

TOWARD A BIOETHICS OF COMPASSION

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INTRODUCTION

Bioethics, the study of legal and ethical issues arising in health care, centers on four essential values: respect for patient autonomy, nonmaleficence, beneficence, and justice.¹ Although some commentators have criticized overreliance on such broad principles for ethical decision-making,² others agree that at least the four principles describe common, core values.³ Autonomy refers to the patient's self-rule, and the opportunity to make meaningful choices;⁴ nonmaleficence, to the physician's obligation to do no harm;⁵ beneficence, to contributing to patient welfare;⁶ and justice, to fairness and equity.⁷ These moral principles establish ideals for relationships between physicians and their patients.⁸ In addition, emotional responsiveness—the caregiver's feeling response to the patient—enhances the moral quality of the relationship in a way that transcends ethical principles and rules.⁹

A medical institute for law faculty provided an opportunity to evaluate the operation of these principles in clinical settings. I was one of nine law professors who participated in the program, and accompanied the physicians on rounds as an observer. This Article describes that experience in the context of bioethical norms and rules. Part I distinguishes two models of physician-patient relations, caregiving and curegiving. Part II describes these models through a narrative impression of the rounds, providing the basis for the evaluation of bioethical values in Part III. Part IV extends the model of caregiving by describing its application in an intersubjective framework for health care.

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1. See Tom L. Beauchamp, *The Principles Approach*, 23:6 HASTINGS CEN. REP. S9 (1993).
2. See, e.g., Ronald M. Green, *Method in Bioethics: A Troubled Assessment*, 15 J. MED. & PHIL. 179 (1990).
3. See, e.g., Susan Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798, 840 (1991).
4. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 121 (4th ed. 1994).
5. *Id.* at 189.
6. *Id.* at 259.
7. *Id.* at 327.
8. *Id.* at 463.
9. *Id.* at 462. "Principles and rules cannot fully encompass what occurs when parents lovingly play and nurture their children, or when physicians and nurses provide palliative care for a dying patient and comfort to the patient's distressed spouse." *Id.*

I. CAREGIVING AND CUREGIVING

Ten days at the medical facility produced a multitude of impressions. Many physicians were caring, sensitive, and emotionally responsive to patients; others followed a more detached, objective, institutional model. The following incidents are impressions and recollections, not verbatim transcripts of conversations or actual events.

The first type of physician-patient relation might be described as *caregiving*: employing personal powers in the "art" of medicine.¹⁰ Caregiving might include, for example, asking questions about the body that take into account the patient's meanings,¹¹ or, for instance, promoting the expression of feeling by patients to enhance psychological well-being.¹²

The second type of physician-patient relation might be described as *curegiving*, in which "the doctor knows best," the patient follows "doctor's orders," and the physician-patient relationship follows the physician's historical role as an omniscient, authoritative dispenser of healing.¹³ Curegiving occurs when physicians reinforce patient feelings of dependence and personal estrangement, "as they exchange the status of person for that of patient."¹⁴

Physicians' tendency to adopt the curegiving model in some situations is not so much a moral failure on the part of the profession, but rather a series of unconscious individual choices which reflect a larger societal failure to honor patient feeling states and responses. Medical care is dominated by technology;¹⁵ many new technologies, touted merely for their innovation, actually harm or even kill patients.¹⁶ Medical care tends to hide the

10. See ERIC J. CASSELL, 2 TALKING WITH PATIENTS 2 (1985). Cassell argues that "scientific doctors who lack developed personal powers are inadequately trained." *Id.* at 1. According to Cassell, the *art* of medicine includes not only scientific competence, but also the ability to acquire and integrate *subjective* information. *Id.* at 2. Cassell gives the example of a medical intern whose care is limited by his feeling of hopelessness, which he has unconsciously adopted from the patient. *Id.* at 3.

11. *Id.* at 16-17. Cassell notes: "History taking is often taught as if the object is to strip away all the confusion heaped on the facts by patients in order to get at the diagnosis." *Id.* at 17.

12. See, e.g., Rosanne M. Radziewicz & Susan Moeller Schneider, *Using Diversional Activity to Enhance Coping*, 15:4 CANCER NURS. 293-94 (1992).

13. See generally JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984). The view that only physicians heal is reflected in state physician licensing statutes, which typically criminalize the unlicensed practice of medicine, and arguably define practicing medicine overbroadly. See, e.g., MICH. COMP. LAWS ANN. § 333.17001(1)(b) (West 1992) (defining the practice of medicine as "diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition, by attendance, advice, device, diagnostic test, or other means"); Michael H. Cohen, *A Fixed Star in Health Care Reform: The Emerging Paradigm of Holistic Healing*, 27 ARIZ. STATE L.J. 79 (1995).

14. KATZ, *supra* note 13, at 209.

15. Eric J. Cassell, *The Sorcerer's Broom: Medicine's Rampant Technology*, 23:6 HASTINGS CENTER REP. 32 (1993) (Cassell quotes Emerson: "Things are in the saddle and ride mankind.").

16. David A. Grimes, *Technology Follies: The Uncritical Acceptance of Medical Innovation*, 269 JAMA 3030, 3030 (1993) (citing examples of harmful technological innovations). For instance, electronic fetal monitoring during labor was widely disseminated during the 1970s and abandoned when randomized controlled trials showed the monitoring conferred no demonstrable benefit to the fetus, yet posed significantly increased

experience of suffering, perhaps in the attempt to disguise human vulnerability, or to protect physicians from emotional overload.¹⁷ Even with the hospice movement, which seeks to provide a humane, caring environment for the dying, our culture engages in a kind of “pornography of death—the thing without the appropriate human emotions.”¹⁸ Physicians often keep demented, elderly patients alive by feeding tubes, not because they believe it is right, but to avoid legal consequences.¹⁹ The result is widespread estrangement between physicians and patients, evoking feelings of abandonment in patients, and retreat by patients into silence.²⁰ Consequently, patients bring their own self-estrangement to the doctor, along with unconscious idealizations, transferences, and disempowerment.²¹

The most frequently used metaphor for the physician-patient relationship is the physician as “benevolent parent”—hence, the term, “paternalism.”²² Whether supported by silent codes within the profession or within the culture, the paternalistic, curegiving model denies patient dignity, and contradicts core values such as autonomy, nonmaleficence, beneficence, and justice. Some of the ensuing distortions in the patient-physician relationship are illustrated below.

II. ROUNDS

A. Intensive Care

Mattie, a 94-year-old patient, lies open-mouthed, her chin hanging down in a grotesque, silent moan. Her eyes stare, without blinking, at the ceiling. Her breath is faint, almost inaudible, drowned out by the steady blip of the video monitor over her head. Her gray hair is thinned, her face withered.

“She is completely passive, totally tuned out,” says Dr. S. “She’s what you call a ‘bad’ patient,” he jokes. “She went home from surgery, fell and broke her hip. Complications developed, and she ended up here.”

The words echo in my mind. *She’s what you call a “bad” patient.*

A nurse lifts Mattie’s arm as if it were a shopping bag. She pokes it with a series of needles. Mattie does not register the piercing of her skin. She does not speak. She has

risks of operative delivery. *Id.*

17. See Patricia L. Starck & John P. McGovern, in *THE HIDDEN DIMENSION OF ILLNESS: HUMAN SUFFERING* xi (1992).

18. Eric J. Cassell, *The Nature of Suffering: Physical, Psychological, Social, and Spiritual Aspects*, *THE HIDDEN DIMENSION OF ILLNESS: HUMAN SUFFERING* 1 (1992).

19. Timothy E. Quill, *Risk Taking by Physicians in Legally Gray Areas*, 57 *ALB. L. REV.* 693, 697 (1994).

20. KATZ, *supra* note 13, at 208-09. Physicians thus “deprive patients of vital information, or pat patients on the back and assure them that everything will be all right.” *Id.* at 210. This in turn makes patients feel “disregarded, ignored, patronized, and dismissed.” *Id.*

21. *Id.* Katz provides the example of a cardiology patient’s initial meeting with Dr. Chris Barnard regarding a heart transplant operation; the patient compares Barnard to a “handsome Smuts,” and then to a “martyred Christ.” *Id.* at 131-32 (quoting PHILIP BLAIBERG, *LOOKING AT MY HEART* 65-66 (1968)).

22. JAMES CHILDRESS, *WHO SHOULD DECIDE?: PATERNALISM IN HEALTH CARE* 6 (1982). Other metaphors include: fiduciary, partner, accomodator, contractor, technician, friend, teacher, and bureaucrat. *Id.*

not spoken in weeks, we are told. Her son, an executive, visits her once in a while. More injections.

