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### Fragments on the Deathwatch

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# Fragments on the Deathwatch

Louise Harmon\*

## TABLE OF CONTENTS

Section I: Deathwatches .....	1
Section II: Paintiffs, Procedure, and the Limits of Law Wishes .....	35
Left Hemisphere Interlude .....	84
Section III: Moving up the Brainstem .....	86
Section IV: Death Thought, Death Talk, and the Eviden- tiary Implications of Taboo .....	91
Section V: Law and the Architecture of Ritual Space ....	129
Right Hemisphere Coda .....	160

## I. DEATHWATCHES

The other night I saw a documentary on television about some elephants in Botswana.<sup>1</sup> The herd was in trouble. Water was scarce, and the elephants were on the move. They travelled north to the Linyanti River, following the ancient paths of their ancestors. An elderly cow staggered behind the others, weakened from starvation, dehydration, and advanced age. Suddenly she slipped in the sand. The wind blew so fiercely across the hot, dry land that when she fell only a muffled cry could be heard over the white howl of air in motion. It was like

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\* Associate Professor of Law, Jacob D. Fuchsberg Law Center, Touro College. I would like to thank the following students for their excellent research assistance: Irwin J. Berkowitz, Nancy Ellis, Margie Forbes, and Leslie Ann Rosenstein. I would also like to express my gratitude to Charles B. Wheeler for his editorial assistance and to Marsha L. Freeman, Susan J. Goss, Beth Mobley and Geraldene Roselle of the Touro Law Center Library for their dogged and cheerful pursuit of arcane materials.

This piece is dedicated to my father, John E. Harmon, Jr.—to his soul and to the trillium in the ravine.

1. *Journey to the Forgotten River* (PBS television broadcast, Mar. 14, 1990). In Botswana, the animals had relied on the Linyanti River and the Savuti Channel for water. In 1982, seismic shifts and a severe drought occurred. The rainwater pans dried out and drained the Savuti, forcing the animals to retreat 70 miles north to the Linyanti. Thousands of buffalo, zebra, elephants and other animals trudged through the dust in the searing heat. *Id.*

watching a silent movie. Her legs sprawled and dangled; her parched body almost rolled over, propelled by her weight and the speed of her fall. Her head arched back; her trunk curled; her mouth opened wide in a protest of pain. But the sound of her body as it hit the ground could not be heard over the unrelenting wind. At least I could not hear it as I drank a cup of coffee and watched her die from my cozy kitchen on Long Island.

As she lay there panting on the ground, the narrator commented in his neutral male voice, the voice of science and reason, "They wait, clearly reluctant to leave her. In the blazing sun, she became dehydrated. Because the survival of the herd is more important than the life of an individual, the old cow is left to die—alone."<sup>2</sup>

Then, because the medium of film forces us to see the world through the eyes of another, I too, like the elephants, had to move on, following the herd as it crossed the wheat-colored land in search of food and water. And I too, like the elephants, wanted to stay with her. I did not want her to die alone.

Elephants attend the births and deaths of members of their species. When an elephant calf is born, some of the herd will encircle the mother, acting as midwives and sentries. When the calf is delivered, the attendants will trumpet loudly, swaying their bodies and flapping their ears. Then they will fondle and caress the dark, damp baby and help it to stand. After the celebration is over, a hush will descend upon the herd.<sup>3</sup> Perhaps the elephants fall silent out of respect for the new family; perhaps out of fatigue; perhaps out of wonder, if there is such a thing as elephant wonder. I see no reason why there should not be.

At the end of life, an elephant rarely dies alone. The same research team that filmed the fallen cow in Botswana also documented the death of an old bull. After the elephant had fallen, the other members of the herd huddled around him. Four hours later, when he died, they approached his body in twos and threes,

sweeping their trunks slowly over him, not touching him for the most part but maintaining an inch of distance between his skin and the moist tips of their trunks. The ritual was more impressive for its silence. Not a rumble was uttered, and no scraping of skin or sand

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2. *Id.*

3. RAMESH BEDI, *ELEPHANT: LORD OF THE JUNGLE* 19 (1969).

broke the afternoon stillness.<sup>4</sup>

There is beauty in their gestures, in their shared silence, in the very fact that they attend.

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When I first learned about the complex social behavior of whales and dolphins, it occurred to me that, in many ways, these cetaceans were just like wet elephants.<sup>5</sup> Like elephants,<sup>6</sup> whales and dolphins exhibit what animal behaviorists call "epimeletic" behavior, the succorant behavior of the adult members of a group toward another adult that is in distress or dying.<sup>7</sup>

There are different kinds of epimeletic behavior. One kind

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4. Dereck Joubert, *Eyewitness to an Elephant Wake*, 179 NAT'L GEOGRAPHIC, May 1991, at 39, 40.

Elephants are particularly vigilant when their young die, for they are loath to let go. One African cow carried about her calf that had been dead for two days. She would put it down to eat or drink, but then would pick it up again when she moved on. BEDI, *supra* note 3, at 62.

Elephants also mourn their dead. Lakshmi, an elderly circus cow, died of grief after the death of her longtime mate. "Lakshmi continued to walk around the empty post of her departed companion and would not be consoled." *Id.* at 64. She stopped eating when he died and, within two weeks, was dead as well. *Id.*

5. "The order Cetacea is divided into three suborders: the Archaeoceti, all of which are extinct and known only from fossil remains; the Odontoceti or toothed whales, containing the majority of the living species forming the order; and the Mysticeti, the whalebone or baleen whales." L. HARRISON MATTHEWS, *THE NATURAL HISTORY OF THE WHALE* 25 (1978).

"Most of the members of the Odontoceti are comparatively small porpoises and dolphins, though some, such as the Beaked whales and the Killer whale, reach a length of 30 feet and one, the Sperm whale, reaches 60 feet or more." *Id.* at 28. While the number of species of whalebone whales, the Mysticeti, is small, each animal is enormous individually. The Mysticeti include such mammoths as the Humpback whale, the Blue whale and the Fin whale. The Blue whale can measure one hundred feet or more. *Id.* at 43-46.

6. There are many documented instances of elephants helping a member of the herd in distress or appearing unwilling to desert an injured member. In one account, a bull, wounded by a gunshot, fell to the ground. His three adult male companions "closed in on him, one on either side and one behind, and they just boosted him on to his feet and, in that formation, supporting him on either side, set off, wheeling gradually round to the left and back to the forest." RICHARD CARRINGTON, *ELEPHANTS* 83 (1958) (quoting DAVID E. BLUNT, *ELEPHANT* 97-98 (1933)).

Another elephant watcher reported that most accounts described the efforts of cows to assist a stricken bull. While bulls have on occasion helped another bull, there are few reported instances of other elephants trying to help a stricken cow. *Id.*

7. See generally Melba C. Caldwell & David K. Caldwell, *Epimeletic (Care-giving) Behavior in Cetacea*, in *WHALES, DOLPHINS, AND PORPOISES* 755 (Kenneth S. Norris ed., 1966) (discussing research involving odontocetes).



is called "standing by," although the old whalers used more nautical terms such as "heaving to" or "bringing to." When a cetacean companion is distressed or wounded, the entire school remains close, or "stands by," even at the risk of danger.<sup>8</sup> In a second kind of epimeletic behavior, called "excitement," the succorants approach the distressed animal and make a display of extreme agitation, sometimes even attempting a rescue.<sup>9</sup> A third kind of epimeletic behavior is called "supporting behavior." Cetaceans exhibit supporting behavior when an animal is rendered unable to break surface; members of the group will push him towards the light and air so that he can breathe.<sup>10</sup> There have even been reported instances of dolphins pushing a drowning human swimmer to the surface.<sup>11</sup> The urge to render aid may even extend to other species.<sup>12</sup>

What motivates cetaceans to care for one another? Animal behaviorists do not agree. Some argue that epimeletic behavior is nothing more than an instinctive reaction—it is all a matter of ancient chemistry.<sup>13</sup> Others believe that whales and dolphins are capable of altruism,<sup>14</sup> but differ on the conditions for

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8. MATTHEWS, *supra* note 5, at 172.

9. Sperm whales, for example, have been known to attack whale boats that have harpooned a member of their school, or to push an injured animal away from a source of danger. *Id.* at 173.

10. While land mammals, particularly other gregarious species like the elephant, may exhibit the other two kinds of epimeletic behavior, only cetaceans can exhibit "supporting behavior" because they alone live in an aquatic environment and must surface at short intervals to breathe. The supporting of a distressed adult odontocete by its companions is probably an extension of maternal behavior toward a newborn calf. W. NIGEL BONNER, *WHALES* 174 (1980). As soon as the calf is born, the mother pushes it to the surface to draw its first breath. Frequently, her adult companions assist her. *Id.* at 173. Much like the elephants, the group seems to take an active interest in the fate of a newborn.

Bonner refers to other whales, typically other females, who attend a birth as "aunts." Not only will the "aunts" help the mother push the newborn toward the surface, but they will also help keep other whales in the group away from the new mother and baby. *Id.* "In Bottlenosed Dolphins, the 'aunt' is often the only other dolphin that the mother will allow near her calf." *Id.* Naturalists have also observed female odontocetes assisting with the delivery of the calf. *Id.*

11. MATTHEWS, *supra* note 5, at 173.

12. Cf. BONNER, *supra* note 10, at 173-74 (describing account of whales in captivity assisting a dolphin in giving birth).

13. The stimulus of seeing an object behave abnormally (for a dolphin or whale) may cause the instinctive reaction of pushing the object toward the surface. See MATTHEWS, *supra* note 5, at 173. "There are no grounds, however, for imputing any use of intelligence in such acts, nor even for supposing that the animals know what they are doing." *Id.*

14. Altruism is generally thought to be the promotion of the good of others. PETER A. ANGELES, *DICTIONARY OF PHILOSOPHY* 7 (1981). "Reciprocal

its occurrence.<sup>15</sup> All theorists, regardless of their point of view, warn of the dangers of anthropomorphism.<sup>16</sup>

I am not certain that I understand the sin of anthropomorphism. Am I supposed not to argue that whales and dolphins are like human beings, or am I supposed not to argue that human beings are like whales and dolphins? Or is it just that I am not to confuse their intelligences, cetacean and human, to take one for the other?

I am also not certain that it matters. Since I am not an animal behaviorist, I do not fall under the jurisdiction of their gods: I can probably commit the sin of anthropomorphism with impunity. Of course, I might be wrong about this. By virtue of my tenuous membership in the academy, I may be bound by a version of intellectual comity.<sup>17</sup> I have crossed the boundaries

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altruism . . . is the sociobiological model for a system in which an individual performs an altruistic act for another, nonrelated individual. Such an 'altruistic act' is one that engenders a cost to the altruist. The compensating benefit for this act is delayed, and contingent upon the cooperation of others." Christine M. Johnson & Kenneth S. Norris, *Delphinid Social Organization and Social Behavior*, in *DOLPHIN COGNITION AND BEHAVIOR: A COMPARATIVE APPROACH* 335, 342 (Ronald J. Schusterman et al. eds., 1986).

15. Some scholars believe that epimeletic behavior might be attributable to kin selection. Others suggest that the cetaceans' fluid social structure does not allow stable schools of related individuals to form. Therefore, a theory of kin selection could not explain their altruistic behavior. PETER G.H. EVANS, *THE NATURAL HISTORY OF WHALES AND DOLPHINS* 203 (1987).

Other naturalists believe that expectations of reciprocity underlie epimeletic behavior. In the absence of strong evidence that cetaceans can recognize other individuals (a necessary condition for reciprocity), this theory seems inapplicable. *Id.* at 204. As one researcher warned, however, "we are still far from understanding the full content of vocalisations by any species." *Id.*

16. One of the most deceptive, and therefore one of the most dangerous, pitfalls awaiting the observer of dolphins is reliance on anthropomorphism. . . . The observer is led to describe the behavior of the animal in human terms, and ascribe to the animal motives that he cannot be sure are actually there, as he is incapable of seeing inside the mind of the animal to determine its purposes. Some descriptions of dolphin behavior abound in statements of purpose that can properly be ascribed only to humans. It is sincerely to be hoped that such accounts, most of which are misleading and probably inaccurate, will not gain credence in the literature to the extent that they are believed implicitly by other workers in the field.

Margaret C. Tavolga, *Behavior of the Bottlenose Dolphin*, in *WHALES, DOLPHINS, AND PORPOISES*, *supra* note 7, at 718, 729.

17. "Comity," in the legal sense, is neither a matter of absolute obligation, on the one hand, nor of mere courtesy and good will, upon the other. But it is the recognition which one nation allows within its territory to the legislative, executive or judicial acts of another nation, having due regard both to international duty and convenience, and to

of my own competence, and when venturing into a foreign land, I may have to submit to the authority of foreign deities.

So perhaps I do sin, but the fact is I recognize the behavior of those elephants as they gather around a dying bull, sweeping their trunks over his parched body and facing his death with reverence. I recognize the behavior of those whales and dolphins as they nudge a floundering member of their school towards the air. It does not matter to me if you call the behavior human or if you call the behavior elephantine or cetacean. What matters to me is that I have seen the behavior before. I see something there that has meaning for me.<sup>18</sup>

My father died last year.

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He was ninety-two pounds when he died. During those last few months, my mother was with him every day, to sit beside him, to read to him, to tune the radio to his favorite station, to dress his bedsores, to remind the nurses to turn him over from side to side. He could not talk or see, but she thought that he might be able to hear the music, the books, the words of love and affection.<sup>19</sup>

I was far away. Inside the body they had both given me, another struggle was going on. As he was painfully pulling

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the rights of its own citizens or of other persons who are under the protection of its laws.

Hilton v. Guyot, 159 U.S. 113, 163 (1895).

18. I am undoubtedly guilty of taking an anthropocentric approach to the study of animal behavior. Harry F. Harlow, a scholar of animal psychology, was unabashed about his commission of this variant of the sin of anthropomorphism.

Throughout my entire academic life I had never suffered for research ideas, since I simply stole the research ideas from human studies or human problems. I always believed that I should never do anything with monkeys that would not have significance with man. . . . I firmly believe that one should never study problems in monkeys that cannot be solved in man. What direction my research might have taken had this not been true, I have no idea.

E.W. Menzel, Jr., *How Can You Tell if an Animal is Intelligent*, in DOLPHIN COGNITION AND BEHAVIOR: A COMPARATIVE APPROACH, *supra* note 14, at 167, 173 (quoting HARRY F. HARLOW & CLARA MEARS, THE HUMAN MODEL: PRIMATE PERSPECTIVES 1 (1979)).

19. "Extensive research on the auditory brain-stem function of comatose patients shows that the majority have normal brain-stem auditory evoked responses (BAERs), a recording of afferent nerve impulses, regardless of the level of coma." John LaPuma, M.D. et al., *Talking to Comatose Patients*, 45 ARCHIVES OF NEUROLOGY 20, 21 (1988). Normal BAERs suggest that many comatose patients can actually hear. There are anecdotal accounts of comatose patients who have recovered and can remember the words of encouragement from doctors and family members. *Id.*

away, his granddaughter, curled up tightly inside of me, was hanging on. Because I was her vessel, I could not move. The seas were too turbulent. And so we were both bed-bound, my father and I—each of us intent on an act of creation, a moment of definition, one of us at the beginning and the other at the end.

My father managed his mission before I could bring her to him. I am sorry he did not get to see those dark brown eyes, or to feel the cool alabaster of her skin. I love her all the more for the tentative way in which she arrived, but I will always regret that she kept me in my bed. That I was not able to sit beside him, read to him, tune the radio to his favorite station, or turn his fragile body from side to side.

I belonged there, inside that green curtain in the nursing home, with my mother, my brother and my sister. I wanted to attend.

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In many ways, a dying human being is like any other dying animal: an organism in extremis.<sup>20</sup> The body's task is winnowed down to the bare essentials: heartbeat and breath, heartbeat and breath. Maintaining homeostasis is all that matters. The mind—the thinking, expressive, remembering part of the human being—often withdraws, sacrificed on the crumbling altar of survival. There is a turning in toward the self, a curvature of the spine that directs the remaining life force towards the center. The knees of a dying human being are tucked up under the body; the arms are folded in like a praying mantis, a caricature of mute supplication. It is more than just a metaphor: we literally do curl up and die.<sup>21</sup>

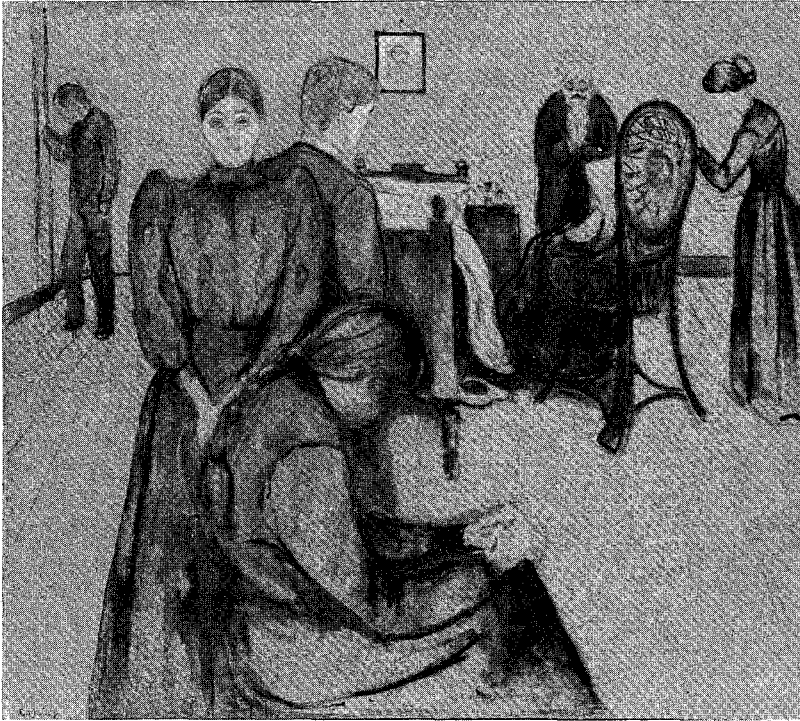
This does not happen in isolation. A human being usually dies in the presence of others. Someone keeps vigil on his going out, a vigil known as the deathwatch.<sup>22</sup> Depending upon the time and place, the deathwatch has a distinct *mise en scène*. In Western culture, up until the end of the nineteenth century, the deathwatch looked something like this:

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20. "In extremis" means "at the point of death." STEDMAN'S MEDICAL DICTIONARY 779 (25th ed. 1990).

21. See *infra* notes 56-57 and accompanying text.

22. Originally "deathwatch" referred to a small beetle that makes a ticking sound that supposedly presages death. Since about 1890, it has meant either "a vigil kept over the dead or dying," or "the guard set over a criminal before his execution." WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 328 (1991).



Edvard Munch, *Death in the Sick-Room* (prob. 1893). Photograph courtesy of the Nasjonalgalleriet, Oslo. By permission of the Oslo Kommunes Kunstsamlinger Munch-museet and Arne Munch-Ellingsen

Dying was a public affair. As soon as serious illness made its presence known, the windows and doors were closed, the candles were lit, and the sickroom filled up with people.<sup>23</sup> Eve-

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23. PHILIPPE ARIÈS, *THE HOUR OF OUR DEATH* 18-19 (1981). Saint-Simon described a dying woman in the early eighteenth century: "[S]he lay in bed with all her bed-curtains open, candles all around the room, and women keeping vigil around her. . . . She summoned all her servants, down to the lowest one, asked their forgiveness, confessed her sins, and presided . . . over . . . her own death." LOUIS DE ROUVROY SAINT-SIMON, *MEMOIRES* 486 (1901), *quoted in* ARIÈS, *supra*, at 18-19.

Franz Kafka described a similar deathwatch occurring almost two centuries later:

The bed was set up in the middle of the room, the candlesticks were borrowed from friends and relatives. . . . Some forty men stood around his bed all day to receive inspiration from the death of a pious man. He was conscious until the end and at the right moment, his hand on his breast, he began to repeat the death prayers. During his

ryone came: family, friends, neighbors, fellow workers, the faithful, sometimes even strangers.<sup>24</sup> When Emma Bovary ate

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suffering and after his death the grandmother, who was with the women gathered in the next room, wept incessantly, but while he was dying she was completely calm because it is a commandment to ease the death of the dying man as much as one can. "With his own prayers he passed away." He was much envied for this death that followed so pious a life.

FRANZ KAFKA, *THE DIARIES OF FRANZ KAFKA, 1910-23*, at 103-04 (Max Brod ed., 1964).

A more disturbing Kafkaesque description of a deathwatch occurs in *A Country Doctor*. In this story, the family and village elders strip a doctor who failed to save a boy with a worm-ridden wound. As they strip him, a school choir sings: "Strip his clothes off, then he'll heal us;/ If he doesn't, kill him dead?/ Only a doctor, only a doctor." FRANZ KAFKA, *A Country Doctor*, in *THE PENGUIN COMPLETE SHORT STORIES OF FRANZ KAFKA* 220, 224 (Nahum N. Glatzer ed., Penguin Books 1983) (1917). Surely, the story is an account of a doctor's nightmare.

24. In the Jewish tradition, members of the community, discharging their duties to visit the sick, would attend the deathwatch. One source of Jewish law concerning visitation of the sick, death and mourning is the *Shulhan Arukh*, compiled in the sixteenth century by Rabbi Joseph Karo of Safed. Rabbi Moses Isserles of Kracow composed the glosses that accompany almost every paragraph of the work and added traditions of the Ashkenazic community to Karo's compilation, which derived primarily from the Sephardic tradition. JEWISH REFLECTIONS ON DEATH 15 (Jack Riemer ed., 1974).

Chapter 335 of the *Shulhan Arukh* covers visitations of the sick: "It is a religious duty to visit the sick. Relatives and close friends should enter at once, others after three days. If the illness is serious, both groups can visit him at once." SHULHAN ARUKH 335:1 (Chaim N. Denberg trans.), in JEWISH REFLECTIONS ON DEATH, *supra*, at 17, 17.

