judicial interventions in medical matters. Indeed, in one sense, the case is quite unusual; there are almost no reported cases where courts have ordered medical interventions to save a fetus over the mother's objections, except for the now-routine judicial override of religious objections to blood transfusions for mother and child.⁹ In these transfusion cases, however, the procedures to save the fetus involve little or no risk to the mother. In Angela Carder's case, the judge understood that the forced Cesarean was likely to shorten the mother's life, though perhaps only by a few days' time. In this respect, the case is unique.

Nonetheless I believe the case is typical in other, and more important, senses. Precisely because the question was posed so starkly as requiring a choice between life for the mother or for the child, this case pressed into unusual visibility the confrontation with death that Jay Katz has identified at the core of doctor-patient interactions. The *Carder* case thus intensely illuminates the forces at work, and the likely impact of those forces, in all such cases where judges determine medical interventions. There is, moreover, one aspect of the judicial proceedings in this case that demonstrates the continued force of Jay's vision: that is, the apparent unwillingness of the judge to confront his own uncertainty and his consequent turning away from any direct encounter with Angela Carder herself.

Between 1:00 p.m. and 5:00 p.m. on June 18, 1987, in an improvised hearing room in the George Washington hospital, Judge Emmet Sullivan took testimony and rendered his decision. Several floors above this hearing room, Angela Carder lay in her hospital bed. She was both struggling to remain alive and inexorably dying. Though there is no logical inconsistency between these two characterizations of her, there is an emotional tension; in the course of the hearing, this tension was bleached away. When Judge Sullivan issued his ruling at the end of the hearing, Angela was dead in the judge's mind.

This is, of course, a bold and perhaps presumptuous speculation on my part; and, of course, I may be wrong. But I rely on two specific events in the hearing for my conclusion.

Here is the first way in which, I believe, Angela Carder was obliterated from these court proceedings. At the outset of his extemporized opinion, Judge Sullivan stated, "The Court is of the view that it does not clearly know what Angela's present views are with respect to the issue of whether or not the child should live or die. She's presently unconscious. As late as [four days ago,] she wanted the baby to live. As late as yesterday, she did not know for sure."¹⁰ The judge's uncertainty about

Angela's wishes permitted him to avoid the implication that he was directly overriding her wishes. This uncertainty was, however, quickly placed in doubt.

Immediately after Judge Sullivan issued his ruling, one of the testifying physicians, Louis Hamner, went upstairs to Angela's room. Dr. Hamner returned several minutes later and reported that she was now "much more lucid" than earlier that morning, and that he had "explained to her essentially what was going on":

I said it's been deemed we should intervene on behalf of the baby by Cesarean section and it would give it the only possible chance of it living. Would you agree to this procedure? She did say yes. I said, do you realize that you may not survive the surgical procedure. She said yes. And I repeated the two questions to her [and] again asked her did she understand. She said yes.¹¹

Angela's apparent willingness to undergo the operation seemed to change the context of the entire proceeding, though ambiguity persisted in the way the physician presented the situation to her as an already "deemed" fait accompli.

Discussion followed among the judge, the physicians and the various court-appointed attorneys about whether additional confirmation should be sought from Angela. The judge expressed concern about whether "it would be overwhelming, for want of a better word, for Ms. Carder to be exposed to additional questioning, one or two questions by the attorneys involved in this case." Dr. Hamner responded that she was "pretty overwhelmed by the whole environment." Judge Sullivan then observed, "I guess the issue for the attorneys is do you wish to accept the representations of the doctor."¹² The court-appointed attorney for Ms. Carder, who had never talked with her but had opposed the operation based on his conversations with her family, asked to confer with the family members who were then at Angela's bedside. The judge agreed.

After a short recess, the attorneys and physicians returned to the hearing room. Dr. Hamner had again spoken with Ms. Carder, with her husband and mother and at least one other physician in the room. This other physician described the exchange to the judge:

She does not make sound because of the tube in her windpipe. She nods and she mouths words. One can see what she's saying rather readily. She asked whether she would survive the operation. She asked Hamner if he would perform the operation. He told her he would only perform it if she authorized it but it would be done in any case. She understood that. She then seemed to pause for a

few moments and then very clearly mouthed words several times, I don't want it done. I don't want it done. Quite clear to me.¹³

Dr. Hamner then confirmed that this was an "accurate" account of his conversation with Ms. Carder and that she was "much more alert" than earlier that day.¹⁴