Dr. S reminds us that Mattie is feeling no pain. "She's really out of it," he says, throwing his head back and rolling open his mouth in an O-shape to mimic Mattie's cadaverous stare. "A classic case of incompetence."

Some of the law professors are happy now. At last, they have something they can discuss: decision-making for an incompetent patient. The debate begins: Who should decide when to terminate Mattie's life support? Her son? The physician? We have shifted from a real encounter with Mattie's pain, to an esoteric discussion of legal standards. This is clearly more comfortable.

From the back of the group, I ask Dr. S: "How do you know what Mattie wants? Have you asked *her*?"

"Of course not."

"Then, have you asked her whether she would like to see a member of the clergy, to talk about the end of her life?"

He dismisses the question and takes another: "What is the son's position?" Mattie's own choice in the matter is not terribly interesting. Or perhaps it is too immediate. Nor has the attending physician bothered to ask about Mattie's emotional or religious needs. Mattie's death, like her life now, is medicalized. The discussion swirls around patient decision-making, ignoring the fact that the patient has not been consulted, and is lying in bed—awake—within earshot. It is as if we were in the midst of a very interesting hypothetical. But we are not in the lecture hall; we are in Mattie's presence. Then again, Mattie is like anaesthetized patients in surgery—tuned out, vegetative, uncommunicative (after all, she doesn't speak); and Dr. S again reminds us that Mattie feels no pain—in fact, she feels nothing at all.

I push my way to the front of the group. "How do you know she's feeling no pain?"

"It's simple." Dr. S nods in Mattie's direction. "Just look at her."

I pause, taking in the human being before me. The expression on her face reminds me of Edvard Munch's painting, *The Scream*. "Look at her face. How can you claim she experiences no pain?"

Dr. S is indignant. He cannot believe I have challenged his pronouncements. He grabs my elbow and pulls me to the patient's bedside. He is going to prove his point. The tubes connected to Mattie's arms flap like seaweed as more medicine is pumped in. I hear the video screen beep.

"Mattie," the doctor intones, leaning into her ear. "ARE YOU IN PAIN?"

"No," she groans, turning her head the other way. I am surprised; Dr. S had given the impression that she was incapable of communicating.

"ARE YOU SUFFERING?"

"No," she moans feebly.

"ARE YOU SURE?" he insists.

"Yes." She turns away, closes her eyes.

Dr. S flashes a triumphant smile. "See? See?" He shakes his head, realizing he has not yet won, and jabs his thumb toward the patient. "You ask her!"

"No"

"Go ahead!" His face, flushed, leans into mine. "See for yourself."

Instinctively, my hand reaches for Mattie's. Her grasp is frail, but tender. Something flashes—a shared sense of inner life; memories of family; a mutual recognition of the

moment's physical reality; a shared awareness of Mattie's experience in this bed. I am breathing, I am feeling the ground under my feet, and I am feeling a connection with this person. The emotions rise, subside. I do not know whether emotions are safe. There are the machines. There are the injections. The doctors. The rising and falling of Mattie's breath. The snaking tubes. The video bleeps.

Dr. S storms off. I am left alone with Mattie, the nurse, and the bewildering technology.

"It's okay," I say. "We care about you."

The emotions rise, refuse to subside. Her face contracts. "I want to cry," she says softly.

"It's okay, Mattie. It's okay to have feelings." I experience thick, choking grief. Mattie begins to cry, then glances at the nurse and stops.

A colleague comes up behind me and gently pulls on my arm. "It's time to go."

Our group has a coffee break. I am quiet. My colleagues complain that the communication with physicians is one-way; we pay them deference, but they have no interest in our legal thinking. Later, when pressed, one professor—a former nurse—admits she felt buoyed when she saw Dr. S challenged to confront Mattie's pain. She asks what Mattie whispered.

I tell her: "She wanted to cry."

But otherwise, Mattie is forgotten. Nobody wants to talk about it.

B. Pediatrics

"And this is our pediatric ward," says Dr. T, a tall, gaunt man in his early thirties. He leads three of us into a clean, narrow, corridor where medical personnel in scrub uniforms are gazing quizzically at our nametags. He ushers us into the children's playroom, shows off the art on the wall, done by children, and describes awards. The cartoon drawings tell all: they hate the injections, they like the nurses, and they want to go home as soon possible.

A four-year-old, wearing an eyepatch, is playing ball with her mother, who sits cross-legged on the floor. I kneel down to say hello. The ball rolls towards me.

"It's a tough place, pediatrics," Dr. T says. "Extra training. Credentials."

Our next stop is an operating room at the end of the hall. The operating table is child-sized. A hand-written sign above the table reads:

REMEMBER PERSON AWARENESS.

There Is A *Person* Under
Those Jabbing Needles.

Talk To Me.

Comfort Me.

I Could Be *Your* Child.

In the next room, a child is undergoing a heart procedure. He is completely covered with a green drape, presumably to keep a sterile field. The only thing showing is the offending organ.

"You can't even tell there's a person under there."

Dr. T shrugs. "Best medical care," he says. That's jargon. It means: "leave the doctoring to the doctors." It reminds me of something a student told me, when he asked

his wife's physician which drugs were safest during her pregnancy. The doctor replied: "We know what to give her and when."

Dr. T proudly introduces the "parent room." There are sofas, books, a sturdy table, and a great view out the window. A couple is sitting at the table. The wife puts together the largest jigsaw puzzle I have ever seen. There must be over three hundred pieces.

"How is the puzzle coming?" I ask.

The woman lowers her eyes. "The doctors kicked us out."

Dr. T, ushering us out and closing the door behind him, editorializes: "That tells the whole story, doesn't it?"

C. Surgery

"If anything happens, you'd better have an anesthesiologist around," says Dr. P. "He knows what's going on; the surgeon's just a pair of hands."

Dr. P is an old-timer. He calls all of the male surgeons, "Boy." They call him, "Sir."

Dr. P notes: "I'm the one who puts people to sleep."

We watch brain surgery. In a delicate maneuver, a man's ear has been sliced out of the way; the right side of his head has been cut away, allowing access to a particular part of the brain. The surgeons are playful as they scoop out some muck.

In the next room, rock music blares while the surgeons excise the cancer from an old man's liver. A green curtain separates the patient's face from his body; all the surgeons see is the slit-open skin, and the underlying organs. This is somebody's grandfather. Under the plastic bag that covers the patient's face, I see a grey moustache. Dr. P explains that for years they tried to find a way to keep the patient's body warm during surgery. Most of the heat escapes out the head. Finally, they made a breakthrough discovery: the plastic bag over the face.

The chief surgeon is young, handsome. "We can cut it up and take it out," he says. "No more cancer." He smiles, clearly impressed with the technology and with his skill. "Couldn't do this a few years ago." The radio announces a baseball game. Now there is a commercial for facial cream. This torrent of verbiage, electric guitars, sales pitches: is this moustached, old man really not "there"? What does it mean to say he's "asleep"? Isn't he aware, *on some level*, of everything around him—commercials, bad jokes, electric guitars, braggadocio and all?²³ If he dies, will the last thing he hears before leaving this world be the facial cream ad? Would the surgeon be this cavalier with his own grandfather? Or would someone be praying? Perhaps someone is praying, upstairs in the chapel, right now.

The attending nurse smiles at us and makes chit-chat. "You're law professors?"

The surgeon from the last operation enters. "Did anyone see my keys?" The others shake their heads. The operation continues.

Now Dr. P jokes: "Are you guys okay? Nobody's nauseous, are they?" He rolls his eyes. "Okay, let's get some excitement."

We rendezvous with our colleagues. One has seen a penile implant. It's the joke of the day ("how about that penile implant in O.R. 23?"). We split up again. A woman is

23. See David Cheek, *Unconscious Perception of Meaningful Sounds During Surgical Anaesthesia as Revealed Under Hypnosis*, 1 AM. J. CLIN. HYPNOSIS 101, 109 (1959) (reporting auditory impressions by hypnotic subjects of surgeries experienced under anesthesia).

lying naked on the operating table, legs splayed like a chicken. We enter; the surgeon flashes an angry look at Dr. P.

“Do you have a problem, *boy?*” Dr. P says.

The surgeon pauses, then says: “No problem, sir.” He looks us over and continues. We watch, huddled in the corner of the room. We can see the patient’s innards on a giant computer screen over her head. We watch the surgical instruments travel through her body.

“Why don’t they cover up her breasts?” one of the professors whispers to me. Another answers her: “Must be standard medical procedure.”