Specific rules govern seating ("One who visits the sick . . . should sit in front of the patient, for the Divine Presence rests above a sick person." *Id.*); when to visit ("One should not visit the sick during the first three hours of the day . . . and not during the last three hours of the day . . ." *Id.*); what language to pray in (if in the presence of the sick person, in any language; if not in his presence, in Hebrew. *Id.* at 18.); whom to visit (Refrain from visiting those who suffer from diseases that might be too embarrassing or uncomfortable to withstand a visit. *Id.*); and how the sick person should look after his debts and outstanding credits. *Id.*

Chapter 339 covers how to treat someone who is dying:

One who is dying is considered a living being in all respects. We may not tie up his jaws, nor remove the pillow from under him, nor place him on sand, nor summon the town on his behalf, nor close his eyes before his soul departs. And whoever closes his eyes before death, is regarded as a murderer. One may not rend garments nor make a lamentation for him nor bring a coffin into the house for him before he dies.

*Id.* at 18-19. Once again, there is a religious duty to attend the dying person: "When a person is about to die one should not leave him so that he does not depart this life alone. Gloss: It is a *mitzvah* to stand by a person during the departure of his soul." *Id.* at 19.

Confession by the dying person is part of the Jewish tradition as well. It is encouraged "as a rite of passage to another phase of existence . . . . The con-

arsenic, her doctor considered bringing his two sons to witness her death, "in order to accustom them to great occasions; that this might be a lesson, an example, a solemn picture, that should remain in their heads later on."<sup>25</sup> Only a maternal veto kept them away.

There were different roles to play in the deathwatch. Depending upon the circumstances of the patient—social, economic, and medical—a doctor would be called.<sup>26</sup> The doctor's

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fessional on the deathbed is the recognition of the ending of one cycle and the beginning of another." Audrey Gordon, *The Psychological Wisdom of the Law*, in JEWISH REFLECTIONS ON DEATH, *supra*, at 95, 96. Gordon also emphasizes the psychological advantage of witnessing the death; it "does not permit the mourner to escape the reality of death; it bids him see it." *Id.* at 97.

25. GUSTAVE FLAUBERT, *MADAME BOVARY* 236 (Paul De Man trans., W.W. Norton 1965) (1857). One literary critic claimed that the Victorians in particular used deathbed scenes to encourage piety. "It allowed for a moral lesson. It strengthened social and religious values by rallying the faithful and troubling the doubters." Eric Rhode, *Death in Twentieth-Century Fiction*, in MAN'S CONCERN WITH DEATH 160, 160 (Arnold Toynbee et al. eds., 1968).

Ariès argued that Flaubert's vivid and medically detailed description of Emma Bovary's hideous and agonizing death by suicide foreshadowed the modern notion of the "dirty death." ARIÈS, *supra* note 23, at 568. Ariès contrasted the early nineteenth century, in which death was seen as beautiful, to the second half of the nineteenth century, when death was "sometimes even depicted as disgusting." *Id.* at 569. As further evidence of the view that death was dirty and indecent, he also discussed Leo Tolstoy's *The Death of Ivan Ilyich*, an unsentimental and relentlessly realistic portrayal of the dying process. The protagonist, a former judge, dies a painful, protracted death. Tolstoy detailed the pain, odors, discomfort, denial, isolation, and anger that terminal illness and impending death can generate. In the death scene of the last chapter, the doctor, priest, and members of the family were called. Ilyich, however, took three terrible days to die. He screamed incessantly and "struggled in that black sack into which he was being thrust by an invisible, resistless force." LEO TOLSTOY, *The Death of Ivan Ilyich*, in THE GREAT SHORT WORKS OF LEO TOLSTOY 247, 301 (Louise Maude et al. trans., Harper & Row 1967) (1886). Finally, when the gasping and rattling in his throat became inaudible, he heard someone say, "It is finished!" *Id.* at 302. He repeated to himself, "Death is finished . . . it is no more!" *Id.* He "drew in a breath, stopped in the midst of a sigh, stretched out, and died." *Id.* It is a horrible scene, a deathwatch to remember.

26. Each family and each illness presented different facts that determined whether the doctor would play a role in any given deathwatch. I use the term "doctor" generically. Different places and different historical periods have seen a variety of practitioners and healers. Individuals who did not consider themselves to be doctors (and whom others did not consider to be doctors) would also provide medical care: midwives, apothecaries, and bone-setters, to name only a few. GEORGE ROSEN, *THE STRUCTURE OF AMERICAN MEDICAL PRACTICE 1875-1941*, at 2 (Charles E. Rosenberg ed., 1983). In this country, as late as 1864, one observer noted that practitioners of medicine included "allopaths of every class in allopathy; homeopaths of high and low dilutions; hydropaths mild and heroic; chronothermalists; Thomsonians, Mesmerists, herbalists, Indian doctors, clairvoyants, spiritualists with healing gifts, and I

role was that of referee. He presided over the body's decline, calling the shots and keeping score. The doctor would declare death the winner, closing the eyelids as a sign the game was over.<sup>27</sup> There was little he could do. Although a doctor could

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know not what besides." *Id.* at 15 (quoting THOMAS L. NICHOLS, FORTY YEARS OF AMERICAN LIFE 226 (1937)).

Nor were this country's physicians a monolithic group in terms of training, social standing, or methods of practice. In the early nineteenth century, a handful of successful urban practitioners—such as Henry James's character, Dr. Austin Sloper, father of Katherine Sloper, the remarkable heroine of *Washington Square*—comprised the top of the hierarchy. They enjoyed formal medical training, often with hospital experience and education in Edinburgh or London, and competed for the wealthiest and most socially prominent patients. Most of the nation's physicians, however, trained under the apprentice system, and may never have attended formal lectures or seen the inside of a hospital. Many apprentice-trained physicians competed directly with the other assorted practitioners. *Id.* at 3-4.

Even though alternative healers existed, most families in the nineteenth century turned to physicians in the face of serious illness. The question was not whether to call the physician, but when. The answer depended, among other things, on whether the patient lived in a town, city, or rural setting; and on the patient's cultural background and economic status. *Id.* at 2. In general, the poor received inferior medical care. "Physicians render curable diseases mortal, in many instances, by their connecting the measure of their services to the sick with pecuniary considerations. This is one reason why more of the poor than of the rich die of mortal epidemics." BENJAMIN RUSH, *On the Causes of Death In Diseases That Are Not Incurable*, in SIXTEEN INTRODUCTORY LECTURES (1811), reprinted in MEDICAL AMERICA IN THE NINETEENTH CENTURY 90, 92 (Gert H. Brieger ed., 1972). The poor tended to wait until the very last minute to call the doctor because of the extravagant charges for medical advice. "These delays, though apparently originating with patients, should be traced wholly to the conduct of physicians." *Id.*

The type of illness could also determine whether to call a doctor. For example, doctors often were not called for seriously ill infants, since most people felt there was little that anyone could do. Some adult diseases never warranted medical intervention: ailments such as rheumatism, mild diarrhea, influenza, or malaria where it was endemic, almost never triggered a call for the doctor. With influenza, for example, the patient invariably recovered, and with rheumatism, he almost never did. ROSEN, *supra*, at 2-3.

27. Closing the eyes of the dead appears to be a very old custom, common to most cultures.

And God spoke unto Israel in the visions of the night, and said, Jacob, Jacob. And he said, Here am I. And he said, I am God, the God of thy father: fear not go down into Egypt; for I will there make of thee a great nation: I will go down with thee into Egypt; and I will surely bring thee up again: and Joseph shall put his hand upon thine eyes.

*Genesis* 46:2-4.

The practice of closing the eyes of the dead developed from the fear that some sort of danger or curse would threaten a living person seen by the corpse's eye. People often believed that anyone "who came within the field of vision of a dead person was thereby doomed to follow soon that person to the grave." WEBB GARRISON, STRANGE FACTS ABOUT DEATH 29 (1978).

It was not always easy to keep the eyes closed before rigor mortis set in;



try to make his patient comfortable, medical science had a limited arsenal to forestall or reverse the process.<sup>28</sup> There was little anyone could do but watch and wait.

A spiritual leader also played a role in the deathwatch. In the Christian tradition, at a sign from the doctor that the end was near, the priest or minister would be sent for. He would say prayers and perform rituals on the body in preparation for the transition from life to death.<sup>29</sup> The presence of the spiri-

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often the eyelids had to be weighted. Coins sometimes served this purpose. They also provided the dead person with "the toll exacted for crossing into the next world." *Id.*

28. Indeed, some doctors expressed a fatalism about certain kinds of illnesses, wondering whether medical intervention could accomplish anything. Jacob Bigelow defined a "self-limited disease" as

one which receives limits from its own nature and not from foreign influences; one which, after it has obtained foothold in the system, cannot, in the present state of our knowledge, be eradicated or abridged by art, but to which there is due a certain succession of processes to be completed in a certain time; which time and processes may vary with the constitution and condition of the patient, and may tend to death or to recovery, but are not known to be shortened or greatly changed by medical treatment.

MEDICAL AMERICA IN THE NINETEENTH CENTURY, *supra* note 26, at 98, 99 (quoting JACOB BIGELOW, ON SELF-LIMITED DISEASES (1836)). The young medical student "goes forth into the world believing that if he does not cure diseases it is his own fault. Yet, when a score or two of years have passed over his head, he will come at length to the conviction that some diseases are controlled by nature alone." *Id.* at 103. A doctor facing a self-limited disease should not

frustrate the intentions of nature, when they are salutary, or embitter the approach of death when it is inevitable . . . we may do much good by a palliative and preventive course, by alleviating pain, procuring sleep, guarding the diet, regulating the alimentary canal—in fine, by obviating such sufferings as admit of mitigation . . . . The longer and the more philosophically we contemplate this subject, the more obvious it will appear that the physician is but the minister and servant of nature . . . .

*Id.* at 105-06.

29. One such ritual involves anointing the body of the dying person. Anointing, the smearing or pouring of an unctuous substance (especially olive oil) on a person, plays a part in the administration of certain Christian sacraments, such as Baptism, Confirmation, and Ordination.

Catholics who are seriously ill receive the sacrament of the Anointing of the Sick (formerly called Extreme Unction) from a priest. The rite involves anointing the organs of the external senses with consecrated oil and praying at each unction while mentioning the corresponding sense. *Anointing of the Sick*, 1 NEW CATHOLIC ENCYCLOPEDIA 568-75 (1967). The recipient must be baptized and "have attained the use of reason," reflecting the theological tradition that "this Sacrament is a complement of the Sacrament of Penance." *Id.* at 573 (discussing the competing purposes underlying the anointing of the sick). "To receive the Sacrament, an adult possessing the use of reason must have an intention to receive it." *Id.* That intention need never have been ex-

tual leader was not only for the benefit of the dying person; he was also there for the participants of the deathwatch. It was a religious occasion and required the authority of a holy man.

But the most important role in the deathwatch was played by the dying person. The spotlight fell on him. It was his day to die, and he had certain obligations. Before lapsing into silence, he was expected to bid farewell to those he loved, to make gifts, to extract promises, to make amends for ancient wounds, and to make preparations for his departure.<sup>30</sup> During his own deathwatch, the dying person knew just what to say; he

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pressly formulated; it may be implied, even if the subject is now unconscious, from his or her desire to live and die as a Catholic. Today, theologians do not wait until the subject is in the last moments of life, believing that the sacrament's maximum benefit can be derived as soon as the subject is in danger of death from sickness or old age. Thus, it may be received as many times as the subject succumbs to serious illness. *Id.*

"All Protestants reject the Anointing of the Sick as a Sacrament instituted by Christ. . . . Calvin not only denies its Sacramentality, but goes to the excess of designating it as 'merely playacting.'" *Id.* at 574 (citing JEAN CALVIN, *INSTITUTES OF THE CHRISTIAN RELIGION* 1466 (John T. McNeill ed. & Ford L. Battles trans., Westminster Press 1960) (1536)). The English Book of Common Prayer originally recognized the practice in 1549, but it was deleted in 1552. The Scottish and American Prayer Books, however, contain an optional provision for the rite. *Id.*

30. It became customary to record the alleged final utterances of famous people, presumably for purposes of instruction. Religious leaders in particular seemed to plan their last words with great care. For example, Martin Luther supposedly said on his deathbed, "Father in heaven, though this body is breaking away from me, and I am departing this life, yet I know that I shall forever be with thee, for no one can pluck me out of thy hand." GARRISON, *supra* note 27, at 99. Henry Ward Beecher uttered, "Now comes the mystery," and closed his eyes. *Id.* at 101. Statesmen, too, seem to have given their last words serious consideration. Thomas Jefferson said, "I resign my soul to God, and my daughter to my country." *Id.* at 103.

If we are to believe the accounts, others were not so well-prepared for the performance of their dying words, distracted perhaps by the event of their own death. Some dying words were simple requests concerning the arrangement of the sickroom. Goethe said, "Macht doch den Fensterladen in Schlafgemach auf, damit mehr Licht herein komme." ("Open the shutters in the bedroom and let in more light"). *Id.* at 102. A stern housekeeper attended Carl Jung in his final illness; he gasped his final words to his son as she left the room: "Quick, help me out of bed before she comes back or she will stop me. I want to look at the sunset." *Id.* at 99.

My favorite last words say something about the experience of dying itself. Several people left messages of hope for the deathphobic. Cotton Mather allegedly cried in exultation, "Is this dying? Is this all? Is this what I feared when I prayed against a hard death? Oh, I can bear this! I can bear it!" *Id.* at 100. Louis XIV supposedly spoke similar words, "J'avais cru plus difficile de mourir" ("I imagined it was more difficult to die."). *Id.* at 103. Thomas Edison's words are particularly moving to me. In his final moments of con-

was relieved of the burden of originality. The script was written for him.

The deathbed scene was more than a convention of art and literature.<sup>31</sup> It was played over and over again, in cities and in

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sciousness, he gasped, "It's very beautiful . . . over there." *Id.* at 102. I can bear the cessation of self, but not the cessation of aesthetic experience.

There is also a Hasidic tradition of recording the dying words of famous teachers and leaders of the community, in the belief that, since how a man meets his death is the product of how he has led his life, one might capture a whole life's philosophy in how a man chooses to die. Thus, recording the last moments of the masters became a sacred task. JEWISH REFLECTIONS ON DEATH, *supra* note 24, at 16. One such collection is the *Histalkut Hanefesh*, edited by Benjamin Mintz in 1930. Each description contains a deathwatch. For example, "at the hour of the death of the Ari, all of his students gathered around him." HISTALKUT HANEFESH (Samuel H. Dresner trans.), in JEWISH REFLECTIONS ON DEATH, *supra* note 24, at 25, 26. On the last evening of Baal Shem Tov's life, "his intimates were gathered around him and he preached to them about the giving of the Torah." *Id.* When death came to Rabbi Elimelekh, he "placed his hands upon the foreheads of his four disciples and gave them each a portion of his soul." *Id.* at 28-29.

31. Probably the most famous dying scene in Western civilization is the death of Jesus. See *Mark* 15:1-39. Jesus was crucified, "a Roman penalty reserved for slaves and selected criminals, with the condemned person usually dying from a combination of exhaustion and exposure." DEATH IN LITERATURE 119 (Robert F. Weir ed., 1980).

Another famous deathwatch in Western civilization is the death of Socrates as portrayed by Plato. PLATO, *Phaedo*, in THE WORKS OF PLATO 109 (Irwin Edman ed. & Benjamin Jowett trans., 1956) [hereinafter *Phaedo*]. *Phaedo* relates the conversation between Socrates and one of his students, Crito, after Socrates decided to submit to his death sentence. As the students entered, Socrates was bidding farewell to his family. This deathwatch was a time for philosophic exploration, embracing such subjects as the relationship of soul to body, the crime of suicide, the soul's immortality, and the nature of knowledge. Indeed, there was so much philosophic exploration that the attendant who was to give Socrates the poison worried about its effectiveness, for talking "increases heat, and this is apt to interfere with the action of the poison; persons who excite themselves are sometimes obliged to take a second or even a third dose." *Id.* at 117. Socrates advised the attendant to "mind his business and be prepared to give the poison twice or even thrice if necessary." *Id.* When Socrates eventually stopped the dialogue and took the poison, his students began to weep; he asked them not to, because "a man should die in peace." *Id.* at 189. Finally, when he was on the very edge of death, Socrates uncovered his face (he had covered himself up) and reminded Crito that "I owe a cock to Asclepius; will you remember to pay the debt?" *Id.* And then Socrates died.

The epic of Gilgamesh also contains a famous death scene. Gilgamesh, who reigned in the Mesopotamian city of Uruk during the third millennium, was said to be two parts god and one part man. JOHN GARDNER & JOHN MAIER, GILGAMESH 67 (1984). The epic portrays his friendship with Enkidu, "a child of the mountain" who grew up with wild animals. *Id.* at 77. Gilgamesh and Enkidu embarked on a journey to make a name for themselves, during which they offended the goddess, Ishtar, who placed a curse on Enkidu. Gilgamesh attended Enkidu at his sickbed for over 12 days, and, upon Enkidu's

small towns, and in isolated farmhouses. Just as family and friends convened at the birth of a baby,<sup>32</sup> so they reconvened at his death.<sup>33</sup> With the passage of time, of course, the constituency of the deathwatch would change; different faces attended the entrance and the exit. But every human being was more or

death, addressed the counselors of Uruk in one of the most beautiful laments in all literature. *Id.* at 183-95.

One of the funniest death scenes in literature is in Lewis Carroll's *Through The Looking-Glass And What Alice Found There*. The Walrus and the Carpenter lured the Oysters out for a walk, and then ate them, but not without much carrying on by the Walrus:

"I weep for you," the Walrus said:

"I deeply sympathize."

With sobs and tears he sorted out

Those of the largest size,

Holding his pocket-handkerchief

Before his streaming eyes.

"O Oysters," said the Carpenter,

"You've had a pleasant run!

Shall we be trotting home again?"

But answer came there none—

And this was scarcely odd, because

They'd eaten every one.

LEWIS CARROLL, *THROUGH THE LOOKING GLASS AND WHAT ALICE FOUND THERE* 81-82 (Octopus Books 1981) (1897). Here was an unsentimental Victorian death scene.

32. Cultural patterns vary greatly regarding pregnancy, labor, delivery, and the postpartum period. In almost all cultures, however, others attend to and assist the mother during labor and delivery. One anthropological study found that in the great majority of cultures—58 out of 60—older women actually assisted the mother during childbirth. Other cultures allowed the husband, and occasionally the father-in-law, to be present for the birth. MIKE SAMUELS, M.D. & NANCY SAMUELS, *THE WELL PREGNANCY BOOK* 15-16 (1986).

Anyone who is interested in the experience and institution of motherhood should read Adrienne Rich's *Of Woman Born*. In particular, her chapter entitled "Alienated Labor" is relevant to the birth-watch. For me, the most memorable birth-watches in literature occur in Sigrid Undset's novel, *Kristin Lavransdatter*.

33. In a beautiful piece, Morris Adler discusses the importance of the community and the home in sharing sorrow over the death of one of its members:

Thus does a community symbolically and actually share in the sorrow of one of its members. The grief of the individual reechoes in the life of the group. . . . The religious service of this little group, representing the larger community, takes place in the home. It is a tribute to the central position of the home. Where a family lives and loves and fashions the most intimate bonds to link persons one to the other, there you have a sanctuary no less than the synagogue. Its holiness is of no lesser kind than that with which the formal house of prayer of the entire community is invested. The poignancy and sanctity of grief are best expressed in the intimate sanctuary of the home.

Morris Adler, *We Do Not Stand Alone*, in *JEWISH REFLECTIONS ON DEATH*, *supra* note 24, at 164, 164-65.

less assured that his birth and death would be witnessed.<sup>34</sup> Ultimately, our coming in and going out might have been lonely, but at least we were not alone; the community gathered around to attend, to keep vigil, to create a warm space to envelop us.<sup>35</sup> That warm space was called "home."

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We no longer die at home. Starting in the 1930s, the locus

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34. In my presentation of the deathwatch, I assume that the members of the deathwatch are themselves alive. Katherine Anne Porter made me question this assumption. In *Pale Horse, Pale Rider*, Miranda, a 24-year-old journalist, almost died of influenza at the very end of the First World War. As she fell ill, she thought that she ought to go home, since "it's a respectable old custom to inflict your death on the family if you can manage it." KATHERINE A. PORTER, *PALE HORSE, PALE RIDER* 141, 182 (1990). She chose to stay in her room, however, and was eventually taken to the hospital, presumably to die.

Miranda "sank easily through deeps under deeps of darkness until she lay like a stone at the farthest bottom of life." *Id.* at 199. Pulled toward a "hard unwinking angry point of light," she reached "a deep clear landscape of sea and sand, of soft meadow and sky," where "[m]oving toward her leisurely as clouds through the shimmering air came a great company of human beings . . . all the living she had known. Their faces were transfigured, each in its own beauty, beyond what she remembered of them . . ." *Id.* at 199-200. They encircled Miranda "smoothly on silent feet" and she moved easily among them. *Id.* at 200. Medical intervention brought her back to life, but she felt a stranger to her own body. She mourned "for what she had so briefly won," but did not let on to her friends who visited her the next day. *Id.* at 204-05.

Miranda's experience made me think that there may be a parallel to the deathwatch on the other side, a mirror image of our gathering at her bedside, in which others move toward her on silent feet. The ritual may have two parts, a farewell and a greeting.

35. Emily Dickinson wrote a poem about a deathwatch from the point of view of the dying person who is aware of those gathered around her bed, waiting for death to come:

I heard a Fly buzz—when I died—  
The Stillness in the Room  
Was like the Stillness in the Air—  
Between the Heaves of Storm—  
The Eyes around—had wrung them dry—  
And Breaths were gathering firm  
For that last Onset—when the King  
Be witnessed—in the Room—  
I willed my Keepsakes—Signed away  
What portion of me be  
Assignable—and then it was  
There interposed a Fly—  
With Blue—uncertain stumbling Buzz—  
Between the light—and me—  
And then the Windows failed—and then  
I could not see to see—

EMILY DICKINSON, "Dying," in *FINAL HARVEST: EMILY DICKINSON'S POEMS* 111-12 (Thomas H. Johnson ed., 1961) (1896).

of our dying moved from the home to the hospital or some other health-care facility.<sup>36</sup> On the surface, it seemed like the logical thing to do. After all, sick people went to the hospital because all those things that sick people needed were located there: doctors, nurses, laboratories, new diagnostic and therapeutic technologies. Because all of those things had been so wildly successful in the recent past, we had a new expectation of survival: Dying people came to be viewed as sick people.<sup>37</sup>

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36. The dying person's bedroom has moved from home to hospital due to both our change in attitudes and "technical medical reasons." In the hospital, death can remain hidden: "The hospital is the only place where death is sure of escaping a visibility—or what remains of it—that is hereafter regarded as unsuitable and morbid. The hospital has become the place of the solitary death." ARIÈS, *supra* note 23, at 571.