Though the transcript does not reveal whether anyone besides the two physicians and the family members was with Ms. Carder during this interchange, this much was clear: the judge remained downstairs in his improvised hearing room throughout. Ms. Carder's attorney asked the judge to reconsider his prior order. The judge responded, "I'm not sure we still know what her intent is. Am I correct her first statements were made approximately an hour ago in which she agreed to the surgery?" A District of Columbia government attorney, who had argued for the operation, responded that this statement had been made at 4:40 p.m., just twenty minutes earlier. The judge corrected himself and then continued, "Approximately 5:00 o'clock we are told she does not wish to consent to the surgery. The Court is still not clear what her intent is."¹⁵ Both the government attorney and the court-appointed attorney for the fetus then briefly argued that Ms. Carder's consent was irrelevant since the judge had already determined to protect the fetus' interest in surviving regardless of the mother's wishes. Judge Sullivan reiterated, however, that there had been no clear indication of Ms. Carder's wishes; and that was that.

Beneath all of these confusing interchanges, two facts shine out: Judge Sullivan never directly resolved whether he was overriding Angela Carder's express wishes, and (even more strikingly) he never appeared to entertain the possibility that he should directly talk with her or even observe her conversing with others. To borrow Jay Katz's formulation, in this "confrontation of knowledge and ignorance," Judge Sullivan chose to remain ignorant. In one sense, this posture appears to confound Jay's observation that physicians in similar circumstances embrace false certainty in order to conceal their ignorance and distress. In a deeper sense, however, Judge Sullivan's protestation of ignorance about Angela Carder's intentions was itself a claim of false certainty. He was sure, that is, that he could not learn something that was in fact readily knowable if he had chosen to ask.

Judge Sullivan did not want to know Angela Carder's wishes. He did not want to know her. I would surmise that this was not, as the judge had suggested earlier, because "we don't want to overwhelm her." Judge Sullivan did not want to overwhelm himself. And so he remained downstairs in his improvised courtroom, far away from any direct confrontation with this dying

woman whose death he was prepared to expedite in order to save the fetus she was carrying.

The judge's remoteness is also evident in a small but revealing verbal clue at the end of his extemporaneously rendered opinion. After explaining why he had determined that "the fetus should be given an opportunity to live" notwithstanding that "the performance of a Cesarean section may very well hasten the death of Angela,"¹⁶ the judge concluded thus:

The family of Angela, I appreciate this is a very emotional time in your life, filled with tragedy. My only hope, my only concern is that if this fetus is born, that you learn to love the fetus as you did Angela. I have an obligation to give that fetus an opportunity to live. I have ruled.¹⁷

Judge Sullivan refers here to Angela, and to her family's love for her, in the past tense. In his opinion, she is therefore already dead.¹⁸

Judge Sullivan believed that his decision would hasten Angela's death, and it is therefore not surprising that, having made his decision, he would imagine that she was already dead. I would speculate that Judge Sullivan so rigorously obliterated Angela Carder from these proceedings—by refusing to see her and by referring to her as if she were already dead—in order to alleviate the tension he felt, the cognitive dissonance he was experiencing, in choosing between two tragically incommensurate goals: to save a mother or an infant. In order to make this choice, however, the judge not only removed himself from any interaction with the mother. He also imagined himself so remote from the infant as to deprive it of any recognizable flesh-and-blood embodiment. He transformed the fetus into a lifeless abstraction, an embodiment of Life rather than a living, breathing human being.

The judge did this in two ways. First, he gave no serious attention to the question of who would raise and nurture this infant, or the impact of his decision favoring the infant's life over the mother's and the corresponding implications of this decision for the infant itself as it might grow to maturity. The judge briefly adverted to these questions, but in an abstract moralizing homily directed at Angela's family—that they "would learn to love the fetus." The judge gave no real weight to the agonizing dilemma that his decision imposed on Angela's mother: she believed that Angela's husband was not capable of raising the child, that the task would fall to her, that her long devotion to nursing Angela through years of cancer treatment had exacted a heavy emotional toll on her, that she was herself physically disabled; and yet she could not consider placing the baby for adoption. As she stated at the end of her testimony, "I would take care of that baby. I would never put it up for adoption. I would do the best I could, but we don't

want it. Angela wanted that baby. It was her baby. Let that baby die with her." At that point, Angela's husband said, "Please." This was his only testimony in the entire proceeding.¹⁹

This passionate opposition by Angela's immediate family does not necessarily mean that there was only one correct moral decision in this case, and that their wishes for the baby's death should have prevailed. I am not persuaded even that Angela's own opposition to the operation clearly meant that as a moral proposition her wishes should have prevailed. As I see it, if Angela indeed had only a few day's life remaining and if her sacrifice of those few days would realistically offer a long life to her baby, the question of the proper moral choice seems quite complex.