Dr. P, ushering us out, informs us that earlier this patient stopped breathing for ten seconds. He asks us whether, after the operation, the patient should be informed of this development. He argues that the information is of “no medical value.” I suggest that it might be of psychological or religious significance to the patient. He dismisses the suggestion. “If it’s of no *medical* value, what’s the point?”

Our next patient is a black woman, thirty years old. Cancer. She lies, anesthetized, in limbo; the surgeons around her have opened her up and found that the tumor has spread much further than anticipated. Now they wait for the pathologist’s report. They are expectant, impatient; there is nothing to do but wait. It is as if we are waiting at the bus station. The patient lies before us, anesthetized, opened up.

Finally, the head surgeon breaks the silence. “So where you guys from?”

Somebody answers, awkwardly. “We’re law professors—not lawyers, professors. From different parts of the country.” He describes the program. There is commentary and response. We wait for the pathologist. It is awkward, this conversation. The silence that ensues is equally awkward; we are not used to being present in the face of the moment; something must fill the space. More science, perhaps. Unprompted, the surgeon decides to use the time instructively.

“See, her cancer’s worse than we thought. It’s spread all over the place. It started here.” She lifts the patient’s liver with the tongs. She lifts it up, way up, out of the body. “See? Her diet’s awful. It spread to the stomach.” The tongs drop the liver, seize the stomach and yank it up. Finally, the pathologist arrives and says the magic words to the surgeon. “Yeaah!” she shouts. “Just as I thought.” She is happy because she won a bet with the resident as to what kind of cancer it was.

The pathologist, perhaps aware that he has an audience, reprimands her. “What’re you cheering for? This means she’s going to die.”

Angrily, the surgeon lets a flap of skin fall back toward the patient’s organs. “Then we’ll sew her up. There’s nothing more *we* can do.”

The night after the surgery, at the hotel, we reflect on our experiences. Cigarette smoke fills the space between the dark-paneled walls as we sip our gin-and-tonics.

“That’s so sad,” someone says. “That woman, thirty-three. What will they tell the family?”

“The question is, *who’s* going to tell the family? That surgeon?”²⁴

24. “Disclosing the death of a patient . . . is a duty which goes to the very heart of the physician-patient relationship. . . . The emotional needs of the family . . . must at all times be given foremost consideration.” AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS, Op. 8.18 (1994).

"To think she was operated on for nothing."

"Did they sew her up because it was futile to operate, or because the surgeon was defensive?"

"Who knows—there's no accountability in the operating room."

"Maybe it was because she was black."

"I know one thing," I say. "The next time someone I love goes in for surgery, I'm going to insist on being in the operating room."

"You can't do that!"

"Why not? We were in there today. There's nothing magical about the O.R. that requires excluding loved ones."

"What would you do in there?"

"Just . . . be present. That way the doctors will remember there's a human being on the table, not just a body."

Suddenly the others defend the physicians: they *need* to be desensitized, otherwise they can't do what they do; they cannot personalize every patient.

I argue that every patient *is*, first and foremost, a person. This is debated at great length, the conclusion being that once the individual enters the hospital, the person is, first and foremost, a patient. Once disease enters the body, the best attitude is to be, simply . . . patient.²⁵

III. TOWARD A BIOETHICS OF COMPASSION

The three sets of patients described above—Mattie, the child, and the anesthetized patients—have several features in common. First, they all are dominated by invasive technology and live in a precarious position of extreme dependency and vulnerability. Mattie lives by the grace of constant injections delivered by a nurse; above her, the video screens feed back continuous information as to her physiological state. The child is unconscious, as the surgeons perform a life-saving operation. The other patients undergoing surgery similarly depend on their caregivers, as the anesthesiologist behind the screen constantly monitors vital signs. If the heart stops, or if a reaction occurs, these patients depend on instantaneous, competent decision-making and care.

Second, these patients are *silent*. Mattie cannot, or does not, disclose her wishes or feelings. Although the attending physician presumes to know Mattie's state of mind by her guttural nonresponse to his questions, in actuality we have no idea how she is reacting—other than physiologically—to the steady stream of injections. We do not know how she regards the dying process or the decisions related to her dying. In fact, caught up in the swell of medical, legal, and ethical decision-making—all of which proceeds independent of the patient's psyche—no one has thought it important to ask.

Similarly, because the child is "under," she has no say about anything; and the parents have lapsed into paralysis. They put together a puzzle, as the surgeons put together their child. They can hope or possibly pray, but they can only do these things

25. Cf. ROBERT M. VEATCH, 2 THE PATIENT-PHYSICIAN RELATION: THE PATIENT AS PARTNER 2 (1991) ("The term *patient* is not a good one. Etymologically it implies suffering, the connotation of passivity. But patients can be passive no longer.").

from a distance.²⁶ The anesthetized patients likewise have no voice once the anesthesia takes over; it is as if they are “not there.”

Third, these patients exist at the gray edge of law and bioethics, where legal rules and ethical principles do not necessarily apply, and indeed, where the physician’s emotional responsiveness may be of greater importance.²⁷ For example, it is unclear whether, as a legal matter, Mattie is “competent” or “incompetent.”²⁸ The physician says she is “incompetent,” but that may be a personal judgment more than a medical one. Mattie can speak, but like Herman Melville’s protagonist in *Bartleby the Scrivener*, she prefers not to. Her “care”—whether she perceives it thus or not, that is the term—proceeds as if on its own volition: bleeps, injections, even the dragging of a law professor to her bedside to test his estimation of her suffering.

Likewise, children in general—as evidenced by the sign in Pediatrics—are particularly unaware of legal rights and ethical choices; they exist in the unregulated, undefined world of emotional nuance. Here, the child probably cannot imagine that she will have her entire being covered, save the disabled organ, for several hours. The parents cannot know; nor, to advocates of paternalism, should they be allowed to see. They must bide their time in the duly designated space.

Finally, these different patients lack full awareness and choice relative to decision-making about their bodies. For instance, the patients undergoing surgery probably do not know about the plastic bag over their faces, nor about the crude jokes or operating room banter. The law of informed consent does not require such disclosure;²⁹ and despite the individual’s Fourteenth Amendment “liberty interest,” which includes the right to refuse “unwanted medical treatment,”³⁰ the patient has no opportunity to decline, or even discover, the more tasteless aspects of the experience of surgery. Rights involving dignity are protected when the individual is competent, or even incompetent—provided the person is within view.³¹ As Mattie is screened off from her neighbors, her muffled moans hidden behind the tubes, so the patients in surgery are screened off, and masked—literally—from others. The patients do not operate as autonomous agents; they are literally operated upon. Here the physician-patient relationship is particularly vulnerable, existing as it does beyond legal and ethical norms, and behind the scenes, and with patients who are, above all, silent and powerless.

26. The author witnessed one surgery performed upon a diabetic ten-year-old who had undergone a dozen such procedures in the previous years. The staff knew the situation and knew the child. One of the surgeons appeared to comfort the child, calling him by name, even though the child was anesthetized. This gave the impression of caring and of valuing the child’s dignity and integrity, not as a patient, but as a person.

27. BEAUCHAMP & CHILDRESS *supra* note 4, at 462; *see also supra* note 9 and accompanying text.

28. If competent, the patient has a legal right to refuse life-saving treatment. *Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261, 262 (1990).

29. Informed consent only requires the physician to disclose information material to the patient’s decision to submit to a particular medical procedure. *Canterbury v. Spence*, 464 F.2d 772, 786-87 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

30. *Cruzan*, 497 U.S. at 278.

31. *Cf. id.* at 286 (observing that family members “do not wish to witness the . . . [condition] of a loved one which they regard as hopeless, meaningless, and even degrading”).