Ariès sees a relationship between our change in attitudes toward death and our move from the home to the hospital as the place where death takes place. He argues that in the second half of the nineteenth century attitudes toward death changed; death came to be seen as improper, unseemly, and "dirty."

It is indecent to let someone die in public. It is no longer acceptable for strangers to come into a room that smells of urine, sweat, and gangrene, and where the sheets are soiled. Access to this room must be forbidden, except to a few intimates capable of overcoming their disgust, or to those indispensable persons who provide certain services. A new image of death is forming, a hidden death, hidden because it is ugly and dirty.

*Id.* at 569.

Society's migration from the country to urban centers may also have affected our attitudes toward death. In a radio interview for "Fresh Air with Terry Gross," writer Grace Paley read one of her poems:

I am afraid of nature  
because of nature I am mortal  
my children and my grandchildren  
are also mortal

I lived in the city for forty years  
in this way I escaped fear.

GRACE PALEY, "Fear," in *NEW AND COLLECTED POEMS* 59 (1992). After reading the poem, she remarked:

I really meant what I said. I was simply thinking of the movement of life and death, in the fields and in the mountains, and in the animals around me, which are very close to you, much more close to you. You know, we think about the cities as being so dangerous, and full of guns and so forth, but in a very strange way, you are really closer to birth and life and death in the countryside.

*Fresh Air with Terry Gross* (WHYY, Inc., aired on member stations of National Public Radio, Mar. 26, 1992).

37. The very term "dying" is difficult to define. For an excellent discussion of the semantic complexities involved in the use of the term "dying," see DAVID SUDNOW, *PASSING ON: THE SOCIAL ORGANIZATION OF DYING* 61-72 (1967). While one can properly say of all persons that they are dying from the moment of birth onward, most people in Western society use the term to refer to a certain class of states and persons. *Id.* at 61. Sudnow points out that "dy-

And sick people went to the hospital.

That simple move from dying person to sick person, from the home to the hospital, had hidden, undreamed-of consequences. When we left our homes, we lost power over our own deaths<sup>38</sup> and over the deaths of those we love.<sup>39</sup> Once inside the hospital walls, dying became the sole province of medicine, and this has had a profound effect on the deathwatch. The deathwatch has almost disappeared.<sup>40</sup>

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ing" seems to be an essentially predictive term, the "likelihood of death within some temporal perspective." *Id.* at 64. Some argue that "dying" is a state in which a person suffers from an irreversible disease known to produce death. *Id.* at 65. In a hospital setting, "'dying' takes on its central significance insofar as death is considered likely on the current admission, for it is then that the hospital, its personnel, and its activities are directly involved in the affair of the death." *Id.* at 71. I use the term "dying" to refer to someone who is expected to die within a relatively short period of time. I realize that the definition is not altogether satisfactory, but I do not believe more precision is necessary to understand the twentieth-century deathwatch.

38. Ted Rosenthal recorded his shock when he first discovered that he might not have control over the circumstances of his death. Having just been diagnosed with terminal acute leukemia, he wrote:

My only request was—the thing I was most concerned about was that should I die, I wanted a warning in advance of dying so that I could get out of the hospital, get back to California, get into the country and die there. And I was shocked when the doctor said, "We'll do the best we can." I thought he would say more than that. I thought he would say, "Sure, we'll do that for you," but he said, "We'll do the best we can."

TED ROSENTHAL, *HOW COULD I NOT BE AMONG YOU?* 31 (1973). The physician's response indicated that he regarded himself as the person in control of the deathwatch, not the patient.

39. The death scene in John Gunther's *Death Be Not Proud* is one of the earliest descriptions of a hospital deathwatch and the powerlessness that family members can feel when a loved one dies in that setting. JOHN GUNTHER, *DEATH BE NOT PROUD* 183-89 (1949). When Johnny Gunther took a sudden turn for the worse because of a cerebral hemorrhage, his parents had him immediately moved to the hospital. Everything about the move was a disaster. The emergency door at the hospital was locked. The switchboard had gone to pieces. The nurse did not know what to do. An attendant downstairs was hysterical. The cab driver who drove them back was drunk. *Id.* at 187. When the end was near, someone rang an emergency bell, and after "all those months of doctors and doctors and doctors, it happened that no doctor was there at that precise moment." *Id.* at 188.

The last few lines about the hospital deathwatch are for me deeply moving: "Johnny died at 11:02 p.m. Frances reached for him through the ugly, transparent, raincoat-like curtain of the oxygen machine." *Id.* at 189. It is a terrible thing to have to hold a dying son through a layer of hostile plastic.

40. Other factors have undoubtedly contributed to the disappearance of the deathwatch. One author suggested that improved obstetric and pediatric care has cut down dramatically on the types of death that most commonly occurred in the presence of the family. MELVIN J. KRANT, M.D., *DYING AND DIGNITY: THE MEANING AND CONTROL OF A PERSONAL DEATH* 7 (1974).

In the late twentieth century, most of the people who once gathered around the bed in Munch's painting have been excluded.<sup>41</sup> Even those who remain have a small role to play, and that role is defined not by social custom or religious tradition, but by what is deemed medically necessary.<sup>42</sup> It is true: we

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Furthermore, in today's society, the elderly live separated from their adult children. Thus, the most likely candidates for dying generally do so out of the sight of their children and grandchildren. *Id.* at 9.

41. There are no visitors' waiting rooms on the ward itself; the only place a visitor can await the beginning of visiting hours is in the general hospital lobby, at the front of the building, which, with its long benches, resembles a train station. If, during a visit with a patient, a relative is asked to leave the room, he must stand in the ward corridor. None of the doors to the individual rooms is closed . . . so that a visitor can witness nearly everything that goes on in neighboring rooms. . . . During visiting hours, as one walks down the hall to a patient's room, he is quite likely to see several patients' bodies exposed as bed clothes are changed or examinations conducted.

SUDNOW, *supra* note 37, at 19 (describing the visiting facilities of a large, urban, West Coast charity hospital).

Once a hospital deems a patient to be dying, it "posts" his name on the "critical patients' [sic] list." Once "posted," a patient theoretically has the right to receive visitors day and night, not just during appointed visiting hours. Posting also notifies key hospital personnel that a death may be forthcoming. The hospital drafts tentative autopsy schedules based on the posted lists. *Id.* at 72-73.

In *Quartet in Autumn*, Barbara Pym describes a hospital deathwatch cut short by the arbitrary imposition of a no-visitation rule. BARBARA PYM, *QUARTET IN AUTUMN* (1977). The novel concerns four single elderly people who worked in the same office. After her retirement, one of the women collapsed and was taken to the hospital to die. *Id.* at 172-73. When her friends came to see her, the nurse always refused to let them visit the dying woman, saying that "Miss Ivory was quite comfortable." *Id.* at 176. The nurse explained that the patient must be "kept very quiet, no excitement." *Id.* Consequently, Miss Ivory died alone. As one of her survivors put it, "If they said, 'No Visitors,' then we can't very well barge in." *Id.*

42. The medical staff of one large, urban charity hospital did not encourage relatives to be present in the dying person's room:

Before death, with relatives continuously present in the "dying" patient's room, a more constant vigilance over the patient's condition must be maintained, this requiring, in effect, the removal of a nurse from other activities to spend her time exclusively at the bedside. The routine handling of death as it occurs on the medical wards at County requires that the ward be kept relatively free of outsiders, whose mere presence exacts greater demands on the behavior of staff than the likelihood of a death would normally warrant.

SUDNOW, *supra* note 37, at 85-86. The staff said that they were "shielding" the relatives from the "unpleasantness of seeing someone die." *Id.* at 86. This exclusion of relatives and "shielding" does not seem to occur in middle-class, private hospitals where "relatives are considered specifically entitled to be present at the bedside when the patient 'expires.'" *Id.*

The term "deathwatch" has a more specific meaning to the nursing personnel on medical and surgical units, referring to "guarding a dying patient in



usually do not die alone. If we are lucky,<sup>43</sup> someone will still be in the room, but that someone will most likely be a medical professional, someone whose job it is to be in the room.<sup>44</sup>

If that room is in an intensive care unit (ICU), the death-watch is only a shadow of its former self, a sketch from memory, a vestigial impression laid down in the sand. Just as dying moved from the home to the hospital, within those walls dying moved from the wards to the inner sanctum of the ICU.<sup>45</sup>

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anticipation of his death." *Id.* at 83. During the nursing deathwatch, "the patient is treated as in a transitory state, the relevant facts about him being the gradual decline of clinical life signs." *Id.* As the patient gets closer to death, "his status as a *body* becomes more evident," and the nurses' attention shifts from caring for his discomforts and administering medical treatment to the "sheer activity of 'timing' his biological events." *Id.* at 83-84.

43. George Orwell described how hospitals sometimes deprive the poor of a deathwatch altogether:

I could see old Numéro 57 lying crumpled up on his side, his face sticking out over the side of the bed, and toward me. He had died sometime during the night, nobody knew when. When the nurses came, they received news of his death indifferently and went about their work. After a long time, an hour or more, two other nurses marched in abreast like soldiers, with a great clumping of sabots, and knotted up the corpse in the sheets, but it was not removed till some time later.

GEORGE ORWELL, *How the Poor Die*, in *SHOOTING AN ELEPHANT* 18, 24 (1950).

The denial of the deathwatch has a disparate impact on the hospitalized poor. Deaths on medical and surgical wards in charity hospitals "more often than not occur with no staff members present." SUDNOW, *supra* note 37, at 47. Frequently, the roommates of the patient will notice the death before members of the staff. *Id.* at 45. To avoid this, hospitals often transfer patients who are expected to "terminate" to private parts of the hospital; curtains may be drawn around them. *Id.* at 48. This setting makes those areas of the wards "much less conducive to social interaction and the consequent dangers of discovery that a history of friendliness between patients and an interest in the happenings of one's roommates would entail." *Id.*

44. One study of mourning behavior in Great Britain in the 1960s reported the following regarding the decline of the deathwatch:

Most people, it would seem, now die alone, except for medical attendants; less than a quarter of the bereaved were present when their relative died, and nearly two-thirds of those present were women. . . . [N]early half of the widowed were present at the death of their partner. A child was present in a quarter of the cases when a parent died; but, with insignificant exceptions, brothers or sisters are absent when their siblings die. Nearly all the children died in hospital, alone.

In the upper middle and professional classes it is rare for the bereaved person to be present at death (less than 1 in 8); as one descends the class structure, presence becomes more common, reaching nearly a third in the unskilled working class.

GEOFFREY GORER, *DEATH, GRIEF, AND MOURNING* 5 (1965). But see *supra* note 42 and accompanying text for a study suggesting the contrary in American hospitals.

45. Over the past 40 years, hospitals have developed "special care units:

There death has become mechanized; the struggle for heartbeat and breath has been taken over by machines. For the sick, these machines buy valuable time; they temporarily perform vital functions until the body is ready to work again.<sup>46</sup> But for the dying, these machines just prolong that process.<sup>47</sup> Never-

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preoperative, postoperative, neonatal, coronary, burn, and trauma centers." THOMAS A. RAFFIN ET AL., *INTENSIVE CARE: FACING THE CRITICAL CHOICES* 5 (1989). Underlying the creation of a special unit is the principle that patients with similar medical problems can be treated more efficiently if they are gathered together in one location. *Id.* The first special care unit, established in 1923, was a postoperative recovery room. Specially trained nurses could easily detect and correct common postoperative problems, such as airway blockage or bleeding. *Id.* In 1942, a Boston area hospital set aside a ward to treat 39 burn victims of the Coconut Grove nightclub fire. This burn unit served as the model for the modern ICU. *Id.* During World War II and the Korean and Vietnam wars, the organization of special care units improved. *Id.* As cardiac surgery progressed in the late 1950s, hospitals set up coronary care units to accommodate the intensive nursing and complicated monitoring devices required for postoperative patients. Other medical specialties, such as respiratory and physical therapy, also contributed to the developments of the ICU. *Id.* at 5-6. In the early 1960s, only 10% to 20% of the hospitals in the United States had ICUs. *Id.* at 5. Now most of the nation's 6,000 hospitals have ICUs. *Id.* at 4. A smaller hospital located in a rural area may have only a two-bed ICU, primarily for cardiac monitoring. A major acute-care hospital in an urban area, however, may have several ICUs with large populations of patients and postoperative complications. *Id.*

46. Overall, the survival statistics of ICU patients are rather heartening: 70% to 80% of ICU patients leave the unit alive. Some kinds of patients, however, do better than others. Postoperative patients who were relatively healthy to start with fare well. For example, "there is only a four to five percent mortality rate nationally" for coronary artery bypass operations. *Id.* Trauma victims also tend to survive. *Id.* Predictably the old, the frail, the critically ill, and patients with multiple medical problems do not do well. For example, a patient with respiratory failure who requires artificial ventilation for more than 72 hours faces depressing odds: 40% to 60% die. *Id.* at 14. The patient who has another disease has a much greater chance of dying. Of those patients with renal failure and respiratory failure, 80% to 90% die. Ninety percent of patients with cardiac arrest do not come out of the ICU alive. *Id.* The condition of the patient's body upon admission to the ICU, therefore, largely determines his chances of survival.

47. While life-sustaining equipment may prolong the process, the longer a patient remains in the ICU the less likely she is to leave alive. Typically, patients suffering from acute Organ System Failure ("OSF") are transferred to the ICU. See William A. Knaus, M.D. et al., *Prognosis in Acute Organ-System Failure*, 202 ANNALS OF SURGERY 685, 685 (1985) (describing the prognosis of patients in acute Organ System Failure). For all medical and most surgical admissions, a single OSF lasting more than one day resulted in a mortality rate approaching 40%. *Id.* Two OSFs for more than one day increased the death rates to 60%. *Id.* Advanced age increased both the probability of developing an OSF and of dying once that OSF occurred. *Id.* Mortality for patients with three or more OSFs who lived after three days was 99%. *Id.*

These estimates, while not prescriptive, provide a basis for discussion with the patient or his family and if "the decision is to reduce treatment, it will be

theless, because being sick and dying have become indistinguishable conditions, intensive care is usually lavished upon every patient without discrimination.

There is very little beauty in the ICU. It pulsates with the rhythmic hum of life-support machines.<sup>48</sup> It is aggressively clean. The smells of sickness and death have been washed away with a fluid the color of aquamarine. Day and night, night and day, fluorescent lights cast their purple-yellow glow on the scene, making the healthy look like the sick, the sick look like the dying, and the dying look already gone.

The deathwatches that take place there are sparsely populated. Visiting is only permitted for small groups of close family members, since an ICU is a labor-intensive operation, designed to facilitate nursing, not visitation.<sup>49</sup> In the ICU, nursing consists primarily of the manipulation of machines. The machines are large, three-dimensional objects that take up lots of room; so are people. There is no space in the room for a large deathwatch, and the absence of chairs sends the message that no one is expected. Visitors have to stand.

What is it like to participate in a deathwatch in such a place? Often it is a struggle just to get there. Since the hospital is usually located miles away, each visit may be preceded by a long solitary drive, with time to spare for dreadful anticipation. Once the car is finally parked, there is that terrible jour-

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consistent with acknowledged ethical practice of not prolonging death unnecessarily (death with dignity) and of distributing medical resources equitably so that scarce resources will more likely be available to those that can benefit." *Id.* at 692.

48. Molly Haskell described her first ICU visit, when her husband had fallen ill from some mysterious infection. She, too, was struck by the bizarre physical environment of the ICU, its isolation from the rest of the hospital, and the predominance of machines:

The ICU was itself an otherworldly experience. I was the only visitor—they'd agreed to let me in for a few minutes before regular hours. It was an antiseptic enclosure cut off from the rest of the hospital and the flow of life by its restricted visiting hours (11:00 to 11:45 in the morning, 5:00 to 5:45 in the evening). It was like an airship, suspended in space, sterile because there were none of the ordinary signs or sounds of life, only the whirring and clicking of machines surrounding mummylike patients, each click signaling that death had been forestalled by another moment.

MOLLY HASKELL, *LOVE AND OTHER INFECTIOUS DISEASES: A MEMOIR* 149-50 (1990).

49. In a normal hospital unit, there is approximately one nurse per eight beds; in an ICU, there is usually one nurse per patient. The critical condition of most of the patients and the complex monitoring and life-sustaining equipment require such intensive nursing care. RAFFIN, *supra* note 45, at 4.

ney through the hospital corridors to reach the ICU:<sup>50</sup> The eyes do not obey the order to stare straight ahead, but instead dart in and out of rooms, left and right, drawn by the undeniable attraction of someone else's darkest night. Once through the maze, a "security" guard yields up a laminated cardboard pass, bearing the number of the bed that holds the dying person.

Visiting hours are strictly limited. An ICU deathwatch is therefore episodic. It is sliced into thin slivers of time, and the attendance of such a death becomes a series of black-and-white stills. Upon each successive visit, a new image of a body frozen in time is created and added to the pile of memories. It is never clear which image is the last until someone announces that the series is over.

So for brief intervals, day after day, night after night, sometimes for twenty minutes, sometimes for half an hour, segments of the deathwatch take place. Several feet away, one set of outlets over, there lies another person, sick or dying, dying or sick, and perhaps another deathwatch. At best, members of the nursing staff move silently in and out of the cubicle, monitoring machines. At worst, they make cheerful, brittle remarks about "our night," or "our day." It is difficult to talk at all, and even more impossible to exchange words of intimacy. It is not a good place for prayer or resolution,<sup>51</sup> or even idle chatter. It is not a good place at all.

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50. One of the most disturbing aspects of being in a hospital is the disorientation one feels in the maze of hallways, waiting rooms, elevator banks, and patients' rooms. One study has focused on the prerequisites for "wayfinding" through a complex and unfamiliar environment. Jain Malkin, *Wayfinding: An Orientation System for Hospitals*, PROGRESSIVE ARCHITECTURE, Nov. 1989, at 107, 107. Behavioral scientists seem to agree that the degree of sameness or variation of interior spaces will affect one's ability to recognize and use a landmark. *Id.* Similarly, being able to see one part of the building from another helps maintain a point of reference. The overall complexity of the layout naturally will also affect the comprehensibility of the environment. *Id.* Various design techniques can facilitate wayfinding, however, such as appropriate signage, the use of a main artery, and the use of landmarks to serve as points of reference. *Id.* A deathwatch seems like a poor time to be taxing one's cognitive processes by engaging in spatial problem-solving.

51. The Catholic chaplain in one large urban charity hospital in the late 1960s made rounds every morning and administered Extreme Unction to all Catholic patients appearing on the "critical patients' [sic] list." SUDNOW, *supra* note 37, at 72-73. After completing his rounds, he stamped an index card with a rubber stamp which read:

Last Rites Administered

Date:                      Clergyman:

Every day he consulted the files to see if new patients had been admitted to

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Sometimes the common law reminds me of Columbus, Ohio, where I grew up. In this country, new ideas, fashions, and expressions all tend to start on either edge of the continent and slowly roll inward, like a billiard ball on a slightly elevated field of green felt. Contrary to the parochial opinions of those who have lived their entire lives on the East or West Coast, new ideas, fashions, and expressions eventually do make their way to Columbus, Ohio, provided they were important enough at their point of origin. They just get there later, sometimes by several years.

It is the same with the law. If some new problem is generated from a dramatic change in social reality, that new problem will slowly roll towards the appellate courts. Just as it may take a new idea several years to reach Columbus, Ohio, it may take a new problem several years to reach judicial attention. Arrival at both destinations, however, is ensured by the force of gravity.

Thus it was inevitable that the horrors of the late-twentieth-century deathwatch would eventually land in the pocket of an appellate court. The jurisdiction was New Jersey; the case was *In the Matter of Karen Quinlan, an Alleged Incompetent*.<sup>52</sup>

What an odd expression: "In the matter of." In many ways, the case of Karen Quinlan was about the matter of Karen Quinlan. Perhaps because it was the first such case to reach an appellate court, there are pages and pages of medical details about her body, its functions, its posture, and its ghastly depen-

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the wards and/or put on the critical list. The stamp prevented him from performing the rite twice on the same patient. *Id.*

52. Karen Quinlan was 21 years old when, for unknown reasons, she suffered two 15-minute periods of interrupted respiration that resulted in irreversible brain damage. *In re Quinlan*, 348 A.2d 801, 806 (N.J. Super. Ct. Ch. Div. 1975), *modified and remanded*, 355 A.2d 647 (N.J.), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976) [hereinafter *Quinlan I*]. She was not brain dead, however, according to the definition promulgated by the Ad Hoc Committee of Harvard Medical School, but was instead described as being in a "persistent vegetative state." *Id.* at 810. She could not maintain her vital processes without the assistance of a respirator. *Id.* at 812. After a long period of time, when it became apparent that her condition was irreversible, her family and her parish priest agreed that she should be removed from the respirator. *Id.* at 812-13. When her doctor refused, her father, Joseph Quinlan, petitioned the court to appoint him as guardian of the person and property of his daughter. He also proposed that the letters of guardianship, if granted, contain the express power to authorize the discontinuation of all extraordinary medical procedures. *Id.* at 815.

dence on machines.<sup>53</sup> Although no photographs of Karen Quinlan in her semi-vegetative state were ever published,<sup>54</sup> the lower court described her in this graphic word picture:<sup>55</sup>

In the decorticate posturing the upper arms are drawn into the side of the body. The forearms are drawn in against the chest with the hands generally at right angles to the forearms, pointing towards the waist. The legs are drawn up against the body, knees are up, feet are in near the buttocks and extended in a ballet-type pose.<sup>56</sup>

Who was this ballerina? Why were we so hypnotized by her curling in,<sup>57</sup> by the merger of her body with machines? Was this close scrutiny an effort to conquer our own fear? What were we afraid of? Some unnameable malevolence often associated with other forms of the living dead?<sup>58</sup> Of a human

53. The lower court devoted fully one-third of its opinion to medical details about Karen Quinlan's body. *Id.* at 806-12. Later decisions about termination of life-support systems have winnowed the medical details down to a few terse paragraphs at the beginning of the opinion. See, e.g., *Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990).