Some decision must of course be made. But the choice is in my view inevitably tragic, inevitably based on a complicated and contradictory weighing of incommensurable values. Judge Sullivan could not, however, admit this tragic reality for himself. For him to admit this would in itself have called into question his own authority as a judge to make this decision. The very claim that we are "governed by laws and not by men" implies that judges must restrict themselves to decisions that can be justified by appeal to rational principle. If it is implausible to claim the existence of a single correct answer in a controversy, then a judge has great difficulty in justifying his or her authority to resolve that controversy.

Judge Sullivan did, however, assert that he had authority to decide the question at issue. In order to justify his authority by the norm of judicial conduct that I have cited, Judge Sullivan imposed a false sense of certainty on the question. As a psychological matter, he could maintain this false posture only by blocking out anything that might unsettle this brittle, rationally vulnerable facade of certainty. Thus he refused to see Angela Carder, thus he turned away from the emotional turmoil of her family—and in a final ironic move, the judge distorted the data about the prospects for the fetus's survival if the operation were performed.

This final distortion brings us back to the heart of Jay Katz's portrayal of the psychological and social forces that lie beneath the tradition of medical authoritarianism: the false demand for certainty in order to mask interwoven misgivings about the reliability of personal and scientific knowledge, and ultimately to deny existential vulnerability in the face of human mortality.

In the testimony regarding the fetus's survival prospects, we can see these mutually interlocking deceptions between the judge and the physicians about the scientific data available to guide their decisions. The physicians testified, and the judge relied on this testimony in his opinion, that data regarding twenty-six week old fetuses indicated a survival rate of "fifty to sixty percent." The

judge did not acknowledge, however, that under cross-examination by Angela Carder's attorney, these physicians all admitted that there was no data available regarding the fetuses of mothers whose own health was severely compromised as in Angela's specific situation.²⁰ As a matter of common sense, it seemed likely that Angela's grave circulatory and respiratory difficulties considerably reduced her infant's prospects for survival. But in their false quest for certainty, neither the judge nor the physicians were directly prepared to admit that they simply did not know. This misleading reliance on supposedly "hard"—but actually nonexistent—data about the fetus's prospects for survival was yet another way in which Judge Sullivan transformed the fetus into a lifeless abstraction, an embodiment of Life rather than a living, breathing human being.

One final question will bring us clearly back into the silent world of doctor and patient. This question is, why was Judge Sullivan asked to decide the issue of Angela Carder's treatment? Why, that is, was the lawsuit initiated at all? We know that the physicians immediately involved in treating Angela did not want this litigation. Indeed, none of them was prepared to perform the operation even if the judge ordered it. We know moreover that neither Angela's husband nor her mother wanted the operation or the judge's involvement, and we have good reason to believe that Angela herself shared this position. The testimony makes clear that the administrators of the hospital alone initiated the lawsuit. But why? What was the concern of these remote bureaucratic actors that led them to override the wishes of the family members and physicians intimately involved in Angela's care?

It was surely implausible for the administrators to fear the prospects of a later lawsuit by Angela's family if the physicians had followed their wishes against the operation. In some jurisdictions, the administrators might have feared that if they did nothing to save the fetus, then criminal prosecution might be provoked by pro-life political forces. In the District of Columbia, however, this political fear was also implausible.²¹ If the hospital were itself church-affiliated, then it might be plausible to imagine that the administrators were themselves pro-life advocates. But the George Washington Hospital is a secular institution; and the hospital attorney made clear to the judge that the hospital had no institutional position at all regarding whether the operation should be performed.²² The hospital's only institutional position in the lawsuit was that neither it nor its employees should decide this question. Its only position was that the judge, and the judge alone, was qualified to decide—and this was the core of the matter, as I see it.

The hospital administrators implicitly understood the tradition of medical authoritarianism as Jay Katz has acutely portrayed it. They believed, that is, that

medical decisions must be based on unquestionable authority—on data that is so rigorously based on scientific evidence that it cannot be questioned or (lacking this certainty) by scientists whose social authority is so great that they cannot be questioned. But the hospital administrators also understood that this portrait of medical practice is now outdated; and so, since they could not rely on unquestionably correct data and could no longer invoke the social status of physicians to mask the uncertainty of their data, the hospital administrators turned to the last bastion of unquestionable authority in our society: the Judge, the embodiment of the Law.