The law could easily monitor the surgery room, and other closed-off areas. For example, a court could decide that the right of informed consent requires doctors to make available to patients videotapes of surgeries. That way, a patient could witness whether her liberty and dignity were unfairly and needlessly assaulted during medical procedures. A patient would know, for example, whether more of her body was exposed than necessary—or what kind of jokes were told. Similarly, a legislature could decide that the right to refuse treatment requires an elderly patient's affirmative, express assent to continued medical care.³²

The law's further intrusion, however, would raise additional problems. For instance, surgeons might argue that videotaping chills effective surgery. Similarly, evidence of a patient's continued wishes might be difficult to extract. The law cannot force Dr. S to ask Mattie what *she* wants, anymore than it can force Mattie's son to visit her more frequently, or force Mattie to speak, or force Mattie to respond honestly to Dr. S's questions.³³

In these situations, the patients can rely on neither legal nor ethical norms; nor do the physicians have rules to guide them. The situations are shaped by individual power, a personal sense of responsibility, and by larger cultural expectations. If surgeons can lift organs up for show, and patients can be shut away from their loved ones, then perhaps we accept the situation and *expect* to give up power—and even dignity—in the operating room, or to be shunted from our children in our hour of crisis. Perhaps we expect physicians to be curegivers, and they step into the role to fulfill the unconscious bargain. Or, perhaps the fear and denial of suffering distort the experience of health “care” and transform it into one of health dependency.³⁴ Or perhaps the culture remains enmeshed in outmoded notions of physician dominance.³⁵

The model of caregiving recognizes that patient well-being entails not only cure, but also care.³⁶ It acknowledges “compassion, fidelity, and humanity” as common denominators, across time and cultures, in the ethical aspirations of healing professionals.³⁷ A beautiful prayer encapsulates these values: “May the pain of every

32. The challenged legislation in *Cruzan* required a guardian seeking to “discontinue nutrition and hydration of a person . . . in a persistent vegetative state,” to provide “clear and convincing evidence” of what the individual's decision would have been. 497 U.S. at 284-85.

33. Given the imbalance of power and the “hopeless . . . and even degrading,” *Cruzan*, 497 U.S. at 286, position into which Mattie was thrust, one wonders whether Mattie was capable of disclosing her suffering to a hostile interrogator upon whom she was dependent for life support.

34. See, e.g., RICHARD M. ZANER, *ETHICS AND THE CLINICAL ENCOUNTER* 3 (1988) (describing the bureaucratic, fragmented, and dehumanizing nature of modern health services).

35. See generally KATZ, *supra* note 13. Veatch observes that increasingly, patients visiting physicians are in fact healthy. They come for physical examinations, for example, or for immunizations or other services that do not suggest illness; or patients may have illnesses that are chronic and stable. Veatch notes that none of these patients are sick “to the extent of being incapable of participating actively in an ongoing patient-physician relation.” Veatch thus proposes the model of active bargaining process for the physician-patient relationship. VEATCH, *supra* note 25, at 2-3.

36. See generally SUSAN SHERWIN, *NO LONGER PATIENT: FEMINIST ETHICS AND HEALTH CARE* (1992).

37. Donald Konold & Robert M. Veatch, *Codes of Medical Ethics*, in 1 *ENCYCLOPEDIA OF BIOETHICS* 162, 166 (Warren T. Reich ed., 1978).

living creature/ be completely cleared away./ May I be the doctor and the medicine/And may I be the nurse/ For all sick beings in the world/ Until everyone is healed.”³⁸ Respect for the patient, as person, though embodied in legal rules, perhaps transcends them.

If medicine heals, it also creates a circle of interaction where, in one physician’s words, “the physical does not always have the last word.”³⁹ The rounds highlight, in part, our culture’s overemphasis of the logical and physiological, and its denial of the analogical and psychological.⁴⁰ If patients were no more than magnificent machines, rather than whole persons, then a technocratic approach to health and bioethics would be called for, and any additional sensitivity wasted.

The stories will not solve ethical conflicts according to rigorous, theoretical criteria. They are not criticisms of the institution or its staff, but rather a commentary on a collective consciousness that medicalizes life and death, and that denies the language of the body, the wisdom of feeling, the truth of inner experience. I engage in storytelling more than rulemaking, for in storytelling, we reclaim the parts of ourselves that have been fragmented or denied.⁴¹

The tales suggest that persons do not begin and end at the level of skin.⁴² Persons, as patients, experience physical, emotional, and psychological realities.⁴³ Although anaesthesia and so-called “incompetence” describe physiological and legal states, they also may be states of being that test our respect for personhood. Ideals are tested, not in litigation, but in the warp and woof of human conduct. Whether medicine and law can affirm caregiving over curegiving, and can truly embody respect for persons, is the ongoing, silent task of a bioethics of compassion.

38. SOGYAL RINPOCHE, *THE TIBETAN BOOK OF LIVING AND DYING* 221-22 (1992) (quoting SHANTIDEVA, *A GUIDE TO THE BODHISATTVA’S WAY OF LIFE* 30-32 (Stephen Batchelor trans., 1979)). Cf. Cassell, *supra* note 18:

There is one more way by which we can know that others suffer—by directly experiencing within ourselves their feelings of desperation and disintegration, in the same manner that parents frequently experience the emotions of their children and psychiatrists of their patients. Directly experiencing the emotions of others is . . . not part of our everyday language nor of medical discourse . . . [but] this basis for compassion . . . is part of the everyday world.

Cassell, *supra* note 18, at 9.

39. LARRY DOSSEY, *MEANING AND MEDICINE: LESSONS FROM A DOCTOR’S TALES OF BREAKTHROUGH AND HEALING* 24 (1991).

40. Cf. ROGER J. BULGER, *IN SEARCH OF THE MODERN HIPPOCRATES* 153 (1987) (“The day [in the hospital] is dominated by mechanical worries, dials, buttons, and computers, all of which are essential and even vital, but none gives access to a patient’s feelings. . . . [S]cientific care has eroded the human care which has always been a part of the healing process.”).

41. See John Arras, *Principles and Particularity: The Role of Cases in Bioethics*, 60 *IND. L.J.* 983, 1004 (1994) (describing the notion that “story or history,” as opposed to “a top-down ‘applied ethics’ model,” is the “most appropriate form of representing moral problems”).

42. See JOEL FEINBERG, III, *THE MORAL LIMITS OF CRIMINAL LAW*, ch. 19 (1986), cited in BEAUCHAMP & CHILDRESS, *supra* note 4, at 410 (defining autonomy with reference to a zone of “breathing space” around the body).

43. See KEN WILBER, *NO BOUNDARY: EASTERN AND WESTERN APPROACHES TO PERSONAL GROWTH* 1-14 (1979).

IV. BEYOND A BIOETHICS OF COMPASSION

Postmodern scholarship has shown that different aspects of reality can be illuminated by different perspectives.⁴⁴ As Michael Polanyi observes, "Man lives in the meanings he is able to discern."⁴⁵ Previously, this Article has examined caregiving and curegiving from analytic and narrative perspectives. This Part extends the metaphor of caregiving, by exploring its meaning through myth and archetype.⁴⁶ Exploding ruling metaphors through such "alternative, even conflicting" perspectives can inform, enrich, and challenge unconscious legal paradigms.⁴⁷

For example, my encounter with Mattie exploded the legal dichotomy between "competent" and "incompetent" patient that informs much of bioethics. While described by the attending physician as "incompetent," Mattie was in fact quite capable of communicating.⁴⁸ Imagine that, after meeting Mattie, I dreamed or had a vision of a magnificent lady, wearing a brilliant white gown with a blue sash, who proclaimed: "I am the Mother of all beings. It was I, standing behind Mattie, whom you recognized, as you felt the energy connect between your hand and hers; it was my hand you were

44. See, e.g., Ben Rich, *Postmodern Medicine: Reconstructing the Hippocratic Oath*, 65 U. COLO. L. REV. 77 (1993).

45. MICHAEL POLANYI & HARRY PROSCH, *MEANING* 66 (1975). Polanyi adds: "Men believe in the reality of these meanings whenever they perceive them—unless some intellectual myth in which they also come to believe denies reality to some of them." *Id.*

46. See MILNER S. BALL, *LYING DOWN TOGETHER: LAW, METAPHOR & THEOLOGY* 17 (1985) ("Conceptual metaphors for law can circulate, diversify, increase, stimulate the creating of other metaphors, and challenge the hegemony of monolithic conceptual thinking.").

47. *Id.* at 22; see also CARL JUNG, *SYMBOLS OF TRANSFORMATION* (1956) (contrasting "directed thinking" with "dreaming or fantasy thinking").

48. Communication occurs on many levels, most nonverbal and subtle. See David Cheek, *Communication With The Critically Ill*, 12:2 AM. J. CLIN. HYPNOSIS 75 (1969). Indeed, hypnosis uses such tools as ideomotor signals—tiny, unconscious movements of the head or fingers—to communicate with the subject. See, e.g., ERNEST ROSSI, *THE PSYCHOBIOLOGY OF MIND-BODY HEALING: NEW CONCEPTS OF THERAPEUTIC HYPNOSIS* 89-91 (1987); STEPHEN GILLIGAN, *THE COOPERATION PRINCIPLE IN ERICKSONIAN HYPNOTHERAPY* 337 (1987).