54. It was not for want of trying on the part of the media. Toward the end of her ordeal, armed deputies had to guard Karen Quinlan's room in the nursing home 24 hours a day. One reason for the tight security was the media's repeated efforts to get a photograph of her. It cost the taxpayers an average of \$4,199 a month. JOSEPH QUINLAN ET AL., *KAREN ANN: THE QUINLANS TELL THEIR STORY* 315-16 (1977). Members of the press offered the Quinlans as much as \$100,000 for a photograph of their daughter, and that was only a "starting figure." *Id.* at 223.

55. Interestingly enough, the graphic word picture was the only image to which Judge Muir, author of the lower court opinion, would permit himself access. Karen Quinlan's attorney, Paul Armstrong, urged Judge Muir to "personally witness and appreciate Karen's condition" in the hospital ICU, but Judge Muir did not feel that was appropriate, "recognizing that emotion is an aspect that I cannot decide a case on." *Id.* at 214-15 (quoting the trial court transcript).

56. *Quinlan I*, 348 A.2d at 807.

57. Once the cognitive function of the brain is gone, the central nervous system acts in a more primitive fashion. PAUL SCHILDER, *THE IMAGE AND APPEARANCE OF THE HUMAN BODY* 255 n.1 (1950). Thus, in an individual in whom only the brainstem is active, certain bodily reactions, such as grasping and sucking, are still present. Certain "primitive defense reflexes" persist as well. *Id.* This turning in of Karen's limbs toward the body is a manifestation of such a primitive defense reflex.

58. I am surprised that no science-fiction writer has chosen the permanently unconscious patients in an ICU as suitable subjects for possession by evil spirits (at least no science-fiction writer that I know of). A person in a semi-vegetative state has all the indicia of having experienced a "false death," or having the look of the living dead.

The death rituals of the Haitian Voudoun are directed at preventing both a false death and a false life:

The initial act of the survivor is to determine that the death is real or a false death brought on by magic. For, if the regular rituals that dis-

being who has turned into a machine?<sup>59</sup> Or were we just afraid of ourselves in a similar position, spinning our own futures from a web of dreadful possibilities?<sup>60</sup>

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sociate the soul from the body should be performed in ignorance of the fact that the death is false, the body would remain as a live but emptied vessel, subject to the direction of any alien force (usually the malevolent one which engineered the magic precisely for such a purpose). The dread *zombie*, the major figure of terror, is precisely this: the body without a soul, matter without morality.

MAYA DEREN, *DIVINE HORSEMEN: THE LIVING GODS OF HAITI* 42 (1953). "A zombie is nothing more than a body deprived of its conscious powers of cerebration." *Id.* at 43 n.\*.

The fear that the zombie generates may be the same fear that a human being in a semi-vegetative state generates. In both, consciousness has ceased, but the body's existence continues. To be possessed by the Haitian god, the *loa*, the "self must leave . . . . The serviteur must be induced to surrender his ego . . . ." *Id.* at 249. A human being in a semi-vegetative state has already permanently lost the self. This would make the permanently unconscious patient in an ICU extremely vulnerable to possession, or so it seems to me.

59. Haskell, for example, described the inhuman appearance of the patients in the ICU:

I walked along the small passageway, between two glass panes, where the patients, four on the right, two on the left, were lined up side by side, with tubes of the most expensive lifesaving machinery in the world reaching like tentacles into every orifice, and with their faces, peering out from oxygen masks, unrecognizable as to sex and age. They weren't humans but cyborgs, half man-half machine, new arrivals on display for the planet of near-death.

HASKELL, *supra* note 48, at 149-50.

60. Schilder writes about the "deep community between the postural models of human beings." SCHILDER, *supra* note 57, at 44.

The postural model of our own body is connected with the postural model of the bodies of others. There are connections between the postural models of fellow human beings. We experience the body images of others. Experience of our body-image and experience of the bodies of others are closely interwoven with each other.

*Id.* at 16. The postural model of Karen Quinlan's body may threaten us because we identify with it and experience it as potentially our own.

Another psychologist theorized that the degree to which seeing the disablement of another person provokes an anxiety response depends upon how definite one feels about one's own body boundaries. When an individual sees the mutilated or deformed body of another, this stimulus is threatening because it suggests that the same thing could happen to the perceiver. Thus, the less definite the perceiver's body boundaries are, the more disturbing the perception of body disablement in another will be. SEYMOUR FISHER, *BODY EXPERIENCE IN FANTASY AND BEHAVIOR* 245-46 (1970) (describing R.L. Masson, *An Investigation of the Relationship Between Body-image and Attitudes Expressed Toward Visibly Disabled Persons* (1963) (unpublished Ph.D dissertation, University of Buffalo)).

The fear stemming from deformation in another is not confined to the human species. For example, one adult male member of a troop of chimpanzees had been stricken by polio. When he shuffled up to the feeding area, dragging a useless arm behind him, "the group of chimps already in camp stared for a moment and then, with wide grins of fear, rushed for reassurance

Those are questions I cannot answer, and questions the law does not ask. Instead the cases purport to be about Karen Quinlan and her right of privacy and self-determination. And in a sense, that is indeed what they are about. At least they are about the Karen Quinlan who used to be.<sup>61</sup>

But the cases are not only about Karen Quinlan, that tragic ballerina; they are also about the horrors of the late-twentieth-century deathwatch. Her family asked the court: Who is the choreographer here? Why is our daughter still dancing? The music has stopped, and still we stand silently at her bedside, forced to witness her agony, day after day, night after night, and still nothing happens. Karen has no more story to move through, no more reason to cross the stage. Why doesn't the curtain come down, for God's sake? For Karen's sake? For our sake? Has time stopped? Are we trapped in her deathwatch for eternity?

Her doctor would not let her go,<sup>62</sup> so Joseph Quinlan filed a petition in Chancery Division seeking guardianship over the

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to embrace and pat each other while staring at the unfortunate cripple." JANE VAN LAWICK-GOODALL, *IN THE SHADOW OF MAN* 217 (1971).

61. The trial court heard testimony on whether Karen Quinlan would elect, if competent, to terminate the respirator. QUINLAN, *supra* note 54, at 208-14 (citing the trial transcript). She had made several statements to family members and friends about various friends and relatives who were themselves trapped in interminable deathwatches, including an aunt and a close family friend who had died from cancer. *Id.* at 209-10. Karen Quinlan seemed to have been consistent in her belief that she "would not want to be kept alive that way." *Id.* at 211. Her mother, Julia, testified that Karen Quinlan not only made such statements in the context of terminally ill relatives or friends, but also in "just general conversation. We had discussed the fact of being kept alive by extraordinary means, not referring—not making references to any individual." *Id.*

The Attorney General cross-appealed, challenging on hearsay grounds the trial court's admission of Karen Quinlan's prior statements about her distaste for continuance of life-support systems in circumstances not unlike her own. *In re Quinlan*, 355 A.2d 647, 653 (N.J.), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976) [hereinafter *Quinlan II*]. Both the lower court and the Supreme Court of New Jersey agreed that the statements were "remote and impersonal, lack[ing] significant weight," rendering their admission insignificant. *Id.* Almost 10 years later, the Supreme Court of New Jersey changed its mind, stating that its earlier decision to disregard Karen Quinlan's comments to friends and family about artificial life support had been erroneous. *In re Conroy*, 486 A.2d 1209, 1230 (N.J. 1985).

62. After her family requested that Karen Quinlan's treating physician, Dr. Morse, discontinue the respirator and offered to release him from liability, Dr. Morse "felt he could not and would not agree to the cessation of the respirator assistance." Quinlan I, 348 A.2d 801, 814 (N.J. Super. Ct. Ch. Div. 1975), *modified and remanded*, 355 A.2d 647 (N.J.), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976). He concluded that "to terminate the respira-



matter of Karen Quinlan, and power over her death.<sup>63</sup> What the Quinlans really wanted was spiritual release for Karen and permission to return to the nineteenth-century deathwatch of Munch's painting. They wanted to gather around her bed as a family and let nature take its course. Then, "if it is God's will to take her, she can go on to life after death."<sup>64</sup> They wanted the doctor to give up his fight and retire into the corner to assume his former role of referee. They wanted their parish priest to come forward, anoint their daughter, and prepare her for the journey home. They wanted her deathwatch to come to an end, to move her from that lonely threshold, and to give themselves the freedom and the right to grieve.

The Quinlans' struggle over Karen's deathwatch captured the public's imagination. Later, many others would become silent stars in similar constellations,<sup>65</sup> but Karen Quinlan's deathwatch was the first, the prototype. Although her story was deeply embedded in the soil of New Jersey, it transcended the boundaries of fact and became a twentieth-century tragedy.

Over ten years later, another young woman lay in a Missouri state hospital in a "persistent vegetative state,"<sup>66</sup> that

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tor would be substantial deviation from medical tradition, that it involved ascertaining 'quality of life,' and that he would not do so." *Id.*

63. See *supra* note 52 and accompanying text.

64. *Quinlan I*, 348 A.2d at 813.

65. In numerous cases since *Quinlan II*, at least 23 state courts have addressed the issue of the removal of life-sustaining treatment. See, e.g., *Rasmussen v. Fleming*, 741 P.2d 674 (Ariz. 1987) (en banc); *In re Drabick*, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988), *cert. denied sub nom.* *Drabick v. Drabick*, 488 U.S. 958 (1988); *Lovato v. District Ct.*, 601 P.2d 1072 (Colo. 1979) (en banc); *McConnell v. Beverly Enters.*, 553 A.2d 596 (Conn. 1989); *In re Severns*, 425 A.2d 156 (Del. Ch. 1980); *In re Browning*, 568 So. 2d 4 (Fla. 1990); *In re L.H.R.*, 321 S.E.2d 716 (Ga. 1984); *In re Estate of Greenspan*, 558 N.E.2d 1194 (Ill. 1990); *Morgan v. Olds*, 417 N.W.2d 232 (Iowa Ct. App. 1987); *In re P.V.W.*, 424 So. 2d 1015 (La. 1982); *In re Gardner*, 534 A.2d 947 (Me. 1987); *In re Riddlemoser*, 564 A.2d 812 (Md. Ct. Spec. App. 1989); *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626 (Mass. 1986); *In re Torres*, 357 N.W.2d 332 (Minn. 1984); *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc), *aff'd sub nom.* *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990); *McKay v. Bergstadt*, 801 P.2d 617 (Nev. 1990); *In re Peter*, 529 A.2d 419 (N.J. 1987); *In re Westchester County Medical Ctr. ex rel. O'Connor*, 531 N.E.2d 607 (N.Y. 1988); *Leach v. Akron Gen. Medical Ctr.*, 68 Ohio Misc. 1, (C.P. 1980); *In re Estate of Dorone*, 502 A.2d 1271 (Pa. Super. Ct. 1985), *aff'd*, 534 A.2d 452 (Pa. 1987); *In re Jane Doe*, 533 A.2d 523 (R.I. 1987); *In re Grant*, 747 P.2d 445 (Wash. 1987) (en banc), *corrected*, 757 P.2d 534 (Wash. 1988); *In re L.W.*, 482 N.W.2d 60 (Wis. 1992) (en banc).

66. Dr. Fred Plum coined the phrase "persistent vegetative state," referring to

a body which is functioning entirely in terms of its internal controls.

same physical and spiritual limbo which had held Karen Quinlan captive for so long. The victim of a car accident at twenty-five, a gastrostomy feeding and hydration tube had kept Nancy Cruzan alive without cognitive function for over five years, and "[m]edical experts testified she could live another thirty years."<sup>67</sup> With such oppressive longevity, the parents of Nancy Cruzan were not likely even to survive their daughter's deathwatch. She might outlive them all and die alone, attended only by some indifferent state employee in the first quarter of the twenty-first century.

Like the members of Karen Quinlan's deathwatch, Nancy Cruzan's parents brought their lament to the judicial system, first to the state courts,<sup>68</sup> and finally to the United States Supreme Court.<sup>69</sup> The Cruzans wanted much the same thing: relief for Nancy and for themselves; power over their daughter's death; permission to bring her deathwatch to an end. As Joseph Cruzan put it, "It just consumes me trying to figure out what to do. I feel as Nancy's father, I've let her down . . . It's like having a death in the family, and the state says, 'I'm sorry, but you can't bury that person.'"<sup>70</sup>

Even if the state is not an active player in the conflict<sup>71</sup> and

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It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low-level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner.

*In re Jobs*, 529 A.2d 434, 438 (N.J. 1987).

Why the term "vegetative" has never been stated. My sister-in-law, Joyce Clark Harmon, R.N., M.S., worked for over 10 years in an ICU, and in a liquid conversation one evening, she told me of the terminology that ICU nurses and doctors use. There were private names for certain kinds of patients, names that were cautiously revealed as if they were a source of shame. Someone in a coma was "gorked out." An indigent patient with poor hygiene was a "dirtball." The badly burned were "crispy critters," and those with only lower brain functions were "veggies," "rutabagas," or "squash." (Humor is insulation from the stress of working with the critically ill.) I am struck, however, by the repetition of the vegetable metaphor even in the formal medical terminology.

67. *Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director*, Mo. Dep't of Health, 110 S. Ct. 2841 (1990).

68. *Id.*

69. *Cruzan v. Director*, Mo. Dep't of Health, 110 S. Ct. 2841 (1990).

70. Laurie Abraham, *Ethicists Try to Define Status of Vegetative Patients: Dead? Alive? Treatment Plans Hang on Decisions*, AM. MED. NEWS, Feb. 24, 1989, at 3, 32.

71. Karen Quinlan's father, Joseph, started the lawsuit by seeking guardianship of the person and property of his daughter. *Quinlan I*, 348 A.2d 801, 806 (N.J. Super. Ct. Ch. Div. 1975), *modified and remanded*, 355 A.2d 647 (N.J.),

we merely feel its presence in the wings, the state is always there in some sort of directorial capacity. By providing a judicial forum, the state constructs the theatre in which these conflicts are resolved. It then lines up the players, deciding who may address the audience, and who may not; at the same time, the state decides whose interests matter, and whose do not. And when the families of Karen Quinlan and Nancy Cruzan petitioned the courts, the state decided to focus on the rights of the silent daughters who lay curled up in those hospital beds, waiting for some way, some day, to die. The members of the deathwatch were pushed to one side.

True, they were needed procedurally: someone had to file the petition and ask for relief. The law provides a mechanism for invoking the rights of those who cannot speak for themselves,<sup>72</sup> but once that mechanism is activated, the law ignores

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*cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976). He amended the pleadings to seek a restraining order to prevent the Morris County prosecutor, the attending and treating physicians, and St. Clare's Hospital from interfering with the exercise of the authorization sought, and to enjoin the prosecutor from prosecuting for homicide when the authorization sought was affected. *Id.* At a pretrial conference, the Attorney General intervened, the basis for his action being "the interest of the State in the preservation of life, which has an undoubted constitutional foundation." *Quinlan II*, 355 A.2d 647, 651-52 (N.J.), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976).

In *Cruzan v. Harmon*, the confrontation between the family and the State of Missouri was more direct, due in part to the fact that Nancy Cruzan was a patient in a state hospital. 760 S.W.2d at 411. In addition, *Cruzan v. Harmon* was a product of Missouri law in which the legislature had set its mind to preserving human life, almost at any cost. Legislation in that state concerning abortion, MO. ANN. STAT. § 188.010 (Vernon Supp. 1992), evidences this intent, as does its living will statute, which does not "condone, authorize or approve mercy killing or euthanasia nor permit any affirmative or deliberate act or omission to shorten or end life." MO. ANN. STAT. § 459.055(5) (Vernon 1992). The Missouri Supreme Court found this legislation to be an "expression of the policy of this State with regard to the sanctity of life." *Cruzan v. Harmon*, 760 S.W.2d at 420.

Other states have developed a line of analysis for addressing these issues. In *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977), the Supreme Judicial Court of Massachusetts articulated a balancing test that has been cited in many other jurisdictions. The *Saikewicz* court invoked the following state interests: "(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession." *Id.* at 425. Against these interests the court balanced the individual's right to refuse life-prolonging medical treatment. *Id.*

72. Incompetency can arise in a variety of circumstances: infancy; mental retardation; mental illness; disease, such as senile dementia or a stroke; or as the result of an accident. Incompetency plays a role in a court's determination of what test to apply in cases involving the discontinuance of life-sustaining treatment. Generally, courts apply one of two tests: substituted judgment or

the petitioner, and focuses instead upon the silent party.<sup>73</sup> The guardian may be procedurally expedient, but once the lawsuit is launched, he can be left on the shore. Substantively, he is dispensable, and that is the way it is supposed to be.

But in these deathwatch cases, the petitioners are more than nominal, procedural plaintiffs, triggering a piece of litigation that could not have started in any other way. The petitioners are substantive plaintiffs as well, not just hollow masks through which resounds the pain of another. They too are aggrieved; they too are in pain. It may be derivative pain, the

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best interests. Stewart G. Pollock, *Life and Death Decisions: Who Makes Them and By What Standards?*, 41 RUTGERS L. REV. 505, 525-30 (1989). The best interests test is usually used when the patient has never been competent or has never expressed her views on treatment. *Id.* at 518-20.

The law concerning minors tends to provide prototypical procedures and substantive law regarding how to make decisions for incompetent persons. Infants, for example, are legally incapable of consenting to medical treatment. *Id.* at 507. Thus, a parent or legal guardian must consent before a child can receive treatment, unless there is some kind of emergency. See, e.g., R.J.D. v. Vaughn Clinic, 572 So. 2d 1225, 1230 (Ala. 1990). If for some reason, the parent's decision endangers the child, the courts will take over, usually invoking the doctrine of *parens patriae*. See, e.g., *Newark v. Williams*, 588 A.2d 1108, 1116 (Del. 1991); *Favier v. Winick*, 583 N.Y.S.2d 907, 910 (N.Y. Sup. Ct. 1992). For a discussion of the evolution of the doctrine of *parens patriae*, see Neil H. Cogan, *Juvenile Law: Before and After the Entrance of Parens Patriae*, 22 S.C. L. REV. 147, 155-161 (1970) (discussing the roots of the English Chancellor's parallel jurisdiction over infants and "idiots"); Lawrence B. Custer, *The Origin of the Doctrine of Parens Patriae*, 27 EMORY L.J. 195 (1978). Courts tend to use the "best interests of the child" standard in making decisions for infants under their supervision, appointing a guardian who serves as an officer of the court. See, e.g., *People ex rel. G.S.*, 820 P.2d 1178, 1180 (Colo. Ct. App. 1991); *In re D.L., Jr.*, 589 N.E.2d 680, 684 (Ill. App. Ct. 1992).

73. In *Quinlan I*, Judge Muir addressed whether Karen Quinlan's father had "standing to pursue a constitutional right on behalf of an infant," and found that the only cases where this was true involved "continuing life-styles." *Quinlan I*, 348 A.2d at 822 (citing *Wisconsin v. Yoder*, 406 U.S. 205 (1972); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923)).

The Supreme Court of New Jersey agreed with Judge Muir's holding that "there is no parental constitutional right that would entitle him to a grant of relief in *propria persona*." *Quinlan II*, 355 A.2d at 664. Thus Karen's constitutional rights alone were to be vindicated "by Mr. Quinlan as guardian." *Id.*

The Supreme Court of New Jersey's opinion also suggests that an individual's constitutional right to refuse medical treatment is not destroyed because she can no longer exercise that right due to incompetency; someone acting as guardian for the incompetent will exercise this right. *Id.* The Massachusetts Supreme Court later picked up the same thread, stating: "[T]he State must recognize the dignity and worth of [an incompetent] person and afford to that person the same panoply of rights and choices it recognizes in competent persons." *Saikewicz*, 370 N.E.2d at 428.

pain of watching a loved one linger on in misery, but that does not rob it of its authenticity.

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It went on for months and months, and because we live so far apart, my family had to keep vigil on the telephone. Over the years, this is how we have come to share our lives. We call each other often and talk the private language of our family. Distance does not have to defeat psychic intimacy.

With my mother, the interval of silence between calls is about two weeks long. If more time goes by, I do not feel right in my skin, always imagining the worst: maybe she has been devoured by the San Andreas fault; maybe she is ill, or depressed. When we finally do talk, it is a relief. At first, we cover the intervening weeks with broad, bold strokes of generality. Later, after assurances of reasonably good health, happiness, and terrestrial stability, we exchange bursts of fabulous details about what was said and what was worn and what was said and what was eaten. We say nothing of consequence. Rather, the words exchanged form a crazy quilt of velvet and cotton, of flower prints and moiré satin, joined together by metallic threads and rickrack, by the unfinished sentences of mother and daughter, and by their shared assumptions and history.

But when my father was sick, there was a new and horrible dimension to our conversations. I had to ask, and she had to answer, "How is Daddy?"

There were only two responses: "Just the same," or "Worse." Then there were the words of elaboration.

They were not words about my father. They were not words about the man who gave his children a sense of belonging in the world, a love of music, travel, and history. They were words about my father's body. About his broken, infected skin. About his bladder and his bowels. About what came out, and what went in. About how his hands had frozen into the shape of a garden trowel. About how he moaned all the time, like some miserable animal, beyond names, beyond faces, beyond recognition.

And yet, not beyond pain.

I hated those conversations, and I hated having to repeat them to my brother and sister on the telephone. They left all of us somber and silent. But as much as I hated those conversations, I knew we had to have them. The three of us needed to know what was going on and, more importantly, our mother

needed to tell us. Just as my father was wrapped in his own chrysalis of pain, separated from her by the gauze of disease and debilitation, so too was my mother in pain as she watched him die. It was not a pain to be borne alone.

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It is the pain of those elephants in Botswana who were reluctantly forced to desert the old dying cow in their search for food and water. It is the pain of agitated cetaceans who surround a distressed companion, or support his failing body at the surface of the water so that he may breathe. It is the pain of members of human deathwatches, those who gathered around the dying person's bed in Munch's painting, those who gather around the interminably ill person's bed in twentieth-century hospitals. It was the Quinlans' pain, and the Cruzans' pain. It was my mother's pain as she turned my father's body from side to side, over and over again. It was my pain, and the pain of my brother and sister.