The judge in turn acted in the way that Jay has described for traditional-minded physicians: he pretended to himself and others that the scientific data was certain when it was not; he avoided direct conversation with the patient though it was possible to talk to her; he pretended that she had no capacity to make an informed treatment decision or even to contribute usefully to such decision, though there was no basis for such conclusion; and he based his decision on a lifeless abstract conception of the patient (in this case both the mother and the fetus), giving virtually no weight to the emotional significance of the treatment decision for any of the people intimately involved. Jay Katz's portrait of medical decision-making prevailed in this case, notwithstanding that a judge made the decision: it took place in a "silent world."

Does this mean that judges should not make these "bedside" decisions in a declaratory judgment format, that Judge Sullivan should have refused the request by hospital administrators to take the case and thereby forced them to find their own basis for deciding, leaving open the possibility of some later judicial review by post-hoc litigation? I have advocated this position,²³ though I have not persuaded many others. And I may be wrong. Jay has pointed not only to the traditional proclivity for false certainty in medical decision-making but also to the deep-rooted human yearning for such certainty. Jay powerfully invokes Dostoyevsky's Grand Inquisitor: "And men rejoiced that they were once more led like sheep and that the terrible gift [of freedom] which brought them so much suffering had at last been lifted from their hearts. . . . Tell me. Did we not love mankind when we admitted so humbly its impotence and lovingly lightened its burden?"²⁴ If physicians no longer accept or are acceptable in this role, does this mean that judges must inevitably step forward?

Jay and I have talked about this issue for many hours: in seminars we have taught together, in long walks we have taken. These conversations, on this and many other matters of great and small import, began for me in the first class I attended on the first day I entered the Yale Law School: a class in Family Law taught by Jay with Joe Goldstein. From that first moment of illu-

mination and pleasure, I have had great joy—though tempered with some sadness that the world Jay sees so clearly, the world so enriched by his capacity for human attachment and engaging conversation, is a world in which silence prevails for most people most of the time and ultimately for all of us.

References

1. See Jay Katz, "Informed Consent—A Fairy Tale? Law's Vision," *University of Pittsburgh Law Review* 39 (1977): 137.
2. Robert A. Burt, *Taking Care of Strangers: The Rule of Law in Doctor-Patient Relations* (New York: Free Press, 1979).
3. *In re Quinlan*, 355 A.2d 647 (N.J. Sup.Ct., 1976).
4. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).
5. See, e.g., *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985), *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626 (1986), *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So.2d 921 (Fla. 1984).
6. Jay Katz, *The Silent World of Doctor and Patient* (New York: Free Press, 1984) 171 [hereafter cited as *Silent World*].
7. *Silent World* at 217-19.
8. *In re Carder*, No. 87-609 (D.C. Superior Ct., 1987). Judge Sullivan's order was affirmed by a panel of the District of Columbia Court of Appeals but this affirmance was vacated and the matter set for *en banc* consideration by the full Court; at this time, no *en banc* decision has been rendered.
9. See *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981); Nancy Rhoden, "The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans," 74 *California Law Review* 1951 (1986).
10. *In re Carder* transcript, June 18, 1987, at pp. 83-84 [hereafter cited as Transcript].
11. *Id.*: 89.
12. *Id.*: 89-90.
13. *Id.*: 92.
14. *Id.*: 93.
15. *Id.*: 95.
16. *Id.*: 84.
17. *Id.*: 85.
18. I owe this observation to Stephen Sowle, Yale Law School Class of 1990.
19. Transcript at 60. Later, when the judge interrupted the summation by Angela's attorney and observed, "She's going to die, Mr. Sylvester," Angela's husband interjected, "Who is to say she's going to die?" Transcript at 76.
20. Transcript at pp. 20-21 (cross-examination of Dr. Hamner), p. 33 (cross-examination of Dr. Weingold).
21. A year earlier, another District of Columbia hospital had successfully sought a court order for a Cesarean operation where the mother's prolonged labor endangered the fetus's survival but the mother refused consent for the surgery without giving any specific reason for her refusal. *In re Maydun*, 114 Daily Wash. L. Rptr. (D.C. Super. Ct., 1986). This case differed from Angela Carder's in many ways: in particular, the operation there did not seriously endanger the mother's life, the fetus was virtually certain to survive if the operation were performed, and the hospital physicians all wanted to perform the operation. The *Maydun* precedent created no sensible risk of criminal or civil liability for George Washington Hospital if—as Angela Carder, her family and her physicians all wanted—the Cesarean operation had not been performed.
22. Transcript at 7.
23. *Supra* note 2, at 164-69.
24. *Silent World* at 127, citing F. Dostoyevsky, *The Brothers Karamazov*, trans. D. Magarshack (Baltimore: Penguin Books, 1958) pp. 300-301.