Even if Mattie had *not* said, "I want to cry," she still communicated—through gesture, movement, emotion and silence. Dr. S's description of his patients as "noncommunicative" made a discussion of substituted judgment infinitely more inviting, but actually substituted banter for communication. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 284-86 (1990). Cf. GILLIGAN, *supra* at 261 (observing that a trance state can occur when "the ensuing confusion is amplified to create more uncertainty"); MICHAEL YAPKO, *TRANCEWORK: AN INTRODUCTION TO THE PRACTICE OF CLINICAL HYPNOSIS* 139 (1990) (describing "trance logic" as the "voluntary state of accepting suggestions . . . without the critical evaluation that would, of course, destroy the validity of meaningfulness of provided suggestions").

holding, as I am holding yours always, until the end of time."⁴⁹ Would such a dream change the analysis?

The next morning, at a neighboring hospital, an obstetrician described a new medical technology known as "multiple fetal pregnancy reduction" (MFPR). The technology arises from the woman's capacity to bear more than one fertilized egg through pregnancy at a given time.⁵⁰ Essentially, MFPR helps such patients bear healthy babies by "reducing" the number of embryos—*e.g.*, arranging for destruction of excess embryos.⁵¹ Typically, the selected embryos are "terminated" by injecting potassium chloride into their hearts.⁵² The needle is passed through the mother's abdominal wall, uterus and fetal thorax.⁵³ In most cases, fetal cardiac arrest occurs immediately; otherwise, the procedure is repeated until the embryo is terminated, lest the fetus survive in a state of "permanent damage."⁵⁴

Ethical issues raised by MFPR have only begun to enter the literature.⁵⁵ The practice has been defended on the ethical principle of proportionality, the duty to choose the course of least harm and greatest benefit to all concerned.⁵⁶ In assessing MFPR, our group analyzed the "maternal-fetal conflict," in which the mother's right to choose or

49. Cf. THE BASIC WRITINGS OF CARL JUNG 158-62 (Violet de Laszlo ed., 1959) (describing the *anima* or universal feminine archetype within human consciousness); JOSEPH CAMPBELL, THE HERO WITH A THOUSAND FACES 111 (1949) (describing the archetype of the universal mother); WILLIAM BLANK, TORAH, TAROT & TANTRA 39 (1991) (describing the *Shekhinah*, or receptive, feminine archetype).

50. Multiple fertilized eggs result in three cases: (1) naturally, when the egg splits, (2) as a side-effect of infertility medication, and (3) when the obstetrician, to increase the odds of a successful pregnancy, implants additional eggs. Interview with Dr. Graham Ashmead, Metropolitan Hospital (Cleveland) (October 6, 1994). See also M.I. Evans et al., *Selective First-Trimester Termination in Octuplet and Quadruplet Pregnancies: Clinical and Ethical Issues*, 71 OBSTET. & GYNECOL. 289 (1988) (observing that "[t]he induction of grand multiple gestations is a known complication of infertility treatments"). Dr. Ashmead reports patients carrying up to nine embryos.

51. With "quadruplets or multifetal gestations of more than five fetuses"—in other words, when four or more embryos are present—and "in multiple pregnancies bearing more than one anomalous fetus," "selective termination" of excess fetuses is deemed ethically appropriate. M.I. Evans et al., *Attitudes on the Ethics of Abortion, Sex Selection, and Selective Pregnancy Among Health Care Professionals, Ethicists, and Clergy Likely to Encounter Such Situations*, 164:4 AM. J. OBSTET. & GYNECOL. 1092, 1092 (1991).

52. William Walters, *Selective Termination in Multiple Pregnancy*, 152 MED. J. AUSTRALIA 451, 451-52 (May 7, 1990).

53. *Id.* at 452.

54. *Id.*

55. J.C. Fletcher, *Ethical Aspects of Prenatal Diagnosis: Views of U.S. Medical Geneticists*, 14:2 CLIN. PERNATOL. 293 (1987) (calling for greater study). Obstetricians do not view MFPR as life-destroying but as life-saving: the object is to allow the mother to have one, two or possibly three healthy babies, rather than four to nine sick ones. For this reason, even "right-to-life" patients have requested the technology. Ashmead Interview, *supra* note 50. Moreover, the intention is to continue rather than terminate pregnancy. Walters, *supra* note 52, at 452. Cf. F.N.L. Poynter, *Hunter, Spallanzani, and the History of Artificial Insemination*, in MEDICINE, SCIENCE AND CULTURE 97-113 (Lloyd Stevenson & Robert Multhauf eds., 1968) (giving an historical overview of the public controversy over artificial insemination).

56. Walters, *supra* note 52, at 452; Evans et al., *supra* note 51, at 295.

refuse recommended treatment may conflict with the physician's obligation to promote the well-being of both mother and fetus.⁵⁷ Of course, typically, maternal-fetal conflict involves a clash of interest between the mother and the life inside her, whereas here, there are multiple potential lives, each individualized only by the extent of their "complications." As one physician notes: "[I]t is still problematic as to which particular fetuses should have their existence terminated."⁵⁸ Moreover, the selection process itself may affect the mother's psyche, not to mention future family dynamics.⁵⁹ A further complication is the legal status of potential beings. Courts seem to regard them as *between* "property" and "life"—deserving "greater respect than accorded to human tissue but not the respect accorded to actual persons."⁶⁰ Our own discussion plied abstraction—and the process of abstracting is, perhaps, the source of clarity, as well as artifice, in bioethics.⁶¹ though the organism concerns itself with nourishment, the law confines itself to "rights."⁶²

In a dream, from a myth-making perspective, imagine the following: I entered the feeling-state of those semi-developed, discarded units of consciousness. I felt the joy of physical embodiment, the ecstasy of incarnation. In the next moment, I suffered overwhelming, indescribable grief, as *the embryos experienced themselves* discarded, emptied of life like trash tossed from a car window. In my sense-impression, the embryos

57. See THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS COMMITTEE ON ETHICS, PATIENT CHOICE: MATERNAL-FETAL CONFLICT, Opin. No. 55 (October 1987) [hereinafter MATERNAL-FETAL CONFLICT] (noting the increase in the possibility for such conflicts, given the increasing accessibility of the fetus to diagnostic and treatment procedures); Rosa Kim, *Reconciling Fetal/Maternal Conflicts*, 27 IDAHO L. REV. 223 (1990-91).

58. Walters, *supra* note 52, at 452.

59. Cf. LON FULLER, LEGAL FICTIONS 104 (1967) (affirming "the alteration that reality undergoes in our minds" as other than "falsification"); WILHELM REICH, THE MASS PSYCHOLOGY OF FASCISM 26 (1970) (observing that "[c]onsciousness is only a small part of the psychic life").

60. Davis v. Davis, 842 S.W.2d 588, 594-96 (Tenn. 1992) (quoting Report of the Ethics Committee of the American Fertility Society, 53:6 J. AM. FERTILITY SOC. 345-355 (1990)).

61. Cf. Robert Cover, *Violence and the Word*, 95 YALE L. J. 1601, 1601 (1986) (observing that legal interpretation "takes place in a field of pain and death").

62. Individual rights are "political trumps held by individuals," and exist to protect individuals from collective decisions to either deny them what they wish to have or to do, or to impose some loss or injury on them. RONALD DWORKIN, TAKING RIGHTS SERIOUSLY xi (1978). According to legal positivism, rights thus do not have "some special metaphysical character," but rather exist "only insofar as th[ey] have been created by explicit political or social practice." *Id.* at xii. Dworkin argues that some rights are, however, "fundamental and even axiomatic," such as the "right to equal concern and respect." *Id.* See David Blickenstaff, *Defining the Boundaries of Personal Privacy: Is There a Paternal Interest in Compelling Fetal Surgery?*, 88:3 NW. U. L. REV. 1157 (1994) (arguing for a woman's right to refuse fetal surgery).

mourned the technocratic disposal process⁶³—being treated as objects, dispatched with a shot to the heart.⁶⁴

Again, do symbols, metaphors, and myth-making matter? Should a dream or trance vision shift analytical frameworks?⁶⁵ Does an embryo, terminated like a line of products, suffer?⁶⁶ Does a fly suffer as, having escaped the deadly blow of a swatter, it is being crushed by someone's heel? Does an ant experience pain when it is smushed by a child's thumb? Does an "incompetent" patient like Mattie, who admits to her doctor that she is feeling no pain, suffer? Do patients undergoing surgery suffer from barbs about their organs? Does suffering require articulation through language in order to be validated as "real"? Is consciousness limited to persons, and only ones declared legally competent?⁶⁷ Is the negation of suffering merely denial,⁶⁸ or is it, at times, a lie?⁶⁹

I do not know whether abortion is a good thing or a bad thing, a moral procedure or an immoral one, a right essential to a woman's control of her body or an evil.⁷⁰ I make

63. "Technical civilization is man's conquest of space. . . . But time is the heart of existence. To gain control of the world of space is certainly one of our tasks. The danger begins when in gaining power in the realm of space we forfeit all aspirations in the realm of time . . . where the goal is not to have but to be, not to own but to give, not to control but to share, not to subdue but to be in accord." ABRAHAM JOSHUA HESCHEL, *THE SABBATH: ITS MEANING FOR MODERN MAN* 3 (1983).