But it is not a pain that the law is willing to recognize. Although the anguish of the members of the deathwatch may echo in the courthouse halls, we do not allow that anguish to penetrate the courtroom walls. It is a fiction held tightly into place by the mortar of another fiction. We pretend that we are listening to the voices of the silent curled up daughters; we make decisions to terminate the life-sustaining treatment in the name of their autonomy.<sup>74</sup> Our fictional attention to the words

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74. Autonomy basically means the right to be accorded the respect of others and to exercise free will in the sphere of personal action. Most of our notions of autonomy derive from Kantian philosophy. Kant based his theory on the rational being, or *vernunftwesen*, who exercised practical reason to legislate for himself according to his conception of law. IMMANUEL KANT, *FOUNDATIONS OF THE METAPHYSICS OF MORALS passim* (Lewis W. Beck trans., Bobbs-Merrill 1959) (1785).

In the context of health care, autonomy is the patient's right to make his own decisions regarding medical treatment. Tort law has developed two theories which seek to secure for the patient such self-determination. First, the law has concluded that a physician commits a battery when performing a medical procedure that goes beyond the scope of the patient's consent, thus becoming an intentional touching of a tortious nature. See, e.g., *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his body . . ."). The second doctrine, informed consent, is based on negligence. The issue here is whether the physician made a full and complete disclosure to the patient of all the possible risks of a procedure or treatment so that the patient could make a truly informed decision. See *Canterbury v. Spence*, 464 F.2d 772, 786-92 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972) (defining the scope of disclosure for physicians). Corollaries to this doctrine are the patient's right to refuse medical treatment based upon the information

of someone who is not there ensures another pretense: we do not hear the voices of those who are there, the members of the deathwatch. Their pain may exist as a matter of human psychology, but it does not find expression in pleadings, depositions, transcripts, briefs, or appellate decisions. And as far as

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provided and the duty of the health-care providers to respect the patient's choice. Through these tort theories, courts have recognized that patients should be protected from unwanted bodily intrusions. *Id.* at 781.

The other theory which ensures respect for the patient's choice regarding medical treatment is the constitutional right of privacy, first articulated in this context in *Quinlan II*. Some courts have refused to address the constitutional issue, and insist on relying exclusively on the common law right. *E.g., In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985) (stating that the court need not decide the constitutional issue because the common law right to self-determination encompasses the right to refuse medical treatment); *In re Storar*, 420 N.E.2d 64, 70 (N.Y.), *cert. denied sub nom. Storar v. Storar*, 454 U.S. 858 (1981) (same). In *Cruzan v. Director, Mo. Dep't of Health*, the Supreme Court determined that the due process clause of the Fourteenth Amendment created a constitutionally protected liberty interest that embraced the right to refuse unwanted medical treatment. 110 S. Ct. 2841, 2851 (1990). Thus a competent person has "a constitutionally protected right to refuse hydration and nutrition." *Id.* at 2852. These rights are not absolute, however, and must be weighed against the state's interests. *Id.* at 2853.

Courts have extended these common law and constitutional rights of self-determination to incompetent patients. The problem has been how to exercise such rights since some form of surrogate decisionmaking must be invoked. For a thorough discussion of the various tests governing termination of life-support systems from incompetent patients, see Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375 (1988) (criticizing the current tests used by courts and arguing for a family-based presumption in life-support decision-making); see also Linda Fentiman, *Privacy and Personhood Revisited: A New Framework for Substitute Decisionmaking for the Incompetent Incurably Ill Adult*, 57 GEO. WASH. L. REV. 801 (1989) (examining the state's role in health-care decisionmaking and defining the role individuals should have in those decisions).

One test, often used, is the doctrine of substituted judgment, in which the surrogate puts herself in the position of the incompetent patient and decides as he would decide under similar circumstances. It is a subjective test, seeking to determine not what most people would do under similar circumstances, but what this particular patient, if competent, would do. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT* 132-34 (1983) [hereinafter PRESIDENT'S COMMISSION]. For a discussion of the problems associated with the substituted judgment doctrine, see generally Allen E. Buchanan, *The Limits of Proxy Decisionmaking for Incompetents*, 29 UCLA L. REV. 386 (1981) (critiquing the current use of proxy decisionmakers and discussing difficulties that the substituted judgment standard may encounter); Louise Harmon, *Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment*, 100 YALE L.J. 1 (1990) (discussing the dangers presented by the doctrine); Walter M. Weber, *Substituted Judgment Doctrine: A Critical Analysis*, 1 ISSUES L. & MED. 131 (1985) (critiquing the theory and practice of the standard and proposing an alternative).

the law is concerned, if their pain does not find expression on the right pieces of paper, it does not exist at all.

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## II. PAINTIFFS, PROCEDURE, AND THE LIMITS OF LAW WISHES

In my first year of law school, I had a recurring problem. When I briefed cases, I could not remember who was the plaintiff and who was the defendant. The short hand versions of pi and delta were unfamiliar and did not help; they only added to my confusion. I was too embarrassed to reveal this rather fundamental deficiency to anyone, although now that I read answers to law school exams, instead of write them, I realize that my problem was not unique. At least once during each period of bluebook blues, I encounter a student who zealously analyzes an entire baroque fact pattern, confusing the plaintiff and the defendant.

In order to get straight who the plaintiff was, I used to remove the "l" from the word to create a new word: "Paintiff." Paintiffs were people who came to the courthouse in pain.<sup>75</sup> They had been hurt or injured somehow and were seeking a remedy. It was easy to find them in a tort case, with all that blood and torn tissue. In a property case, it was more difficult, probably because I did not own much at the time. Finding the paintiff in an easement case, for example, was hard for me. I had to mentally move into somebody's house and start walking all over the neighbor's yard, or else be walked all over. In Civil Procedure, I never did find the paintiff, which undoubtedly accounted for my poor performance in the course.<sup>76</sup>

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75. Actually, "pain" originally meant "suffering or loss inflicted for a crime or offense; punishment; penalty; a fine." 2 COMPACT EDITION OF THE OXFORD ENGLISH DICTIONARY 2054 (1971). It came from the Latin, "paena," which meant penalty or punishment.

If I had known my word derivations better, I would have picked the word "complain" as my heuristic device since its original meaning evokes the appropriate imagery. To "complain" meant to "give expression to sorrow or suffering." It also came from the Latin, "com" plus "plangere" meaning to lament or bewail, and originally meaning to strike or beat the breast or head in sign of grief. *Circa* 1450, "complain" also came to mean a "formal statement of a grievance to or before a competent authority; to lodge a complaint, bring a charge." 1 *id.* at 491.

76. Once I had mastered the task of finding the plaintiff, my next intellectual hurdle was to find the referents for the players in an appellate decision: the Appellant and the Appellee. (Just as torts were not filled with strawberries, there were no apples in judicial decisions.) In a sense, the appellant was a



I have carried the heuristic device with me over the years, asking of each case: Who is the plaintiff? Who is in pain? What is the nature of that pain? What caused that pain? What can or should the law do about that pain? Do I care about that pain?

My answer to that last question determines the degree of attention I will pay to a judicial decision. Fortunately, I am not a judge, but a curious reader of curious cases. I read them because I want to, not because I have to. A judge does not have that luxury. He cannot put down a pleading because he is uninterested in the plaintiff's pain; he must take every complaint seriously.<sup>77</sup>

Nor does the judge have the luxury of caring about the pain of peripheral players in a lawsuit.<sup>78</sup> The constraints that the rules of procedure impose do not permit the judge's empathy to graze in any pasture. He is confined by the artificial boundaries of the grievance, by the way in which the pain was packaged and presented.

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meta-plaintiff, someone who came into the appellate court in pain from the decision of the court below.

77. The judge has an obligation to engage in a "dialogue." Owen Fiss, *The Supreme Court 1978 Term, Foreword: The Forms of Justice*, 93 HARV. L. REV. 1, 13 (1979). Our law of civil procedure, as well as the law of evidence, determines what claims the judge must adjudicate, and what witnesses the judge must listen to in order to render his decision:

It is a dialogue with very special qualities: (a) Judges are not in control of their agenda, but are compelled to confront grievances or claims they would otherwise prefer to ignore. (b) Judges do not have full control over whom they must listen to. They are bound by rules requiring them to listen to a broad range of persons or spokesmen. (c) Judges are compelled to speak back, to respond to the grievance or the claim, and to assume individual responsibility for that response. (d) Judges must also justify their decisions.

*Id.*

78. A judge sometimes may consider, however, through a utilitarian analysis, the potential pain to the defendant if he would have exercised more care. Nuisance law provides an example. The *Restatement (Second) of Torts* suggests that, to determine whether "[a]n intentional invasion of another's interest in the use and enjoyment of land is unreasonable," a judge may consider whether "the gravity of the harm outweighs the utility of the actor's conduct." RESTATEMENT (SECOND) OF TORTS § 826 (1979). In determining the utility of the defendant's conduct, one factor that a judge may consider, apart from the social value of that conduct and its "suitability . . . to the character of the locality," is "the impracticability of preventing or avoiding the invasion." *Id.* § 828. Thus, the judge may consider how painful it would have been to the defendant to take the measures needed to avoid the harm or how painful it would be to require him to "carry on his activity with more skill or care or in a different manner or at a different time and thereby avoid a substantial part of the harm." *Id.* § 828 cmt. h.

The judge is fenced in by words, but I am not.

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Who are the plaintiffs in a case like *Quinlan* or *Cruzan*? It might be the silent, curled up daughters, but I doubt it. The question of whether a person in a semi-vegetative state feels pain would be answered, if at all, in a medical journal, not in a law review.<sup>79</sup> Of course, there is always an epistemological problem when we are talking about the pain of others. We can only truly know our own pain, and must infer the pain of others based on trust. We trust that when others wince, or cry, or say they are in pain, they are experiencing an agony akin to our own in similar circumstances.<sup>80</sup> Most of us do not let such

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79. Of course the question could also show up in an interdisciplinary journal. See Michael P. McQuillan, M.D., *Can People Who are Unconscious or in the "Vegetative State" Perceive Pain?* 6 ISSUES L. & MED. 373 (1991). McQuillan distinguishes "between pain as a particular kind of sensation and the affective response to pain that is called suffering." *Id.* at 377. McQuillan discusses various clinical dilemmas, such as whether the human neonate and fetus perceive pain, or whether a patient under general anesthesia or in a coma recalls painful physical touches or unpleasant sensations. *Id.* at 381-82. He concludes that

the pathways sufficient for the perception and modulation of pain need not rise nor descend to levels generally thought necessary for consciousness. Pain may be expressed not only in language, but also in autonomic and motor behavior that can be shown to correlate in a linear fashion with subjective pain sensation.

*Id.* at 383. Thus, we cannot rule out the possibility that an unconscious person, or one in a vegetative state, might perceive pain. *Contra* Ronald E. Cranford, M.D., *Termination of Treatment in the Persistent Vegetative State*, 4 SEMINARS IN NEUROLOGY 36, 40 (1984) (arguing that patients in a persistent vegetative state cannot perceive the pain of starvation or dehydration); Ronald E. Cranford, M.D., *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, HASTINGS CENTER REP., Feb.-Mar. 1988, at 26 (same).

See generally Francis J. Keefe & Laurence A. Bradley, *Behavioral and Psychological Approaches to the Assessment and Treatment of Chronic Pain*, 6 GEN. HOSP. PSYCHIATRY 49, 50 (1984) (describing a system of assessing a patient's pain based upon five "pain behaviors": guarding, bracing, rubbing, grimacing and sighing); Daniel N. Robinson, *Pain and Suffering: Psychobiological Principles*, in 3 ENCYCLOPEDIA OF BIOETHICS 1177, 1180-81 (Warren T. Reich ed., 1978) (discussing the differences between the issues of pain and suffering).

I should perhaps acknowledge here a certain crudeness in my use of the term "pain" with respect to the members of the deathwatch. In McQuillan's terms, I am actually referring more to their suffering—presumably psychic, emotional, and spiritual—although certainly that pain could manifest itself in physical sensations. The pain that the members of the deathwatch witness is the particular kind of physical sensation that is experienced by the dying person, whatever that sensation may be.

80. Sometimes this philosophical problem is referred to as "knowledge solipsism." C.D. Rollins, *Solipsism*, in 7 ENCYCLOPEDIA OF PHILOSOPHY 487,

philosophical quandaries get in the way of feeling the pain of others, however. We let empathy do the job that philosophy cannot handle.

But the pain of Karen Quinlan and Nancy Cruzan, if it ever existed, was so alien to us because it registered on a body that was no longer familiar. We could not crawl into their minds and feel at home there, the way we might crawl into the mind of another who is conscious and alert and inhabits a nervous system much like our own. If Karen Quinlan and Nancy Cruzan felt pain, it was not a pain that I can claim to understand. I can only respond on the level of abstraction: If they felt pain, whatever that might have meant to them, I too would have wanted that pain to come to an end. If they were in fact plaintiffs, their petitions should have been granted.

But it does not take much imagination to feel the pain of the members of Karen Quinlan's deathwatch, or of Nancy Cruzan's, or to appreciate how they were plaintiffs in their respective cases.<sup>81</sup> Perhaps it would help to have lived through a similar deathwatch, to have turned one's own father's body from side to side, over and over again. Perhaps, but it hardly seems a requisite to feeling empathy that we should have to wear the same shoes to understand the pressure of the leather—only that we should have the same kind of feet.

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487 (Paul Edwards ed., 1967). It differs from the more familiar form of solipsism, the metaphysical claim that only the self exists. *Id.* at 488. "Knowledge solipsism" is a much less radical claim that the self is the origin of the knowledge of existence. *Id.* "[I]t does not assert that there is one, and only one," source of knowledge. *Id.* at 490. Rather, it rules out the possibility that one could have direct knowledge of the sensations of others. *Id.* at 491. We can only know our own sensations, and our "knowledge" of the feelings of others must be indirect, based on probability or analogy. *Id.* at 490; see also JOHN WISDOM, *OTHER MINDS* (2d ed. 1965) (considering, through a series of essays, whether we ever know what anyone else is thinking, feeling, or experiencing).

81. In *Quinlan I*, the court heard evidence that Karen Quinlan herself understood the pain of the members of the deathwatch, at least before she lost her cognitive function. QUINLAN, *supra* note 54, at 209-13 (quoting from the trial transcript). Karen Quinlan's sister, Mary Ellen, testified regarding Karen's feelings about the deaths of two people who were well-known to her:

Karen was talking about Mr. Birch dying, and her girl friend's father dying. But when she talked to me, she was saying, in so many words, that she wouldn't want to be kept alive because she watched part of the family die, too. Not just the person who died legally. And she was saying that, like she was very good friends with this girl, and she watched what this girl went through—and that was what she was referring to, to me, when she said she wouldn't want to be kept alive.

*Id.* at 213.

One day last spring, I was at the beach with my friend. Actually, we were having lunch in the front seat of her car, a ferocious March wind having blown away our plan of eating with our feet in the sand. The sky was full of luminous, silver clouds; the water was choppy, slate gray.

I had been telling her about my concern for the families of Karen Quinlan and Nancy Cruzan, for the members of the deathwatch. "They are the ones in pain in those cases, not the patients. As far as anyone can tell, the patients are not even aware of their situations."

She knew what I was talking about, having gone through the prolonged death of her mother last year. "In some ways, what you say is right, of course," she said. "Look at my mother. Her dying almost killed my sister and me. Even though she was virtually gone, we still felt we had to go see her every night. Night after night, week after week, through those endless yellow halls, into that dark little room." She rested her sandwich on her lap and stared out at Long Island Sound through the car window. "And there she was, skin and bones, her mouth open, her eyes staring blankly at the wall." She picked up her sandwich and took a bite. "I don't know why we went at all," she mumbled. "She didn't even know we were there."

I did not respond, but left her in silence with her dredged-up pain. Then, after a while, I said, "You see what I mean, then. The pain in that situation didn't really belong to your mother, even though that is what the law pretends. If she had been on life-support systems, year after year, and you and your sister didn't feel you could stand it any more, keeping vigil over her in that awful situation, you would have to petition a court to withdraw the medical treatment. But you wouldn't petition in your own name. You'd have to bring the lawsuit in her name. Then the court would use a legal fiction called 'substituted judgment'<sup>82</sup> to make the lawsuit sound as if your mother

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82. The doctrine of substituted judgment appeared, in the context of medical decisionmaking, in *Quinlan I*, 348 A.2d 801, 819 (N.J. Super. Ct. Ch. Div. 1975), *modified and remanded*, 355 A.2d 647 (N.J.), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976). The court stated: "The assertion that Karen would elect, if competent, to terminate the respirator requires careful examination." *Id.* The need to use the legal fiction that Karen Quinlan was making the decision herself, that the court was merely placing itself in her place and acting as she would have acted in similar circumstances, stems from her incompetency and the court's desire to "afford to that [incompetent] person the same panoply of rights and choices it recognizes in competent per-

were doing the asking, even though the pain belonged to you and your sister—to the members of the deathwatch. The law doesn't directly confront your pain." I paused for a moment, coming up for air. "I hate that kind of pretense in the law."

She did not respond at first to my spate of words, but unwrapped a baggie of quartered apples. Then, because she is who she is, she sought refuge in the comforting impersonality of legal discourse, in the sanctuary of words that do not self-refer.

"You don't mean to suggest, do you, that we grant the members of the deathwatch some sort of legal recourse?"

I knew that her question was coming. There is a wonderful sameness to our friendship, to the patterns of what we say and what we do not say to one another. I start off by worrying about something. I keep it to myself. It lives inside me for a long time, slowly building pressure against the walls of my body, but never crossing the somatic boundary. Then, in the pale hours of one sleepless morning, it begins to pour out of my mouth and my nose and my ears like ectoplasm, like cool, white steam, and I try to hold it in my hand, to make it palpable, to give it shape, to find it a name.

Within a day or so, I bring my worry to her, crudely formed in new sentences, tentative and conditional, and it always sounds clumsy when it hits the air.<sup>83</sup> What does she do with it, this tender, fledgling expression of concern? She tries to cram it into "some sort of legal recourse." It is her way of

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sons." Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 428 (Mass. 1977).

83. Something always happens to my ideas when they move from the inside of my mind to the ears of another human being. I found a description of the same phenomenon while reading *The House at Pooh Corner*.

Eeyore had been bounced into the river, and Pooh had suggested that he throw a large stone into the water so that Eeyore would be washed to the shore. A.A. MILNE, *THE HOUSE AT POOH CORNER* 97-103 (Ernest H. Shepard illus., 2d prtg. 1961). The plan backfired. Eeyore claimed that he had to dive underwater to avoid being hit by the stone, and was critical of Pooh's idea. *Id.* at 102. Piglet tried to comfort Pooh:

"It's just Eeyore," said Piglet. "I thought your Idea was a very good Idea."

Pooh began to feel a little more comfortable, because when you are a Bear of Very Little Brain, and you Think of Things, you find sometimes that a Thing which seemed very Thingish inside you is quite different when it gets out into the open and has other people looking at it.

*Id.* My problem, I suspect, has something to do with being a Bear of Very Little Brain.

dealing with the unknown.<sup>84</sup>

"I don't know. I've just started thinking about it."

"Well, what sort of lawsuit do you think it would be? I mean, there has to be some sort of right that's being infringed upon." She was sputtering in that ineffable way that only those who teach law can sputter. "What kind of right do you want to give to the members of the deathwatch? And what kind of remedy are you going to grant them if someone infringes on that right?"

Socratic Sputter . . . . Pedagogical Sputter . . . . Critical Sputter. I was searching for the right kind of sputter.

"It's all well and good to talk about hating the legal fiction and having the law be honest and confront the real pain directly," she continued. "But you really have to give the lawsuit more structure than that. Define the harm done to the members of the deathwatch—your plaintiffs, as you call them—and decide what you want done about it."

Structural Sputter.

My friend is a great believer in the natural order of things. She needs to know that the plaintiff has a substantive right, and that for infringements of that right there is an ideal remedy. *Ubi jus, ibi remedium*.<sup>85</sup> I hear her humming over the breakfast dishes, carefully putting the plates on the dish drainer in descending order, the forks and spoons all facing the same way. Closely related to the dichotomy of right and remedy is the dichotomy of substance and procedure. It holds that procedure is distinct from substance. We use procedure as a means of fashioning the remedy, and the remedy, in turn, as a means of protecting against the infringement of the substantive right.<sup>86</sup> Her beliefs are motivated by a deep need for symmetry

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84. It may also be a way of justifying her own existence as a student and teacher of law. She needs the apparent neutrality and abstraction of legal rhetoric to create the illusion that law consists of a body of secret knowledge—secret knowledge that she has mastered and is now charged with the sacred duty of transmitting. For an excellent discussion of the critical legal scholars' critique of the mystifying function of legal rhetoric, see J. Paul Oetken, *Form and Substance in Critical Legal Studies*, 100 YALE L.J. 2209, 2213-16 (1991).

85. This nineteenth-century maxim means, literally, "where there is a right, there is a remedy." BLACK'S LAW DICTIONARY 1520 (6th ed. 1990); see also Robert G. Bone, *Mapping the Boundaries of a Dispute: Conceptions of Ideal Lawsuit Structure From the Field Code to the Federal Rules*, 89 COLUM. L. REV. 1 (1989) (exploring the normative values beneath the rhetoric of procedural reform and tracing the development of the rules that define the party structure of a lawsuit).

86. See, e.g., 1 JOHN N. POMEROY, A TREATISE OF EQUITY JURISPRUDENCE

and logical progression, by the sense of control that she derives from those little numbered boxes into which she puts her ideas. From a dish drainer properly used.

I drive her crazy with my messy mind, by the way I move unpredictably, and often irresponsibly, from thought to thought, making connections between wildly disparate things. Not only do I throw plates on top of knots of forks and spoons, but often I do not wash the dishes at all.

It is odd that we are such good friends, but we need each other. I need her to return to, to her model of social reality and legal order, to the comfort of her certitude. She needs me to depart from, to disturb.

And I was not sure whether the members of the death-watch needed either of us. It was something to think about on a windy March day.

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For a while, I stopped talking to my friend about the death-watch because some of my questions were philosophical. Not only does she not like to ponder philosophical questions, she does not like *me* to ponder philosophical questions.<sup>87</sup>

I started out trying to identify my paintiffs. In trying to determine who the members of the deathwatch might be, I found myself all alone at one end of the spectrum. That solitude itself prompted this question: Is the deathwatch of necessity a

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Secs. 90-91 (Spencer W. Symons ed., Lawyers' Co-op. Publishing Co. 1941) (1881).

87. I have often wondered why my friend does not like me to ask philosophical questions. I suspect that her fear is not for me, but for herself. Few people remember what happens in the end of *The Adventures of Alice in Wonderland*. After Alice wakes up, she tells her sister, who in the beginning of the story was reading a book with no pictures or conversations in it, all about her adventures in her "curious dream." LEWIS CARROLL, *THE ADVENTURES OF ALICE IN WONDERLAND* 192 (John Tenniel illus., MacMillan 1929) (1865). Alice then runs off, and her sister "sat still just as she had left her, leaning her head on her hand, watching the setting sun, and thinking of little Alice and all her wonderful Adventures, till she too began dreaming after a fashion." *Id.* at 194. She dreamed of Alice looking up at her before the dream had started, "and still as she listened, or seemed to listen, the whole place around her became alive with the strange creatures of her little sister's dream." *Id.* at 194-95. Suddenly, the sister's world became inhabited with a White Rabbit, a March Hare, the Queen of Hearts, a baby sneezing on a Duchess' knee, a shrieking Gryphon, a squeaking Lizard, a sobbing Mock Turtle, and "the choking of the suppressed guinea-pigs." *Id.* at 195. Maybe my friend is worried that like Alice and her sister, my dreams too will be infectious. She might herself slip into the unfamiliar, disturbing world of philosophic ruminations.

two-part relation? Could I be the only member of my own deathwatch, all alone in the forest, under falling trees, keeping a solitary vigil over my dying body?<sup>88</sup>

In some sense, and for a while, it seemed to me that I could. After all, the role of a dying person would be no different from the other roles that I have played. Since the first time I leaned over and apprehended that chasm between self and other, I have watched myself perform: the role of child; the role of mother; the role of student; the role of teacher. They are all different persons. Indeed, our idea of persons comes not only from seventeenth-century notions of moral agency, but also from a more ancient source, the Greek theatre.<sup>89</sup> "An actor dons masks, literally *per sonae*, that through which the sound comes, for the many roles he acts."<sup>90</sup>

Some roles I chose to play, and others were forced upon me, but inside, there is an inner self who sometimes takes part, and sometimes does not.<sup>91</sup> Pain and joy command her partici-

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88. The allusion here, of course, is to the famous hypothetical concerning whether a tree that falls in an empty forest makes a sound. George Berkeley (1685-1783) addressed this philosophical issue as he sought to refute a version of materialism, predominant in the seventeenth century, that argued that immediate objects of perception exist independent of the mind. In the *Three Dialogues*, Berkeley claims that sounds "have no real being without the mind." GEORGE BERKELEY, *THREE DIALOGUES BETWEEN HYLAS AND PHILONOUS* 22 (Colin M. Turbayne ed., Liberal Arts Press 1954) (1713). Once we conceive of any "thing," we bring it into a relationship with the percipient—ourselves—and thus Berkeley concludes that nothing can exist independent of the mind. *Id.* at 42. For a good explanation of Berkeley's theories, see H.B. Acton, *George Berkeley*, in 1 *ENCYCLOPEDIA OF PHILOSOPHY* 295 (Paul Edwards ed., 1967); Colin M. Turbayne, *Introduction to THREE DIALOGUES BETWEEN HYLAS AND PHILONOUS*, *supra*, at vii.

89. Amélie O. Rorty, *A Literary Postscript: Characters, Persons, Selves, Individuals*, in *THE IDENTITIES OF PERSONS* 301, 309 (Amélie O. Rorty ed., 1976).

90. *Id.*

91. George Herbert Mead observed the same phenomenon:

The self, as that which can be an object to itself, is essentially a social structure, and it arises in social experience. After a self has arisen, it in a certain sense provides for itself its social experiences, and so we can conceive of an absolutely solitary self. But it is impossible to conceive of a self arising outside of social experience. When it has arisen we can think of a person in solitary confinement for the rest of his life, but who still has himself as a companion, and is able to think and to converse with himself as he had communicated with others. That process to which I have just referred, of responding to one's self as another responds to it, taking part in one's own conversation with others, being aware of what one is saying and using that awareness of what one is saying to determine what one is going to say thereafter—that is a process with which we are all familiar.

GEORGE H. MEAD, *MIND, SELF AND SOCIETY* 140 (Charles W. Morris ed., 1934).



pation, but always she watches and listens. When I am alone and playing no role, she is there with me, and we talk up a blue streak.<sup>92</sup> She is my constant companion and the only witness to the various roles that I have come to play. Sometimes she writes under my name.<sup>93</sup>

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92. A blue streak is "something moving very fast," or "continuous, rapid, or interminable speech: to talk a blue streak." *RANDOM HOUSE DICTIONARY OF THE ENGLISH LANGUAGE* 229 (2d ed. 1987). Its parallel in the British vernacular is to "talk the hind leg off a donkey," which describes a victim of "logorrhea or logomania." *WILLIAM & MARY MORRIS, HARPER DICTIONARY OF CONTEMPORARY USAGE* 574 (2d ed. 1985). Logomania is "abnormal talkativeness," whereas logorrhea is "pathologically excessive and incoherent talkativeness." *WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY OF THE ENGLISH LANGUAGE* 1331 (1986).

In an essay on psychotic polar bears, Patricia Williams writes eloquently about the cacaphony of multiple voices, suggesting that their competition may foster personal growth and the discovery of new ideas:

It is also wise, I know, to maintain some consciousness of where I am when I am other than the voice itself. If the other voice in my head is really me too, then it means that I have shifted positions, ever so slightly, and become a new being, a different one from her, over there. It gets confusing sometimes, so I leave markers of where I've been, particularly if it's not just a voice but a place that I want to come back to in time.

PATRICIA WILLIAMS, *THE ALCHEMY OF RACE AND RIGHTS* 207-08 (1991). With respect to my own inner dialogue, we are definitely logomaniacal, and when worried, we suffer from logorrhea.

93. I found my own thoughts echoing in part of a poem that I read recently by Ray Bradbury:

I do not write—  
The other me  
Demands emergence constantly.  
But if I turn to face him much too swiftly  
Then  
He sidles back to where and when  
He was before  
I unknowingly cracked the door  
And let him out.  
Sometimes a fire-shout beckons him,  
He reckons that I need him,  
So I do. His task  
To tell me who I am behind this mask.  
He Phantom is, and I facade  
That hides the opera he writes with God,  
While I, all blind,  
Wait raptureless until his mind  
Steals down my arm to wrist, to hand, to fingertips  
And, stealing, find  
Such truths as fall from tongues  
And burn with sound,  
And all of it from secret blood and secret soul on secret ground.

RAY BRADBURY, "The Other Me," in *ZEN IN THE ART OF WRITING: ESSAYS ON CREATIVITY* 140-41 (1989). At the end of the poem, he asks:

Did R.B. write that poem, that line, that speech?

There is no doubt that she would attend at least the early stages of my deathwatch. But upon the disappearance of that inner self, the cessation of that private dialogue, someone else would have to see it through, to keep solitary vigil over my dying body. Otherwise, there would be no one to watch the death. I could die all alone in the forest, under falling trees, but I could not be the only member of my own deathwatch.

So I guess that by definition the deathwatch must be a two-part relation. There will always be one who watches, and one who is watched: one

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l and the other horizontal.

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I had settled in my own mind that the deathwatch must be a two-part relation;<sup>94</sup> at a minimum, there would always be one

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No, inner-ape, invisible, did teach.  
His reach, clothed in my flesh, stays mystery;  
Say not my name.  
Praise other me.

*Id.*

94. "This two-sidedness . . . is a fundamental feature of death—not only of the premature death of the spirit, but of death at any age and in any form. There are always two parties to a death; the person who dies and the survivors who are bereaved." Arnold Toynbee, *Epilogue to MAN'S CONCERN WITH DEATH*, *supra* note 25, at 257, 267. Those who strive to "deprive death of its sting" by holding that death is nothing more than an annihilation of the person who dies overlook the "crucial fact that, in a death, there are two parties to the event. . . . [M]an is a social creature; and a fact of capital importance about death's sting is that it is two-pronged." *Id.* at 270.

Dr. Cicely Saunders, founder of St. Christopher's Hospice in London, prefers to invoke the words spoken in the Garden of Gethsemane, "Watch with Me," to capture the needs of the dying. Cicely Saunders, *Watch With Me*, 61 *NURSING TIMES* 1615, 1615 (1965). Her version of the deathwatch is more communal; the dying person and the members of the deathwatch are in collaboration, or at least witness the arrival of death together.

I have tried to sum up the demands of this work we are planning in the words "Watch with Me." Our most important foundation for St. Christopher's is the hope that in watching we should learn not only how to free patients from pain and distress, how to understand them and never let them down, but also how to be silent, how to listen and how just to be there.

*Id.* at 1617.

who watches, and one who is watched. But that statement marked both the beginning and end of certainty. Beyond the notion of a two-part relation, I had to deal with probability. How was I going to identify who the watchers and the watched might be?

More likely than not, the dying member of the deathwatch would be a single individual. Of course, there have been instances of corporate death throughout history, due to natural disasters or the cruelty of man.<sup>95</sup> In our own century, the scale of slaughter during warfare has grown to appalling proportions.<sup>96</sup> When the number of those dying increases substantially, the deathwatch becomes a social convention that must give way to utility. Contemporary accounts of the bubonic, pneumonic, and septicaemic plagues of fourteenth-century Western Europe and Asia, for example, often remarked upon the disappearance of the deathwatch.<sup>97</sup> In some instances, the

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95. There is an entire body of literature on the deathwatches of the Holocaust. One of the most painful pieces to read is Elie Wiesel's *The Death of My Father*. Wiesel, present at his father's death in Buchenwald, found no solace in the circumstances of his father's death or the deathwatch imposed upon him as the survivor:

His death did not even belong to him. I do not know to what cause to attribute it, in what book to inscribe it. No link between it and the life he had led. His death, lost among all the rest, had nothing to do with the person he had been. It could just as easily have brushed him in passing and spared him. It took him inadvertently, absent-mindedly. By mistake. Without knowing that it was he; he was robbed of his death.

ELIE WIESEL, *The Death of My Father*, in LEGENDS OF OUR TIME 1, 2 (1968). In a sense, Wiesel describes a failed death and a failed deathwatch.

96. From the late seventeenth century through the beginning of the twentieth, Westerners abided by "relatively humanitarian" standards for the conduct of war. Arnold Toynbee, *Death in War*, in MAN'S CONCERN WITH DEATH, *supra* note 25, at 145, 148. Those standards plummeted when the Germans invaded Belgium in August of 1914, as civilians were no longer spared from the atrocities of war. *Id.* Horror "swept across the Western world" in 1937 with the bombing of Guernica, Spain, which indiscriminately made victims of civilians of all ages. The bombings of the Second World War, however, dwarfed those of the First World War and the period succeeding. *Id.* Sadly, those bombings "caused less perturbation. For producing a shock, atrociousness, by itself, is not enough; there must also be novelty." *Id.*

97. See generally PHILIP ZIEGLER, *THE BLACK DEATH* (1969) (synthesizing both contemporary accounts of the medieval plagues and the analyses of modern scholars to present the origins, spread, and social and economic impact of the plagues in Western Europe). Cf. DANIEL DEFOE, *A JOURNAL OF THE PLAGUE YEAR* 99-100 (Louis Landa ed., Oxford Univ. Press 1969) (1722) (describing the effect of the Great Plague of 1665 on the deathwatch). Because of the risk of infection, no one wanted to participate in deathwatches, and sick people wandered into the countryside to die alone:

It was known to us all that abundance of poor despairing Creatures,

deathwatch had to be legislated against, to impede the spread of disease.<sup>98</sup> But while there have been many instances of corporate death throughout history, that is not the norm. Most of us will die alone, and those are the deathwatches that I am interested in, with one individual lying down. After all, as with our births, we tend to die seriatim.

More likely than not the other part of the relation, those who watch, will also consist of more than one person. It will probably be a group. A group is defined as a "number of individuals assembled together or having some unifying relationship."<sup>99</sup> But beyond this nebulous definition, how do we determine what individuals are in that number? What does it

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who had the Distemper upon them, and were grown stupid or melancholy by their Misery, as many were, wandred [sic] away into the Fields, and Woods, and into secret uncouth Places, almost any where to creep into a Bush, or Hedge, and Die.

*Id.* at 100. Defoe described the plague's disastrous effect on the birth-watch as well:

[O]ne of the most deplorable Cases in all the present Calamity was that of Women with Child; who when they came to the Hour of their Sorrows, and their Pains came upon them, cou'd neither have help of one Kind or another; neither Midwife or Neighbouring Women to come near them . . . .

*Id.* at 115-16.

98. For example, an Italian statute mandated isolation of the dying and prohibited others from nursing them:

Everyone sick of the plague is to be brought out of the town to the fields, there to die or recover. Those who have nursed plague patients are to remain secluded for ten days before having intercourse with anyone. The clergy are to examine the sick and report to the authorities on pain of being burnt at the stake and confiscation of their possessions. Those who introduce the plague shall forfeit all their goods to the State. Finally, with the exception of those set apart for the purpose, no one shall administer to those sick of the plague on pain of death and forfeiture of their possessions.

JOHANNES NOHL, *THE BLACK DEATH: A CHRONICLE OF THE PLAGUE COMPILED FROM CONTEMPORARY SOURCES* 73 (C.H. Clarke trans., abr. ed. Unwin Books 1961) (1924).

99. WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 539 (1990).

The term "group" may be used, in sociology and anthropology, in at least two ways. Elizabeth Bott, *Urban families: Conjugal Roles and Social Networks*, 8 HUM. REL. 345, 347 n.3 (1955). In one sense, it can "describe any collectivity whose members are alike in some way." *Id.* In a more narrow sense, and in the sense that I am using the term here, "group" refers to units that "have some distinctive interdependent social relationships with one another," i.e., organized groups. *Id.* In an organized group, the individual members "make up a larger social whole with common aims, interdependent roles and a distinctive subculture." *Id.* at 347. Presumably a deathwatch constitutes an organized group, in the sense that its members have a common aim, but it would be fleeting in duration and possess no formal governing structure.

mean to assemble?<sup>100</sup> What is the unifying relationship? Is there some organizing principle for their identification? And even if we could identify the members of the deathwatch, what would the law have to do with that entity?

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At first, I decided that I could always rely upon the nuclear family as my organizing principle.<sup>101</sup> At the deathwatch, I

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100. For example, are public executions a form of deathwatch? For a history of public executions, see MICHEL FOUCAULT, *DISCIPLINE AND PUNISH* 32-69 (Alan Sheridan trans., Pantheon Books 1977). Consider how many qualities of a private deathwatch are present in this description of a hanging:

Death by hanging, like most kinds of death in the eighteenth century, was public. Not isolated from the community or concealed as an embarrassment to it, the execution of the death sentence was made known to every part of the metropolis and the surrounding villages. On the morning of a hanging day the bells of the churches of London were rung buffeted. The cries of hawkers selling ballads and 'Last Dying Speeches' filled the streets. The last preparations for death in the chapel at Newgate were open to those able to pay the gaoler his fee. The malefactor's chains were struck off in the press yard in front of friends and relations, the curious, the gaping and onlookers at the prison gate. The route of the hanging procession crossed the busiest axis of the town at Smithfield, passed through one of the most heavily populated districts in St. Giles's and St. Andrew's, Holborn, and followed the most-trafficked road, Tyburn Road, to the gallows. There the assembled people on foot, upon horseback, in coaches, crowding near-by houses, filling the adjoining roads, climbing ladders, sitting on the wall enclosing Hyde Park and standing in its contiguous cow pastures gathered to witness the hanging.

Peter Linebaugh, *The Tyburn Riot Against the Surgeons*, in DOUGLAS HAY ET AL., *ALBION'S FATAL TREE* 65, 67 (1975).

In our own century, and outside the context of criminal punishment, the media will publicize a deathwatch. Have all those who read or hear about the event in some sense "assembled" and become members of the deathwatch? In the early 1970s, the horrors of toxic poisoning were being discovered in the fishing and farming town of Minamata on the southern Japanese island of Kyushu. W. EUGENE SMITH & AILEEN SMITH, *MINAMATA* (1975). "[P]arades of politicians and governmental environmentalists would move rapidly from home to home among a select few patients, bowing, listening, looking sad and moving on. All this was dutifully and 'objectively' recorded by reporters and cameramen." *Id.* at 61. The photograph of a cluster of cameramen and politicians around the bed of a man dying from Minamata Disease is incredibly moving, indeed as are all the photographs in this remarkable book. *Id.*

101. "The term *nuclear family* refers to a unit consisting of husband, wife, and dependent offspring. The nuclear family is generally contrasted with the *extended family*, typically a residential unit composed husband, wife, dependent offspring, and married sons and their spouses and offspring." Michael Gordon, *Introduction to THE NUCLEAR FAMILY IN CRISIS: THE SEARCH FOR AN ALTERNATIVE 1* (Michael Gordon ed., 1972) [hereinafter *NUCLEAR FAMILY IN CRISIS*].

Sociological literature often uses these terms more loosely, however. *Id.* at 1-2. For example, a nuclear family that happens to have other adult mem-

would get out a piece of yellow chalk and draw a circle on the floor around the spouse and the children, or the mother and father and the dying person's siblings.<sup>102</sup> All the other members

bers residing with them (besides the mother and father, such as an unmarried sibling of one of the parents, or a widowed parent or grandparent), may be labeled an "extended family." *Id.*

102. Many other commentators have argued that the family should decide whether to terminate life-support systems. See, e.g., Corrine Bayley, *Who Should Decide?*, in *LEGAL AND ETHICAL ASPECTS OF TREATING CRITICALLY AND TERMINALLY ILL PATIENTS* 3, 9 (A. Edward Doudera and J. Douglas Peters eds., 1982) [hereinafter *LEGAL & ETHICAL ASPECTS*]; Richard P. Byrne, *Deciding for the Legally Incompetent: A View From the Bench*, in *LEGAL & ETHICAL ASPECTS*, *supra*, at 25, 25; cf. Robert M. Veatch, *Limits of Guardian Treatment Refusal: A Reasonableness Standard*, 9 AM. J.L. & MED. 427, 441-42 (1983) (arguing that "bonded guardians," who may be family or close friends of the patient, should make decisions). This deference to family decisionmaking reflects a long tradition of noninterference by the state in family matters. Martha Minow, *The Role of Families in Medical Decisions*, 1991 UTAH L. REV. 1, 13-14. I italicize the term "long" because the view of the family as a sphere of privacy and autonomy is primarily a product of the nineteenth century. See generally LAWRENCE STONE, *THE FAMILY, SEX AND MARRIAGE IN ENGLAND: 1500-1800* (1977) (arguing that in earlier centuries, the state did not perceive distinct boundaries between the family and society and intervened more directly in family life).

Notions of familial privacy and a tradition of noninterference in the family developed from a broader nineteenth-century tradition of liberal individualism, as embodied in John Stuart Mill's Harm Principle:

[T]he principle requires liberty of tastes and pursuits; of framing the plan of our life to suit our own character; of doing as we like, subject to such consequences as may follow: without impediment from our fellow-creatures, so long as what we do does not harm them, even though they should think our conduct foolish, perverse, or wrong. . . .

....  
The only freedom which deserves the name, is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it. Each is the proper guardian of his own health, whether bodily, or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest.

JOHN STUART MILL, *ON LIBERTY* 11, 14 (David Spitz ed., Norton Books 1975) (1859).

Expanding Mill's principle from the individual to the family, however, has some inherent conceptual difficulties. In particular, the meaning of "harm to others" is unclear in a context in which, by definition, there are interpersonal relations. Carl E. Schneider, *Moral Discourse and the Transformation of American Family Law*, 83 MICH. L. REV. 1803, 1840 (1985). Any time the law deals with one person's relationship to another, there is the risk of harm to others. Schneider argues that "not only are there many opportunities within families to harm other members; there are many incentives," including psychological and "financial interest[s] in a decision adverse to the interests of other family members." *Id.*

The constitutional right of privacy, discovered in the Fourteenth Amendment and the penumbrae of the Bill of Rights, derives in part from legal prin-

of the deathwatch who might be gathered around the bed would be outside the circle; their toes would be covered with the yellow dust of exclusion. I would not let them sue because of their tenuous relationship with the dying person.

That sounded like a good rule to me, both for its apparent simplicity and accuracy. Simple because of its ease of application: To find the potential plaintiffs, a court would only have to consult a roughly-hewn family tree. Accurate because in *Quinlan* and *Cruzan*, the two most famous cases, the moving parties had been the parents of the dying person, even if the siblings had been left out. It seemed like a harmless expansion to include the brothers and sisters in such a lawsuit, and if the dying person were married, it seemed appropriate to look to the spouse and children too.

When I was learning how to sew, my mother used to complain that I could complicate anything. Any time a single stranded thread presented itself in a furrow of fabric, my fingers would mysteriously find a way to turn that single stranded thread into an octopus with snarled limbs.

Sartorially speaking, she was right. Later she used to accuse me of the same tendency in my everyday dealings with life. I could start out with a single-stranded choice of what to order for lunch, and my mind would mysteriously find a way to turn it into a tangled moral choice about eating meat.

Philosophically speaking, she was wrong. I did not create that knot of threads; it had been there long before I opened the menu. The difference was that I had seen the knot, and perhaps because the threads lay close together, she had seen only a single strand. What looked to her like filial alchemy was in fact just her misperception of the problem's simplicity.