64. Cf. Scott Altman, *(Com)modifying Experience*, 65 S. CAL. L. REV. 293, 302 (1991) ("[M]edical technologies that shorten or risk the life of a person, or something that resembles a person, for the benefit of another . . . demonstrate that persons have noninfinite value and that people treat others as objects that can be used solely as means.") See also Margaret Radin, *Reflections on Objectification*, 65 S. CAL. L. REV. 341 (1994).

65. Gilligan notes that "trance is an experiential continuum of involvement rather than an 'all or none' phenomenon." GILLIGAN, *supra* note 48, at 337. Tart goes further, arguing that "enlightenment" is a "continuum of development rather than an all-or-none state," with altered states such as hypnosis creating "jumps" in the continuum. CHARLES TART, *WAKING UP: OVERCOMING THE OBSTACLES TO HUMAN POTENTIAL* 7 (1987). Tart observes that since childhood, his subjective experience has contradicted the Western view that states such as dreaming are "not real"; he uses the term "consensus consciousness" to suggest that "ordinary consciousness" does not connote "naturalness and normality," but rather is a trance state shaped by the "consensus of belief" of Western culture. *Id.* at 5, 11.

66. The ACOG opinion speaks in terms of "jeopardiz[ing] the fetus," "distress or deterioration," "fetal interests, "fetal needs," and "welfare of the fetus." MATERNAL-FETAL CONFLICT, *supra* note 57.

67. Cf. SWAMI MUKTANANDA, *PLAY OF CONSCIOUSNESS* 5 (1978) (describing all creation as conscious); Walt Whitman, *Leaves of Grass* (1855) ("I bequeath myself to the dirt to grow from the grass I love,/If you want me again look for me under your boot-soles.").

68. Cf. GUIDO CALABRESI & PHILIP BOBBIT, *TRAGIC CHOICES* 26 (1978) ("Though subterfuge may bring us peace, for a while, it is honesty which causes the tragic choice to reappear . . . [and] permits us to know what is to be accepted and, accepting, to reclaim our humanity and struggle against indignity.").

69. Cf. HANNAH ARENDT, *TOTALITARIANISM* 111 (1968) ("Systematic lying to the whole world can be safely carried out only under the conditions of totalitarian rule, where the fictitious quality of everyday reality makes propaganda largely superfluous.").

70. For differing religious views, see Laura Bishop & Mary Coutts, *Religious Perspectives on Bioethics*, 4:2 KENNEDY INST. OF ETHICS J. 155 (1994) (describing attitudes towards reproductive and other technologies in African religious traditions, Bahai Faith, Buddhism and Confucianism, Eastern Orthodoxy, Hinduism, Islam, Jainism, Judaism, Native American religious traditions, Protestantism, and Roman Catholicism). Cf. AMERICAN

no judgment on MFPR or selective termination.⁷¹ Similarly, I do not judge whether Mattie's care was "reasonable under the circumstances."⁷² From a myth-making perspective, all beings experience trauma, whether their pain is intelligible to their human caretakers, or not,⁷³ and although legal rules circumscribe choices, humans choose how to act in a realm infinitely larger than rules can dictate.

What links the excess embryos to Mattie, the children, and the surgery patients, from a myth-making perspective, is that their experience of care occurs in a consensus reality that denies their capacity to feel and suffer. The embryos are simply "multifetal gestations";⁷⁴ Mattie, the children, and the surgery patients are "tuned out." Their objectification results from a reduction of "care," as a ruling metaphor, to "medical care";⁷⁵ from an overly mechanistic view of their condition;⁷⁶ from the denial that they have, at the moment of care, a consciousness of that care. Their dignity, if you will, is impinged because in treating them as objects of technological intervention, their aliveness is ignored—*e.g.*, the euphemism "reduction" as substitute for "destruction"; the terms "incompetent" and "noncommunicative" as medical pronouncements rather than functional realities; the reference to the body part, rather than the person (the "penile implant in O.R. 23").⁷⁷

MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS, Opin. 2.01 (1994) ("[T]he Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law.").

71. Indeed, one can hardly frame the language of "rights" to this analysis. On one side, there is the couple's interest in a healthy baby; on the other side, the egg's right to avoid being fertilized, only to be "selectively terminated." "Egg rights" arguably are no less compelling than "fetal rights," particularly in light of the difficulty in determining the moment at which the latter rights attach. See Charles Kester, *Is There a Person in That Body? An Argument for the Priority of Persons and the Need for a New Legal Paradigm*, 82 GEO. L.J. 1643, 1650, 1681-83 (1994) (rejecting "viability" as a criterion for granting legal standing to the fetus, and arguing that fetuses, once they develop brain function, should be "presumed to possess . . . consciousness," and hence be recognized as persons with legal standing).

72. Mattie probably received the standard of care customary in the locality. See *Smith v. Menet*, 530 N.E.2d 277 (Ill. App. 2 Dist. 1988) (describing the standard of care in medical malpractice).

73. Cf. HUSTON SMITH, *THE RELIGIONS OF MAN* 148 (1989) (describing Buddha's First Noble Truth, that life is suffering). In Sanskrit, the word *budh* means both to wake up and to know; hence, Buddha is the Awakened One. *Id.* at 122.

74. See *supra* note 51.

75. See Eric Cassell, *The Sorcerer's Broom: Medicine's Rampant Technology*, 23:6 HASTINGS CENTER REP. 32 (1993) (describing the reduction of "human illness" to "the biological problem of disease").

76. See *infra* note 81.

77. An obstetrician who attempts to commune, on an inner level, with embryos—to inform himself of their experience and inform them of medical alternatives—might be regarded in the same vein as a person who talks to plants; or to pets (which may be more common); or to themselves (which most of us do mentally rather than out loud, thus avoiding a DSM-IV diagnosis). Cf. R.D. LANG, *THE POLITICS OF EXPERIENCE* 121 (1967) (describing schizophrenia as a "political event," a "social prescription that rationalizes a set of social actions whereby the labeled person is annexed by others . . . into a role"); MIRCEA ELIADE, *THE SACRED AND THE PROFANE* 209 (1957) ("A purely rational man is an abstraction; he is never found in real life.").

Moral progress, it has been argued, "often depends as much on finding (or fashioning) the right words as on applying the right principles."⁷⁸ In many cases, the care itself may be the intervention;⁷⁹ the kind behavior within the boundaries of the rule may be the moral good; and decision-making may be less important than simply communicating.⁸⁰

Debates on *rights* and decision-making *power* often obscure intersubjective realities, whether the subject is an elderly woman, a naked, pre-op patient, or an embryo. If myth, archetype, metaphor, and feelings matter, then the analysis shifts from rights and power to embrace perceptual realities.⁸¹ For instance, insisting on the state's so-called interest in prolonging life shifts to enhancing the quality or radiance of one's final moments,⁸² and concern in "physician-assisted suicide" debates about altering the "natural course" of illness yields to concern for furnishing dignity, comfort, and peace in dying.⁸³ These propositions challenge the conventional view of the physician's role as "healer,"⁸⁴ and underscore the notion that mythical, archetypal and intersubjective realities can, and should, play a role in medical care and bioethical decision-making.⁸⁵ Perhaps the personal sphere must reclaim power ceded to the medical. Perhaps MFPR is more than "intervention";⁸⁶ perhaps the decision to end one's life is not "suicide," the decision to

78. See Arras, *supra* note 41, at 997.

79. See EMPATHY AND THE PRACTICE OF MEDICINE: BEYOND PILLS AND THE SCALPEL (Howard M. Spiro et al. eds., 1993).

80. For example, in Mattie's situation, the ethical issue is not whether someone else has the right to disconnect her life support, but whether someone has the right to pronounce her as good as dead. Cf. Kester, *supra* note 71, at 1667 (proposing that "[a]n individual whose body is irreversibly . . . incapable of sustaining the functions necessary for consciousness is not a person").