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ciples relating to the family. *Griswold v. Connecticut*, 381 U.S. 479, 486 (1965) (finding that privacy rights in the marriage relationship are "older than the Bill of Rights"). The privacy doctrine has "some extension to activities relating to marriage . . . procreation . . . contraception . . . child rearing and education." *Roe v. Wade*, 410 U.S. 113, 152-53 (1973) (citing, respectively, *Loving v. Virginia*, 388 U.S. 1, 12 (1967); *Skinner v. Oklahoma*, 316 U.S. 535, 541-42 (1967); *Eisenstadt v. Baird*, 405 U.S. 438, 453-54 (1972); *Pierce v. Society of Sisters*, 286 U.S. 510, 535 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923)); see also *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 69 (1976) (holding that "the State may not constitutionally require the consent of the spouse . . . as a condition for abortion during the first 12 weeks of pregnancy"). The law still uses a "rights approach" in these cases, however, regarding the family as a collection of individuals. See Robert A. Burt, *The Constitution of the Family*, 1979 SUP. CT. REV. 329, 331 (characterizing the Court's role with respect to the family as "addressing conflicting claims of individual and community, of liberty and authority.").

So it was with the circle on the floor around the nuclear family. The longer I lived with that organizing principle, the more the problem increased in complexity, and as my fingers discovered the density of the knot, I came to appreciate the crudeness of my solution. What had seemed like a rule endowed with the virtues of simplicity and accuracy turned out to be an unyielding formal abstraction that flew in the face of reality.<sup>103</sup>

By looking at the other deathwatch cases, the other cases in which pleadings were made to terminate life-support systems, I became convinced that my yellow chalk line was a useless convention. Some of those people who participated most intensely in deathwatches were not members of the dying person's nuclear family.<sup>104</sup> Some of those dying persons did not have any members of the nuclear family to gather around them;<sup>105</sup> at times it was difficult to find a family member who

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103. One scholar notes that "the concept of the family is culturally determined and subject to ethnic and cultural variations." Walter O. Weyrauch, *The Family as a Small Group*, in *GROUP DYNAMIC LAW: EXPOSITION AND PRACTICE* 153, 154 (David A. Funk ed., 1988).

Legally, a family group may be based on consanguinity, or affinity by marriage alone; but there may be *de facto* relationships also, without blood relationship or marriage, and these may or may not be legally recognized. . . . [S]mall group classifications, regardless of whether they originate in psychology, sociology, or anthropology, do not necessarily coincide with legal classifications. . . . [L]egal classifications [of family] tend to be more narrow and rigid than group classifications. . . . [They are] "cerebral" . . . [a]bstract and relatively removed from specific factual situations.

*Id.* at 155-56.

104. See, e.g., *In re Storar*, 420 N.E.2d 64 (N.Y.), *cert. denied sub nom. Storar v. Storar*, 454 U.S. 858 (1981) (local director of 83-year-old incompetent patient's religious order applied to be appointed committee of his person and property, with authority to remove the respirator; patient's 10 nieces and nephews supported application); *In re Conroy*, 486 A.2d 1209 (N.J. 1985) (nephew, only surviving blood relative, appointed guardian of 84-year-old incompetent aunt whom he had known for over 50 years and had visited once a week for four or five years); *In re Peter*, 529 A.2d 419 (N.J. 1987) (friend who had lived with patient for several years and whom patient had previously authorized to consent to medical treatment sought appointment as guardian and approval of state Ombudsman for the Institutionalized Elderly for withdrawal of medical treatment); *In re Browning*, 568 So. 2d 4 (Fla. 1990) (second cousin, and only living relative, of incompetent patient sought guardianship and petitioned for authority to terminate artificial feeding).

105. See, e.g., *In re Hier*, 464 N.E.2d 959 (Mass. App. Ct. 1984) (incompetent 92-year-old patient, in a psychiatric hospital for 57 years, represented by court-appointed temporary guardian; no mention of any family members); *In re Hamlin*, 689 P.2d 1372 (Wash. 1983) (hospital and guardian petitioned to terminate life-support systems for patient, retarded from birth, who had no relatives or close friends with whom medical staff could consult). These patients



cared enough to come forward to serve the role of procedural plaintiff.<sup>106</sup> And in other instances, there were bitter conflicts over who would be a member of the deathwatch and who would not: instances where members of the nuclear family sought to exclude others from the circle who could not claim consanguinity.<sup>107</sup>

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had both been mentally disabled and institutionalized for a long period of time and, therefore, were not part of any social network. Their personal histories almost guaranteed that no one would be present for their deathwatches.

In a beautiful essay, Kathryn Montgomery Hunter confronted the problem of decisionmaking for a homeless patient, William T., who "lost contact with his family; he was lost to work and friends and a home before he was through adolescence." Kathryn M. Hunter, *Limiting Treatment in a Social Vacuum: A Greek Chorus for William T.*, 145 ARCHIVES INTERNAL MED. 716, 719 (1985). She suggested the image of a Greek chorus, consisting of all those in the hospital who have cared for him: the attending physicians, residents, nurses, and other personnel. *Id.* at 718. In the absence of any family and in the context of ample resources, this informal, ad hoc group would assemble to advise William T's attending physician. *Id.*

William T.'s life intersects the lives of those who hoped to cure, who never meant to become gatekeepers to medical care or arbiters of death. Some of them believe their care was wasted on William; some believe it was their duty. Some believe both things at once. For their own well-being and the well-being of their profession, a ritual that takes note of these intersecting lives and crossed purposes is required. We cannot ask for one better than that which served Sophocles and his inescapably tragic view of human life.

*Id.* at 719.

106. See, e.g., *Rasmussen v. Fleming*, 741 P.2d 674, 679 (Ariz. 1987) (en banc) (incompetent patient represented by public fiduciary; three siblings "did not take an active role in the determination of Rasmussen's treatment, they expressed a willingness to abide by the decision to place DNR and DNH orders on Rasmussen's medical chart"); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 420 (Mass. 1977) (superintendent of institution where mentally retarded 67-year-old patient had lived for almost 50 years petitioned for appointment of guardian ad litem with authority to make medical treatment decisions regarding his leukemia: "Two of his sisters, the only members of his family who could be located, were notified of his condition and of the hearing, but they preferred not to attend or otherwise become involved"); *In re Torres*, 357 N.W.2d 332, 335-37 (Minn. 1986) (incompetent patient represented by court-appointed conservator and court-appointed counsel; a first cousin testified he saw patient "at least once a week"); *In re Ingram*, 689 P.2d 1363 (Wash. 1984) (attorney for son of incompetent patient petitioned court for authorization to perform needed cancer surgery which patient opposed having).

107. See, e.g., *In re Kowalski*, 382 N.W.2d 861 (1986). Sharon Kowalski, a 27-year-old woman, suffered brain damage from a car accident. Kowalski currently lives in a nursing home; she has the mental capacity of a four- to six-year-old child, and her ability to communicate is severely limited. She often gives inconsistent responses to questions. Kowalski's family and her roommate of four years, Karen Thompson, have litigated extensively over the issues of guardianship and visitation. Thompson and Kowalski "had exchanged rings, and named each other as beneficiary in their life insurance policies." *Id.*

At first glance, *Quinlan* and *Cruzan* may have looked like the norm, but upon closer scrutiny that was an illusion. As with so many aspects of human relations, there really was no norm, or what was passed off as the norm turned out to be someone's unarticulated aspiration.<sup>108</sup> This did not mean there

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at 863. Thompson characterized their relationship as lesbian, although Kowalski's parents were not aware of the nature of the relationship, nor had Kowalski "admitted it prior to the accident." *Id.*

Both Thompson and Kowalski's father, Donald, petitioned for guardianship. The probate court appointed Donald Kowalski, but granted both parties equal visitation rights, access to financial and medical records and the right to confer with Kowalski's financial and medical overseers. The relationship between Thompson and Kowalski's family deteriorated, however, and eventually the trial court terminated Thompson's access to Kowalski's records and overseers. The trial court also gave Donald Kowalski the power to limit visitations, and he immediately terminated Thompson's visitation rights, based primarily on expert psychiatric testimony that Kowalski became depressed after Thompson's visits. *Id.* at 864.

On appeal, Karen claimed that her confidential relationship with the ward, which was essentially that of spouse, warranted her appointment as guardian. The Minnesota Court of Appeals, however, upheld the trial court's appointment of the father as guardian, including his power to determine who might visit his daughter. Thompson later brought another appeal, and lost that round as well. *In re Kowalski*, 392 N.W.2d 310 (1986).

Recently the Minnesota Court of Appeals granted guardianship of Sharon Kowalski to Karen Thompson. *In re Kowalski*, 478 N.W.2d 790, 797 (Minn. Ct. App. 1991). In 1990, "Mr. Kowalski resigned his guardianship, citing heart problems and weariness with the extended court proceedings." Tamar Lewin, *Disabled Woman's Care Given to Lesbian Partner*, N.Y. TIMES, Dec. 18, 1991, at A26. The trial court had granted guardianship to a "neutral" third person in an effort to allay hostilities between Kowalski's family and Thompson. 478 N.W.2d at 794. The Court of Appeals set aside the appointment, holding that the trial court abused its discretion in denying Thompson's petition for guardianship. *Id.* at 794-95. The court found that "Sharon has the capacity reliably to express a preference . . . and she has clearly chosen to return home with Thompson if possible. This choice is further supported by the fact that Thompson and Sharon are a family of affinity, which ought to be accorded respect." *Id.* at 797.

108. Some have argued that the ideal of the nuclear family is an anachronism as well. Colonial families were "extensions of the larger community" and also served as the primary unit of economic production, education, and socialization of the young. Lee E. Teitelbaum, *Moral Discourse and Family Law*, 84 MICH. L. REV. 430, 435 (1985). The same was true of the preindustrial family in England. In the mid-eighteenth century, "work, religion, recreation, and amusements were confined to a small, relatively undifferentiated community." NEIL J. SMELSER, *SOCIAL CHANGE IN THE INDUSTRIAL REVOLUTION: AN APPLICATION OF THEORY TO THE BRITISH COTTON INDUSTRY* 183 (1959).

The introduction of factory methods of production and the move from the country to the cities led the father, and later the mother, to work outside the home. This decline of domestic economic production meant that public authorities assumed increasing responsibility for the education and socialization of the young. Teitelbaum, *supra*, at 436. Others have taken on most of the

were no deathwatches with members of the nuclear family in close attendance. Most were.<sup>109</sup> It just meant that the scene with the members of the nuclear family gathered around the dying person's bed was only the most common of the many kinds of deathwatches. And by drawing the chalk circle at those heels, and those heels only, the state would be implicitly sanctioning one pattern of family life and punishing all others.

I did not want any part of a project like that. Even though I came from a nuclear family much like the Quinlans and the Cruzans, I can see that there are many kinds of gardens to grow in, and that human love and intimacy can flourish in any kind of soil<sup>110</sup>—or in no soil at all, like stubborn moss in the

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traditional functions of the family, and the ideal family of the eighteenth century has become little more than a romanticized social construction.

Clearly, the constituency of the modern family has changed. For example, the percentage of single-parent families is steadily increasing. The United States Census Bureau's 1985 estimates indicated that more than one out of five American families with children were single-parent families. Alan L. Otten, *Deceptive Picture: If You See Families Staging a Comeback, It's Probably a Mirage*, WALL ST. J., Sept. 25, 1986, at 1. In 90% of these, the head of the household was a woman. *Id.* The Census Bureau also indicated that in 1986 just eight percent of households in the United States consisted of "traditional family units" in which the parents were married for the first time. Roberta Ostroff, *Growing Up Behind Locked Doors: A Look Inside America's Hidden System of Teen Control*, ROLLING STONE, Nov. 20, 1986, at 71, 76.

There have been many excellent recent contributions to the history of families and family law. See, e.g., MICHAEL GROSSBERG, *GOVERNING THE HEARTH: LAW AND THE FAMILY IN NINETEENTH CENTURY AMERICA* (1985); STONE, *supra* note 102; Martha Minow, "Forming Underneath Everything that Grows": *Toward a History of Family Law*, 1985 WIS. L. REV. 819; Lee E. Teitelbaum, *Family History and Family Law*, 1985 WIS. L. REV. 1135.

109. Spouses of the dying person brought the largest number of cases. See, e.g., *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921 (Fla. 1984) (wife); *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626 (Mass. 1986) (wife); *In re Farrell*, 529 A.2d 419 (N.J. 1987) (husband); *In re Colyer*, 660 P.2d 738 (Wash. 1983), *overruled by In re Hamlin*, 689 P.2d 1372 (Wash. 1984) (husband).

110. People in the industrial West from traditional nuclear families often assume that this family structure is universal. Scholars, however, have debated that issue. George P. Murdock, for example, argued that the nuclear family was not only universal, but typically had four functions: sexual, economic, reproductive, and educational. GEORGE P. MURDOCK, *SOCIAL STRUCTURE* 2-3 (1949). Murdock defined the family as "a social group characterized by common residence, economic cooperation, and reproduction" that includes "adults of both sexes, at least two of whom maintain a socially approved sexual relationship, and one or more children, own or adopted, of the sexually cohabiting adults." *Id.* at 1. It sounds a great deal like *Leave it to Beaver*.

Anthropologist Melford Spiro's study of kibbutz life in Israel challenged Murdock's assumptions. Spiro initially concluded that, at least in a familial society like the kibbutz, the nuclear family could be eliminated. Melford E. Spiro, *Is the Family Universal—The Israel Case*, 56 AM. ANTHROPOLOGIST 839

cracks of city sidewalks, or graceful epiphytes suspended in air. To exclude from the deathwatch those who have truly loved the dying person, just because their names cannot be painted on a family tree, seemed not only arbitrary, but an act of cruelty.<sup>111</sup> There had to be some other organizing principle, some

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(1954), reprinted in *NUCLEAR FAMILY IN CRISIS*: *supra* note 101, at 81, 89. Spiro later altered his interpretation of the data from the kibbutz study, concluding that the strong role of the nuclear family in the socialization of children required a reconsideration of his previous conclusion that "marriage and the family are not universal." Melford E. Spiro, *Addendum, 1958*, in *A MODERN INTRODUCTION TO THE FAMILY* (Norman Bell & Ezra Vogel eds., 1968), reprinted in *NUCLEAR FAMILY IN CRISIS*, *supra* note 101, at 89, 92.

111. If courts apply formal, abstract legal classifications, such as those defining "family," regardless of the reality of group dynamics, "the impact of this is felt by the persons concerned as being severely damaging, if not disastrous. In other words, a result supported only by law is likely to be perceived as inhumane and unjust." Weyrauch, *supra* note 103, at 156. Homosexual partners who are in permanent, monogamous relationships certainly must perceive the law this way.

Given the Supreme Court's holding in *Bowers v. Hardwick*, 478 U.S. 186 (1986), it is unlikely that the Court will recognize family groups consisting of homosexual partners any time soon. *Hardwick* challenged the constitutionality of a Georgia sodomy statute which he had been charged with violating for engaging in oral sex with another consenting adult in the privacy of his home. *Id.* at 187-88. The Court framed the issue as "whether the Federal Constitution confers a fundamental right upon homosexuals to engage in sodomy." *Id.* at 190. "Six decades of privacy precedents from *Meyer v. Nebraska* and *Skinner v. Oklahoma* to *Griswold v. Connecticut* and *Roe v. Wade* were dismissed in two brisk paragraphs as having no relevance to this issue, since those cases involved rights related to 'family, marriage or procreation.'" LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 15-21, at 1422 (2d ed. 1988) (quoting *Bowers*) (citations omitted).

Sometimes when things are darkest in federal constitutional jurisprudence, hope flickers in the state courts. Consider the case of *Braschi v. Stahl Assocs.*, 543 N.E.2d 49 (N.Y. 1989). *Braschi* examined a New York City rent and eviction regulation providing "that upon the death of a rent-control tenant, the landlord may not dispossess 'either the surviving spouse of the deceased tenant or some other member of the deceased tenant's family who has been living with the tenant.'" *Braschi*, 543 N.E.2d at 50 (quoting 9 NYCRR 2204.6(d)) (emphasis supplied by the court). The appellant had lived with a rent-controlled tenant for over 10 years as a "permanent life partner." They regarded one another, and were regarded by friends and family, as spouses. The two men regularly visited each other's families and attended family functions together. *Id.* at 55. Furthermore, they shared finances and the appellant was the beneficiary under the statutory tenant's life insurance policy and will. On the tenant's death, the landlord served the appellant with a notice to terminate since he was not a family member of the decedent. The Court of Appeals concluded that the term family

should not be rigidly restricted to those people who have formalized their relationship by obtaining . . . a marriage certificate or an adoption order. The intended protection against sudden eviction should not rest on fictitious legal distinctions or genetic history, but instead should find its foundation in the reality of family life.

other way of determining who should be able to bring their pain to the court's attention, and who should not.

I was finding no answers in the law. Then one day while hiding in a colleague's kitchen at a party, I broke the cardinal rule of academic socializing—Thou Shalt Not Discuss Ideas—and vented my frustration. Someone casually suggested that I look into “network theory” in sociology.<sup>112</sup> Maybe the members of the deathwatch did not belong to a nuclear family, but instead belonged to a network. Maybe that was a way to figure out who deserved to be the plaintiffs in my lawsuit, and who did not, by throwing a net into the sea.

So I read up on networks. It was not a very productive inquiry, probably due to my lack of expertise and my visceral reaction to the ugliness of sociological prose. But it did lead me to some literature about the characteristics of the interactional process. This literature suggested a different kind of organizational principle, based not on status, but on the content, directedness, durability, intensity, and frequency of the interaction between the dying person and the member of the deathwatch.<sup>113</sup>

Maybe I could convince judges to sit down and look not at the formal relationship the two parties bore to one another, but at their behavior towards one another. Thus siblinghood, for example, would not qualify a potential plaintiff, but a history of mutual regard and affection over a long period of time, the number and regularity of contacts between them, a record of honoring reciprocal obligations, evidence of freedom to exercise the rights and privileges of friendship, the right to confide, and

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*Id.* at 53.

112. With a “network formation . . . some, but not all, of the component individuals have social relationships with one another. . . . They do not form an organized group, but there will be varying degrees of connectedness between them.” Bott, *supra* note 99, at 347. In a *dispersed network* “there are few relationships amongst the component units”; in a *highly connected network* there are many such relationships. *Id.* at 348. Conceptually, the network fits in somewhere between the family and the total social environment. For a further discussion introducing the concept of social networks, see J. Clyde Mitchell, *The Concept and Use of Social Networks*, in *SOCIAL NETWORKS IN URBAN SITUATIONS: ANALYSES OF PERSONAL RELATIONSHIPS IN CENTRAL AFRICAN TOWNS 1* (J. Clyde Mitchell ed., 1969).

113. See MITCHELL, *supra* note 112, at 20-29.

Another sociologist defined the “strength” of an interpersonal tie as a “combination of the amount of time, the emotional intensity, the intimacy (mutual confiding), and the reciprocal services which characterize the tie.” Mark Granouetter, *The Strength of Weak Ties*, 78 AM. J. SOC. 1360, 1361 (1973).

to be confided in, the right to hurt, and to be hurt, the right to forgive and to be forgiven.<sup>114</sup> It would be like one of those tests that one finds in women's magazines: Is Your Relationship an Intimate One? Do You Deserve Standing In Your Loved One's Deathwatch?

It all sounded like a lot of work, and I could see that opposition to an organizing principle would soak up so much judicial time and energy. The nuclear family was a much easier rule to apply, and judges might not have the skill, resources, or inclination<sup>115</sup> to discover whether what looks like a single strand of

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114. This kind of functional test for family status is not unheard of in the law. For example, the Oregon legislature allows someone who "has established emotional ties creating a child-parent relationship with a child" to petition the court for custody of the child or visitation rights. OR. REV. STAT. § 109.119(4) (1991). The child-parent relationship is defined as:

a relationship that exists or did exist, in whole or in part, within the six months preceding the filing of an action under this section, and in which relationship a person having physical custody of a child or residing in the same household as the child supplied, or otherwise made available to the child, food, clothing, shelter and incidental necessities and provided the child with necessary care, education and discipline, and which relationship continued on a day-to-day basis, through interaction, companionship, interplay and mutuality, that fulfilled the child's psychological needs for a parent as well as the child's physical needs.

*Id.*

The Oregon statute is modeled on the concept of the "psychological parent." Nancy D. Polikoff, *This Child Does Have Two Mothers: Redefining Parenthood to Meet the Needs of Children in Lesbian-Mother and Other Non-traditional Families*, 78 GEO. L.J. 459, 487 n.131 (1990). Polikoff suggests expanding the definition of parenthood to include anyone who performs "parenting functions" and whom the child views as a parent. *Id.* at 490-91. Consideration of those parents' "actions and intent . . . in creating additional parental relationships" would protect the autonomy of the child's legal parents. *Id.* at 491; see also Katharine T. Bartlett, *Rethinking Parenthood as an Exclusive Status: The Need for Legal Alternatives When the Promise of the Nuclear Family Has Failed*, 70 VA. L. REV. 879 (1984) (describing parental rights and responsibilities and proposing an alternative functional test for identifying the "psychological parent").

115. Deeper values than just the ease of administration are undoubtedly at stake. The family traditionally has been the subject of constitutional protection: "Our decisions establish that the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation's history and tradition. It is through the family that we inculcate and pass down many of our most cherished values, moral and cultural." *Moore v. City of East Cleveland*, 431 U.S. 494, 503-04 (1977) (Powell J.). In *Moore*, the Court held that a local zoning ordinance which defined single family dwellings to exclude a woman living with two grandchildren violated the Due Process Clause of the Fourteenth Amendment. *Id.* at 499. While *Moore* declared the virtues of the family tradition and expanded them beyond the nuclear family, the Court in dictum spoke only of blood relatives ("uncles, aunts, cousins, and especially grandparents") when defining the constitutional "family." *Id.* at

thread is really a tangled knot. That is so often the way it is with good ideas: No one really likes them because they frequently sound like a lot of work.<sup>116</sup>

I was beginning to feel desperate about my lawsuit. Who were my paintiffs going to be?

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"Do you know what really worries me about your paintiffs?"

It was several weeks later, and my friend and I were sitting alone quietly in the faculty library, grading papers, or so I thought. It was raining, a good day for a meaningless task. It had been weeks since we had discussed the deathwatch, and

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504. The Court has specifically refused to extend the concept of family privacy to groups of unrelated individuals living together in a single household. *Village of Belle Terre v. Boraas*, 416 U.S. 1 (1974) (no family privacy rights infringed by a local zoning ordinance that excluded households consisting of unrelated persons from living in the village).