81. See Arras, *supra* note 41, at 997-98 (describing such a shift in ROBERT BURT, TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS (1979)). Arras notes that Burt "enlarged the understanding" of autonomy by "attempting to place the patient's treatment refusal in an emotional context," rather than resorting to "a mechanical application of the principle." Arras, *supra* note 41, at 997-98.

82. This is the position taken by those who practice *phowa*, the transference of consciousness at the moment of death: prolonging life is less important than providing a peaceful atmosphere for the dying process. See RINPOCHE, *supra* note 38, at 231-35, 372.

83. See generally Quill, *supra* note 19. Indeed, according to some, what happens just before, during, and after death is of "immense importance": life-sustaining treatment that "merely prolongs the dying process may only kindle unnecessary grasping, anger, and frustration in a dying person." RINPOCHE, *supra* note 38, at 372. Rinpoche argues that "[p]eaceful death is really an essential human right." Cf. Daniel Callahan, *Pursuing a Peaceful Death*, 23:4 HASTINGS CENTER REP. 33, 34 (1993) (observing that the process of dying is "deformed" by "technological brinksmanship").

84. See, e.g., AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS: REPORTS, Rep. 59 (July 1994) (rejecting "physician-assisted suicide" as "fundamentally inconsistent with the professional role of physicians as healers").

85. See, e.g., NEL NODDINGS, CARING: A FEMININE APPROACH TO ETHICS & MORAL EDUCATION 79-103 (1984); Birgit Victor, *Theoretical Discussion of a Model of Caring for Persons with HIV Infection*, 7 SCAND. J. CARING SCI. 243 (1993).

86. In fact, the intervention determines which of the embryos within the family will develop into "persons," thus eliminating future siblings and initiating a whole array of family dynamics. Since courts have

guide the dying process is not necessarily "killing,"⁸⁷ and the notion of death as either nothingness or heaven is limiting and reflective of cultural taboos and Western belief systems.⁸⁸ Perhaps "healing" refers not to a particular technology, medication or procedure, but rather to a process of moving towards wholeness at all levels of being.⁸⁹ Perhaps such movement can, and should, force Western culture to reexamine its assumptions⁹⁰ about life and consciousness.⁹¹

The conventional wisdom is dualistic: one is either *for* something, or against.⁹² Humans have slaughtered each other for millenia, for such differences in belief.⁹³ Being for or against something never gave rise to compassion, a fountainhead of religious feeling⁹⁴ and bioethics.⁹⁵ A myth-making perspective suggests that the embryos suffered; that Mattie suffered; that the woman whose organs were yanked up into the air by the

imposed a duty on the physician to avoid injury to the fetus, if embryos are considered persons, a conflict of interest arises between the various candidates. See Jeffrey Phelan, *The Maternal Abdominal Wall: A Fortress Against Fetal Health Care?*, 65 S. CAL. L. REV. 461, 472 (1991) (citing cases).

87. See Arras, *supra* note 41, at 997 ("Is the withholding of artificial nutrition through a nasogastric tube an example of intentional 'killing' or an example of a humble, merciful withdrawal of ineffective medical treatments?").

88. See generally ERNEST BECKER, *ESCAPE FROM EVIL* (1975) (describing the denial of death in American culture); ELIZABETH KUBLER-ROSS, *ON DEATH AND DYING* (1979).

89. See generally DOSSEY, *supra* note 39 (describing meaning in medicine); KENNETH PELLETIER, *HOLISTIC MEDICINE* 23-39 (1979) (critiquing the Newtonian view of disease as mechanical and reductionist, and advocating a new medical model integrating prevention, lifestyle modification, psychological counseling, and supporting patient responsibility for self-care).

90. See Arras, *supra* note 41, at 995 (noting the effect of culture on bioethical principles and theorizing).

91. Indeed, the "universal" experience of death—as expressed in dreams, poetry and recurrent world myths—is that death "is never seen to stand alone as a final act of annihilation," but rather occurs in a cycle of death and rebirth, with initiation from one stage of development to another, and hence, redemption. JOSEPH HENDERSON & MAUD OAKES, *THE WISDOM OF THE SERPENT: THE MYTHS OF DEATH, REBIRTH & RESURRECTION* 4 (1963). Thus, the compassion or consciousness with which one ends life matters to the organism, just as the compassion or consciousness that attends birth is significant. Cf. WILHELM REICH, *CHILDREN OF THE FUTURE: ON THE PREVENTION OF SEXUAL PATHOLOGY* 3-4 (1983) (describing birth-related trauma).

92. Cf. Stefano Rodota, *Cultural Models and the Future of Bioethics*, 10 J. CONTEMP. HEALTH L. & POL'Y 33, 33 (1994) (referring to stances such as that of the Catholic Church which "bundl[e] together abortion, contraception, euthanasia and reproduction technologies and rejec[t] them wholesale"); Kester, *supra* note 71, at 1676 (citing "sincerely held but incompatible views" as to whether fetuses are "persons").

93. Cf. GOPI KRISHNA, *REASON AND REVELATION* 43 (1979) ("It is the human ego, with its intolerance of other's views, that is often responsible for the battles and wrangles in the domain of knowledge. Almost every great thinker, skilled in penmanship, with appropriate arguments tries to win finality for his views. This is an incorrigible habit of reason. It can never be stilled into that perfect calm which knows that the search is over.").

94. See generally SMITH, *supra* note 73.

95. See, e.g., Alexander Capron, *Easing the Passing*, 24:4 HASTINGS CENTER REP. 25 (1994) (describing "compassion in dying" as ground for legalizing medically-assisted death).

surgeon—whether or not she was consciously aware—suffered. Awareness of suffering cannot be evoked by legal rules, cannot be circumscribed by bioethics, cannot be taught at the blackboard. The placard in the Pediatrics operating room expressed it well: “Talk to Me. Comfort Me. I could be *your* child.” In short, caregiving—through the lens of dream, emotion, and myth—includes transcending hierarchical relations and dependencies through the immediate, body- and feeling-centered awareness of our shared vulnerability.

CONCLUSION

Whether motivated by external rules or inner guidelines, autonomy, nonmaleficence, beneficence, and justice do, on one hand, express a quest to encourage compassionate caregiving. On the other hand, emotional responsiveness transcends principles.⁹⁶ To unite principles with responsiveness suggests being willing to acknowledge both parts of one’s being: the professional and the shaman, the core that is at once institutional and healing.⁹⁷ The professional helps individuals surmount problems by manipulating technological or institutional know-how;⁹⁸ the shaman—the “medicine man” or “witch doctor”—helps individuals transcend their normal, ordinary definition of reality, by moving easily between ordinary and nonordinary states of consciousness:⁹⁹

When shamans enter nonordinary reality, the rules of the outer world are suspended. Horses fly, plants talk, fairies and leprachauns abound. Time as we know it is suspended. . . . Outer rules of space are equally voided in these nonordinary worlds.¹⁰⁰

96. See *supra* note 9 and accompanying text.

97. For examples of this dual identity, see KYRIACOS C. MARKIDES, *THE MAGUS OF STROVOLOS: THE EXTRAORDINARY WORLD OF A SPIRITUAL HEALER* (1985) (sociology professor’s initiation into Christian spirit mysteries); ANDREW HARVEY, *HIDDEN JOURNEY* (1992) (Oxford professor’s initiation by Indian guru); TART, *supra* note 65 (psychology professor’s initiation into trance states through Gurdieff work).

98. See generally BURTON J. BLEDSTEIN, *THE CULTURE OF PROFESSIONALISM: THE MIDDLE CLASS AND THE DEVELOPMENT OF HIGHER EDUCATION* (1976).

99. MICHAEL HARNER, *THE WAY OF THE SHAMAN xvii-xix* (1990). Shamanism does not require “faith,” but rather rests on one’s own experience of different states of consciousness. *Id.* at *xix*. Harner notes that it is “unnecessary and even distracting to be preoccupied with achieving a scientific understanding of what ‘spirits’ may really represent and why shamanism works.” *Id.* at *xxiii*.

100. SANDRA INGERMAN, *SOUL RETRIEVAL: MENDING THE FRAGMENTED SELF* 33 (1991). Eliade notes: “The shaman is, therefore, the man who can die, and then return to life, many times Through his initiation, the shaman learns . . . what he must do when his soul abandons his body—and, first of all, how to orient himself in the unknown regions which he enters during his ecstasy.” MIRCEA ELIADE, *DEATH AND REBIRTH* 95 (1958) (*quoted in* HENDERSON & OAKES, *supra* note 91, at 207).

The shaman is a healer.¹⁰¹ Shamanic cultures existed long before written history, and believed all things to be permeated by Spirit.¹⁰² Physicians, as healers, are their modern counterparts.¹⁰³ So are psychotherapists,¹⁰⁴ and even lawyers.¹⁰⁵

In each case, the dual identity—professional and shaman—has an overt side and a covert side. The professional (overt) side publishes in respectable journals, articulates ideas in neat intellectual packages, impresses with credentials and a detached, neutral language; the shamanistic (covert) side delves into dream, myth, fantasy and archetype, plunges into metaphor, nurtures the inner landscape, and allows the “inexhaustible energies of the cosmos”¹⁰⁶ to pour through his or her being.

This duality expressed itself at the medical facility, where the professional-shaman identity was split, often between husband and wife, or between physician-professional and physician-private citizen. Although the senior physician expressed little interest in holistic medicine, his wife, a cancer survivor, practiced yoga and wore an angel on her necklace. Another physician, a cardiologist, was fascinated by “the possibility that something beyond, that we cannot prove, exists”; he had me speak to his wife, who had premonitory dreams on a regular basis. A third physician, who was born in India, quoted the *Vedas* to me, and privately observed: “The universe gives you a little bit of knowledge to play with, and watches what you do with it.” Quietly, covertly, behind the machinery and the titles, far from the gaze of committees and the Annual Physician Review (which rewarded, among other things, patient volume),¹⁰⁷ lurked the spectre of the inner, the hidden, the whole being behind the instrumentation.

It is true that “cultural models that are adopted, consciously or otherwise,” affect one’s views in bioethics.¹⁰⁸ I share the myth-making to honor the shaman in self and others; to bring the covert into the overt; to validate subjectivity, intuition, and mystery

101. HARNER, *supra* note 99, at xxiii.

102. INGERMAN, *supra* note 100, at 17.

103. Cf. IN SEARCH OF THE MODERN HIPPOCRATES 122 (Roger J. Bulger ed., 1987) (observing that “a real cure emerges by virtue of a relationship that will be beneficial to both patient and doctor”). Bulger emphasizes physicians’ reliance on the placebo effect—the “therapy of the word”—as the most powerful healing tool, and observes that western medicine’s association with action rather than words creates “a most peculiar and persistent separation of medicine from the great healers and healing associated with religion and religious leaders.” *Id.* at 121-22.

104. See HARNER, *supra* note 99, at xviii.

105. See Patricia King, *Rights Within the Therapeutic Relationship*, 6:1 J. LAW & HEALTH 31, 31 (1991-92) (arguing that conceiving autonomy in terms of a “narrow image of rights . . . independent of care” distorts therapeutic relationships and “makes implementation of rights, as expressed in this individual autonomous model, impossible”). Judicial language, particularly in cases involving mental illness, “tells only part of the truth of the human experience. . . . [E]ach articulates some dimension of human experience but no one articulates the wholeness of human experience.” *Id.* at 57. Rather than protecting autonomy, this disconnects persons from relationships where “their autonomy might flourish.” *Id.*

106. CAMPBELL, *supra* note 49, at 3.

107. We were told of a physician who spent too much time with her patients. She was told to either increase her efficiency, or accept a salary cut; she chose the latter.

108. Rodota, *supra* note 92, at 33.

in equipoise to science and law. By acknowledging these other dimensions of caregiving, the field of knowing may be broadened and enriched.¹⁰⁹

From Dr. S's insensitivity to Mattie's suffering, to Dr. P's insistence that only things of *medical* relevance have significance, the stories reflect our culture's reliance on outer pronouncements rather than inner truths.¹¹⁰ The children's crayon drawings provide as much a representation of their medical care as an article in JAMA or a law review. East has met West, contrary to Rudyard Kipling's famous lines, and, if we consider East and West to be metaphors for the journey within, perhaps our age will acknowledge a greater integration between, science and intuition, intellect and feeling.¹¹¹ Ascribing legal "personhood" to a fetus is one thing;¹¹² relating as one form of consciousness to another, dimly understood form, is another.¹¹³ In any event, the more deeply we delve into human consciousness, the more clearly we can shape legal rules to reflect essential values.¹¹⁴

109. I am also challenging three premises of conventional wisdom which are embedded in the stories, namely:

1. Anything not subject to scientific proof (*e.g.*, the angel on the necklace) is a matter of personal belief and hence irrelevant to healing and/or rule-making.
2. All intersubjective experience (*e.g.*, the dream of the lady in blue and white) must fit into a well-defined belief system adopted by a mainstream religious body. As a corollary, mystical experience is "religious," and hence, not real.
3. All legal rules must be "neutral," free from inner vision, body wisdom, and feeling; distinctions are rational and made on a purely intellectual basis, without regard to unconscious and archetypal elements.

Cf. JOHN HERMAN RANDALL, JR., *THE MAKING OF THE MODERN MIND* 282-307 (1976) (describing the "deification of reason").

110. Martin Buber writes that humans live in "two tidily circled-off provinces, one of institutions and the other of feelings—the province of *It* and the province of *I*." MARTIN BUBER, *I AND THOU* 43 (2d ed. 1958). According to Buber, feelings are "'within,' where life is lived and man recovers from institutions." *Id.*

111. The Western notion of personhood dismisses subjectivity and "sharply opposes reality and nonreality," asserting that "imagining, dreaming, and hearing voices, for example, are not 'real.'" Willy DeCraemer, *A Cross-Cultural Perspective on Personhood*, 61 *MILBANK FUND Q./HEALTH & SOC.* 1, 21 (1983). Central African and Japanese perspectives, by way of contrast, emphasize the "'inner,' emotive, symbolic, and ritual aspects" of personhood in society. *Id.* at 32.

112. See GUIDO CALABRESI, *IDEALS, BELIEFS, ATTITUDES AND THE LAW* 95-96 (1985) (quoted in Rodota, *supra* note 92, at 34) (arguing that the United States Supreme Court in *Roe v. Wade* should have "simply denied that fetuses were alive," leaving "unprovable, metaphysical arguments" to the people, rather than proclaiming that "anti-abortion beliefs as to commencement of life, *whether true or not*, are part of our Constitution").

113. Buber critiques the manipulative, ends-oriented view of life: "If a man lets it have the mastery, the continually growing world of *It* overruns him and robs him of the reality of his own *I*, till the incubus over him and the ghost within him whisper to one another the confession of their own non-salvation." BUBER, *supra* note 110, at 46. Buber describes the *I-Thou* relationship as one in which the "whole being" participates; thus, "[a]ll real living is meeting." BUBER, *supra* note 110, at 3, 11.

114. Only beings recognized as having "conscious awareness" can have legally cognizable interests. BONNIE STEINBOCH, *LIFE BEFORE BIRTH: THE MORAL AND LEGAL STATUS OF EMBRYOS* 14 (1992). Thus we must understand consciousness to determine whether legal interests pertain. See *id.* Some argue, for example, that anencephalic infants should be harvested for organ donation, because, like Mattie, they "experience no pain

The patient *is* more than the physical body,¹¹⁵ and beyond scientific proof, is the proof of the heart.¹¹⁶ Before the law, stands a doorkeeper,¹¹⁷ filtering unconscious impressions and condensing experience into rules and phrases, and beyond a bioethics of compassion, is compassion itself.

or suffering, and therefore, can never be aware of what happens to them.” *Id.* at 33 (quoting RONALD CRANFORD & JOHN ROBERTS, *USE OF ANENCEPHALIC INFANTS AS ORGAN DONORS: CROSSING THE THRESHOLD, IN PEDIATRIC BRAIN DEATH AND ORGAN TISSUE RETRIEVAL: MEDICAL, ETHICAL AND LEGAL ASPECTS* 193 (1989)). A bill recently was introduced to classify infants with anencephaly as dead. *Id.* at 31.

115. See *supra* note 42 and accompanying text; see also Cohen, *supra* note 13, at 88-97 (describing human energy fields).

116. An Israeli poet writes: “Where do you feel your soul?/ Stretched between mouth-hole and asshole/a white thread, not transparent mist,/squeezed into a corner between two bones/in pain./ When satiated, vanishing like a cat./ I belong to the last generation/to separate body and soul.” YEHUDA AMICHAÏ, *TRAVELS* 53 (Ruth Nevo trans., 1986).

117. Franz Kafka, *Before the Law*, in *KAFKA: THE COMPLETE STORIES* 3 (1971).