I hate making an argument based on familial privacy when the cases force me to accept such a narrow definition of family. I suppose I could take solace in Justice Brennan's decision in *Smith v. Organization of Foster Families for Equality and Reform* (OFFER), 431 U.S. 816 (1977). That case addressed whether a foster family deserved the same constitutional protection as a "natural" nuclear family. Justice Brennan discussed three elements that define a "family" and "contribute to its place in our society": biological relationships, emotional attachments and origins entirely independent of the power of the State. *Id.* at 843-45. Still, Justice Brennan's clear preference for a biological relationship in his discussion of these factors does not give me much heart or inspiration to make the argument.

116. Natalia Ginzburg came up with one of the most beautiful ways to define a family that I have ever encountered:

There are five of us children. We live in different cities now, some of us abroad, and we do not write to one another much. When we meet we can be indifferent and aloof. But one word, one phrase is enough, one of those ancient phrases, heard and repeated an infinite number of times in our childhood. We have only to say, 'We did not come to Bergamo for a picnic,' or 'What does sulphuric acid pong off?' for us to pick up in a moment our old intimacy and our childhood and youth, linked indissolubly with these words and phrases. One of them would make us recognize each other, in the darkness of a cave or among a million people. These phrases are our Latin, the vocabulary of our days gone by, our Egyptian hieroglyphics or Babylonian symbols. They are the evidence of a vital nucleus which has ceased to exist, but which survives in its texts salvaged from the fury of the waters and the corrosion of time. These phrases are the foundation of our family unity which will persist as long as we are in this world.

NATALIA GINZBURG, *FAMILY SAYINGS* 23-24 (D.M. Low trans., Carcanet Press 1984) (1963).

It is difficult to imagine a court employing such a criterion as shared "texts salvaged from the fury of the waters and the corrosion of time" to define a family, but for me, Ginzburg's test bears more truth than anything contained in official reporters.

whether its members should be able to bring their pain to court. I felt smug. I had managed to bother my friend enough with my problem that she had initiated the conversation on her own.

"What plaintiffs?" I pretended not to know what she was talking about. Like someone with a secret passion who wanted to hear her lover's name spoken, I wanted my problem to come back to me through the voice of another. Besides, she always lent grace to my ideas—grace and termination. She would capture the flailing legs of my newborn child and gently fold them into the soft white fleece of a question mark.

"You know perfectly well what plaintiffs. The Quinlans and the Cruzans, the members of the deathwatch." I had not fooled her. "Their pain is purely emotional, and the source of that emotional pain is the physical pain of another."

"I'm not so sure that I am willing to admit their pain is purely emotional," I responded. "For one thing, that pain could manifest itself in physical symptoms, and for another, those long, drawn-out 'medicalized' deathwatches can be a tremendous drain on family resources.<sup>117</sup> Besides, there is the spiritual pain, the pain of watching someone you love in limbo, not being able to return to whatever version of God you believe in." I took a deep breath in recognition that I was about to tread on some of the more tender grass of our friendship. "I probably shouldn't say 'you,' since you may not recognize that spiritual pain because of your profound skepticism about its premises."

"Well, it just doesn't sit right with me," she said, ignoring my last comment, "letting people come into court and seek a remedy for watching the pain of another. Don't you have to be careful about granting them the status of substantive plaintiffs, when the defendants aren't really doing anything to them? I mean, what rights of theirs are being infringed upon? That's one of the things standing in the way, you know."<sup>118</sup> Today she was

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117. A good estimate of the basic cost in an ICU is \$2,000 to \$3,000 per day. RAFFIN, *supra* note 45, at 183. Treatment for a patient on a respirator in an ICU for more than 48 hours costs about \$40,000. It also costs a lot to build an ICU. In 1987, estimates placed the number of ICU beds at 60,000, with an aggregate cost of approximately \$40 to \$50 billion. This figure represents 10% of the nation's health-care costs and about one percent of its gross national product. *Id.* at 184.

118. The Constitution limits federal courts to the adjudication of actual "cases or controversies." U.S. CONST. art. III, § 1. In order to raise a case or controversy, a litigant "must allege personal injury fairly traceable to . . . allegedly unlawful conduct and likely to be redressed by the requested relief." *Allen v. Wright*, 468 U.S. 737, 751 (1984) (citing *Valley Forge Christian College v.*



not sputtering, but was proceeding, civilly. "To be sure that the pain, as you put it, belongs to the plaintiff and not to somebody else. You've got to put limits on who can sue."

"Is it time to yell Yazoo?"

Several years earlier when a colleague had taken unexpectedly ill in the middle of a semester, I had fallen heir to the remainder of his Civil Procedure course. What a cruel twist of fate for those poor, unsuspecting first-year students who still harbored the illusion that their teachers knew something that they did not. If it had not been for that colleague's vulnerable

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Americans United for Separation of Church & State, Inc., 454 U.S. 464, 472 (1982)). The injury must be "distinct and palpable." *Warth v. Seldin*, 422 U.S. 490, 501 (1975). It cannot be "abstract or 'conjectural' or 'hypothetical.'" *Allen v. Wright*, 468 U.S. at 751 (citations omitted).

Standing is the "doctrine most central" to enforcement of the case or controversy limitation. See *TRIBE*, *supra* note 111, § 3-14, at 107. "Whether a party has a sufficient stake in an otherwise justiciable controversy to obtain judicial resolution of that controversy has traditionally been referred to as the question of standing to sue." *Sierra Club v. Morton*, 405 U.S. 727, 731-32 (1972). Application of the doctrine centers primarily on the plaintiff, and only peripherally on the issues she brings with her into court. *TRIBE*, *supra* note 111, § 3-14, at 107.

In *Valley Forge Christian College*, the Supreme Court examined the standing requirement and concluded that standing may be denied if a plaintiff fails to meet one of the following three requirements. First, the plaintiff must "rest his claim to relief on the legal rights or interests of third parties." 454 U.S. at 474. Second, the plaintiff must state "abstract questions of wide public significance" which amount to "generalized grievances," pervasively shared and most appropriately addressed in the representative branches." *Id.* at 474-75 (citations omitted). Third, the plaintiff must present a claim falling within "the zone of interests to be protected or regulated by the statute or constitutional guarantee in question." *Id.* at 475 (citation omitted). Arguably my friend's contention was that members of the deathwatch lacked standing to terminate life-support systems based on numbers two and three in the *Valley Forge* trio of standing sins.

This discussion is limited to problems of standing under the federal Constitution, though the termination of life support cases implicate both federal constitutional rights and common law rights of self-determination, and are most often pursued in state courts.

Obviously, the Constitution's standing requirement applies only to the federal courts. The doctrine does not obligate state courts to require, for example, an "injury in fact" before addressing federal claims. *TRIBE*, *supra* note 111, § 3-15, at 112-13. Nor does the federal doctrine of standing tell a state court whether a potential plaintiff has standing to participate in a state judicial proceeding. The principles embodied in the federal law of standing, however, are found in state constitutions, statutes, and rules of civil procedure as well. See generally 59 AM. JUR. 2D *Parties Plaintiff* §§ 19-40, at 406-438 (1971) (outlining and comparing state standing requirements). Given the generality of this discussion, I decided to limit it to the problems of standing under the federal Constitution and not to delve into the substantive laws regarding standing in any particular state.

constitution, I would never have known when to yell Yazoo, or even that one could yell Yazoo, in any meaningful fashion.

I sometimes wonder what others outside the law world would think about a constitutional theory known as the *Yazoo* doctrine. A "Yazoo" should be a soft drink, a plastic party favor to blow on, or a sneeze, not a legal doctrine.

Despite the aggressive silliness of its name, the *Yazoo* doctrine once stood for something. It held that a litigant may only invoke his own constitutional rights and immunities; he may challenge a law only if it applies to him.<sup>119</sup> The *Yazoo* doctrine rested on a view of constitutional adjudication that prohibited courts from declaring the meaning of the Constitution or from enforcing public norms.<sup>120</sup> As Marshall insisted in *Marbury v.*

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119. *Yazoo & Miss. R.R. v. Jackson Vinegar Co.*, 226 U.S. 217, 219-20 (1912). As with the development of substantive constitutional standards, courts have had to determine the nature and procedure of judicial review through a slow evolutionary process of interpretation. Part of the problem derives from the paucity of words to interpret.

The text of the Constitution itself is characteristically terse about the conditions under which constitutional determinations may be made and who may obtain those determinations. It provides only that "the judicial power of the United States" shall extend to certain enumerated "cases and controversies," including those "arising under the Constitution." U.S. CONST. art. III, §§ 1-2.

The Constitution also created the Supreme Court and limited its original jurisdiction, leaving Congress to authorize such inferior courts as it saw fit and to regulate the Supreme Court's appellate jurisdiction. *Id.* Congress immediately enacted the Judiciary Act of 1789, authorizing Supreme Court review of certain state court constitutional determinations and establishing lower federal courts. Judiciary Act, ch. 20, § 13, 1 Stat. 73, 80-81 (1789). For an account of this Act, see FELIX FRANKFURTER & JAMES M. LANDIS, *THE BUSINESS OF THE SUPREME COURT* 15-25 (1928). While the Act established the federal courts, it said little about the conditions appropriate to constitutional determinations, or who might obtain them.

120. See Henry P. Monaghan, *Third Party Standing*, 84 COLUM. L. REV. 277, 279 (1984). The *Yazoo* doctrine is part and parcel of the law of standing. Standing, however, is only one of many judicial inventions designed to avoid constitutional decisionmaking. Other doctrines also shut the door on potential constitutional questions: ripeness, mootness, political question, and exhaustion of remedies. See TRIBE, *supra* note 111, §§ 3-10 to -13, 3-29. These doctrines reflect a strong ambivalence about the propriety of judicial review in a society based upon democratic principles. Henry P. Monaghan, *Constitutional Adjudication: The Who and When*, 82 YALE L.J. 1363, 1366 (1973) [hereinafter *Constitutional Adjudication*]. For a classic articulation of the view that judicial intervention should occur only when absolutely necessary, and under carefully circumscribed conditions, see James B. Thayer, *The Origin and Scope of the American Doctrine of Constitutional Law*, 7 HARV. L. REV. 129 (1893). For further discussions about the utility of these "rules of avoidance," see ALEXANDER M. BICKEL, *THE LEAST DANGEROUS BRANCH* (1962); Burton C. Bernard, *Avoidance of Constitutional Issues in the United States Supreme Court: Liberties of the First Amendment*, 50 MICH. L. REV. 261 (1951); Gerald Gunther, *The*

*Madison*, the "province of the court is, solely, to decide on the rights of individuals."<sup>121</sup> Under this view, the judicial role in constitutional litigation was analogous to the judicial role in common law litigation.<sup>122</sup> Judicial concern was thus limited to the rights of litigants who had suffered an infringement of their individual rights. A plaintiff could only bring his own pain to court, not the pain of another, or the pain of a class of persons.<sup>123</sup>

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*Subtle Voices of the "Passive Virtues"—A Comment on Principle and Expediency in Judicial Review*, 64 COLUM. L. REV. 1 (1964); Henry P. Monaghan, *Overbreath*, 1981 SUP. CT. REV. 1.

121. *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 170 (1803).

122. See Note, *Complex Enforcement: Unconstitutional Prison Conditions*, 94 HARV. L. REV. 626 (1981) (contrasting this older view of the judicial task, to adjudicate discretely a particular incident or practice, with a more modern view of the judicial task in complex litigation, to bring about systemic, structural reform of a social institution offensive to legal norms). See generally *Constitutional Adjudication*, *supra* note 120, at 1365-68 (suggesting that constitutional adjudication evolved around and remains a system aimed at preventing injury to private interests); Cass R. Sunstein, *Judicial Relief and Public Tort Law*, 92 YALE L.J. 749, 758 (1983) (book review) ("Most of our public law—both substantive and procedural—grows quite directly out of private law and corresponding efforts to treat the government as a defendant in a private lawsuit").

123. One way to view the deathwatch is to consider a lawsuit by its members as a class action. The class action, a nontraditional procedural device, challenges the individual autonomy of litigants in a typical lawsuit by providing a representative to litigate for or defend a class of persons who share a common interest in a lawsuit.

The class action arose to promote judicial efficiency, to provide access to the courts for small claimants, and to prevent inconsistent outcomes. 1 HERBERT B. NEWBERG, *ON CLASS ACTIONS* 8 (2d ed. 1985). The binding effect of a class action on all members of the class and the due process requirements that limit the use of this joinder device accomplish these policies. *Id.* at 6, 8-11. Rule 23 of the Federal Rules of Civil Procedure provides authority and guidelines for bringing a class action in federal court. FED. R. CIV. P. 23. Most state courts have adopted an identical or similar rule. See, e.g., MINN. R. CIV. P. 23.01.

Deathwatches occur in isolated, unpredictable circumstances and form small, ephemeral and informal groups. They do not therefore lend themselves to the class action as a way of dealing with a multiplicity of law suits. Rule 23(a) sets out four requirements for a class seeking certification, which are augmented by two additional requirements imposed by the federal judiciary.

First, each class must be so numerous that joinder is impracticable. All the members of all the deathwatches at any given time, would arguably satisfy this requirement. Obviously, the members of a single deathwatch are too few to invoke a class action.

Second, the class must have a common question of law or fact. Assuming that the issue for members of a deathwatch would invariably be the continuance of life-sustaining medical treatment for an irreversibly comatose patient, the class might indeed have common questions of both law and fact.

Third, the class must state claims derived from the same events or resting

Of course, it is no longer in vogue to view constitutional litigation as coextensive with private rights adjudication. No one would be deemed radical for asserting that federal courts do declare the meaning of the Constitution and enforce public norms.<sup>124</sup> This change in view has resulted in the erosion of

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on the same legal theory. The events of each deathwatch would be different, although the legal theory, if I could figure out what it was, would arguably be the same.

Fourth, the class must have representation that fairly and adequately protects the interests of the members. Presumably representation in the case of a deathwatch could meet this requirement.

Fifth, the class must be sufficiently identifiable. This is where I think the class action analysis for the deathwatch really falls flat on its face. The problems are already difficult if we look at a single deathwatch, as discussed above. If we address all of the deathwatches taking place in a given jurisdiction over a certain period of time, however, identifying members of the class would be impossible.

Sixth, the class must be represented by someone who is a member of the class to assure the rights of the entire class are being adequately litigated. This does not pose problems for the deathwatch. In fact, in the termination of life support cases, the petitioner tends to be a single member of the deathwatch, representing the interests of others who also gather around the bed. JACK H. FRIEDENTHAL ET AL., CIVIL PROCEDURE 725-26 (1985).

Class actions in state practice generally mirror the federal requirements, although some states, such as California and New York, have slightly less stringent requirements. *Id.* at 738-40.

Rule 23(b) further mandates that the court certify each class action under one of three categories enumerated by the Rule. Since I do not think the requirements for certification can be met for members of either a single deathwatch or deathwatches in the aggregate, a further analysis of the kinds of litigation that satisfy Rule 23(b) does not seem necessary.

124. "[A]s pervasive a role as disputation may play in litigation, it is equally important to recognize that the *function* of the judge—a statement of social purpose and a definition of role—is not to resolve disputes, but to give the proper meaning to our public values." Fiss, *supra* note 77, at 30.

Fiss compared a model of adjudication described as "structural reform" to the more traditional "model" lawsuit. *Id.* at 17-28. This latter form of lawsuit, which he calls the "dispute resolution model" is "triadic and highly individualistic." *Id.* at 17. Such a lawsuit focuses on some incident of wrongdoing.

Conversely, the "structural reform" suit dwells not on a singular incident of wrongdoing, "but rather upon the conditions of social life and role that large scale organizations play in determining those conditions." *Id.* at 18. The wronged party in a structural reform lawsuit is a group, not an individual. Sometimes the group is defined by institutional affiliation: the inmates of *X* prison, or recipients of welfare. *Id.* Professor Fiss suggests two main features of the group. First, it must exist "independently of the lawsuit." *Id.* Second, the group is more than "simply an aggregation or collection of identifiable individuals." *Id.* For example, it is not necessary to know the names of prison inmates. Future inmates, not yet identifiable, may be members of the group in the sense that they can be harmed once they become inmates of the institution. The plaintiff in a structural reform lawsuit is not a victim, but a spokesperson for the group. *Id.* at 19.

Other scholars have recognized that judicial decisions not only resolve dis-

such doctrines as the *Yazoo*. Courts increasingly permit litigants who fall under a statute's valid application to assert its invalid application with respect to persons not before the court. The rules of third party standing have thus been reduced to rules of judicial discretion. Once the private rights model was rejected, more plaintiffs had access to the courts. Standing became reduced to a requirement that the plaintiff be injured in fact, and the courts interpreted injury expansively, to include economic and even aesthetic injury.<sup>125</sup> A colleague's old class notes, etched in my brain.<sup>126</sup>

If the standing requirement becomes more relaxed, does it become a kneeling requirement? Or if doctrines like the *Yazoo* disappear altogether, will litigants be able to lie down and roll into court, the way children propel themselves down a hill? And if we let everyone in pain sue from a horizontal position, won't there be a terrible pile-up at the bottom of that hill?<sup>127</sup>

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putes, but also give meaning to our public values. See, e.g., GUIDO CALABRESI, *THE COSTS OF ACCIDENTS* (1970) (examining the social policies of justice, loss-spreading, and deterrence in a fault-based insurance system); Richard A. Posner, *A Theory of Negligence*, 1 J. LEGAL STUD. 29 (1972) (asserting that liability for negligence, a judicial creation, brings about an efficient level of safe behavior because rational maximizers will take precautions to avoid mishap only to the extent the cost of avoidance is less than the cost of an accident).

125. See, e.g., *Sierra Club v. Morton*, 405 U.S. 727, 734 (1972) ("We do not question that this type of harm may amount to an 'injury in fact' sufficient to lay the basis for standing. . . . Aesthetic and environmental well-being, like economic well-being, are important ingredients of the quality of life in our society . . .").

126. See *infra* note 273.

127. Large piles of people at the bottom of a hill are only a problem if each person litigates individually. If people organize into groups—indeed if collective litigation, rather than suits by individual plaintiffs, formed the basis of our legal system—we could potentially handle the large numbers. As is often the case, examination of another time and place can give us some insight into how different our own world might be if we operated from different premises.

In a fascinating book, one scholar has explored the evolution of the class action and argued that its history should begin during the medieval period. STEPHEN C. YEAZELL, *FROM MEDIEVAL GROUP LITIGATION TO THE MODERN CLASS ACTION* (1987). More traditional histories of the modern class action usually begin with the procedure of the late-seventeenth-century English Chancery and focus on corporation theory and the growth of the doctrine of individualism.

Yeazell characterized the seventeenth century as the transitional period of group litigation theory. *Id.* at 24. The medieval period, Yeazell claimed, contains the remote origins of the class action. Social organization in the middle ages centered on the group, rather than the individual. Groups such as guilds, parishes, and village communities lent support and much-needed assistance in a harsh world. *Id.* at 85-96 (citing SUSAN REYNOLD, *KINGDOMS AND COMMUNITIES IN WESTERN EUROPE 900-1300* (1984)).

Is my friend right? Do we have to put limits on who can sue? Should derivative pain be something that the law recognizes—the pain of watching someone else's pain? Would that result in a house of mirrors? Next year would we have to recognize the pain of watching someone else's pain caused by watching someone else's pain?<sup>128</sup> The law always seems to be shutting doors to avoid the risk of infinity.<sup>129</sup>

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For about a year of my life, I had to read to my daughter, over and over again, with the maniacal love for repetition that only a two-year-old has, a book called, *What's The Difference?*<sup>130</sup> On one side of the page there is a photograph, and on the other the same picture appears, with one notable exception. One side has the child laughing; on the other, he is crying. One side has the child with long, flowing hair; on the other, her hair is braided. One side has the child standing in the sun; on the other, he is in the rain. "What's the difference?"

For months and months, my daughter dutifully played the game: Here he is laughing, and there he is crying; here her hair is long, and there her hair is in braids; here he is dry, and there he is wet. Then one day she asked, "Why is the boy crying?" She had made a subtle shift in intellectual stance that only a parent sitting on the bed reading the book for the thousandth time would notice. It was the shift from asking what the difference was to wondering what made the difference.

Perhaps it was the repetition, the saying over and over again, "What's the difference?", but somehow the structure of that inquiry has become imbedded in my own intellectual stance. I find that no matter what I am looking at or thinking about, the thing or problem separates itself like a delicate piece of cloisonné into two pools of enamel, on either side of a

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128. This is just a variant of the "floodgates" argument, or the "there is no point at which such actions would stop" argument. *Dillon v. Legg*, 441 P.2d 912, 922 (1968) (discussed *infra* note 131).

129. California jurisprudence provides another formulation of the "floodgates" argument, one of my favorites. In a case decided before *Dillon*, which considered the same issue of tort liability based upon the "plaintiff's apprehension of negligently caused danger or injury to a third person," the California Supreme Court rejected liability, characterizing such an expansion of the duty of care to be an excursion into the "fantastic realm of infinite liability." *Amaya v. Home Ice, Fuel & Supply Co.*, 379 P.2d 513, 525 (Cal. 1963), *overruled by* *Dillon v. Legg*, 441 P.2d 912 (Cal. 1968). The "fantastic realm of infinite liability" properly belongs in the prologue of a *Star Trek: The Next Generation* episode.

130. BILL GILHAM, *WHAT'S THE DIFFERENCE* (1986).

smooth band of metal, sometimes silver and sometimes gold. Two identical pools of enamel, with one notable exception. "What's the difference?"

On one side, the plaintiff witnesses a bloody accident in which his child is hurt, and sues for negligent infliction of mental distress. On the other side, the plaintiff witnesses a bloody accident in which a stranger is hurt, and sues for negligent infliction of mental distress. In each picture, the plaintiff is crying. "What's the difference?"

The factual answer is: On one side, the accident victim was the plaintiff's child. On the other, the accident victim was a stranger. From those facts, we could look up the rules in a number of jurisdictions and come up with the legal answer: One harm is compensable. One is not.<sup>131</sup>

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131. Permitting a bystander to recover for the negligent infliction of mental or emotional distress is a relatively new development in tort law. Traditionally courts would not compensate a plaintiff alleging mental distress unless the plaintiff could also prove accompanying physical injury. WILLIAM L. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 34, at 213-15 (1st ed. 1941).

Eventually courts allowed compensation for mental distress if the plaintiff suffered *any* physical impact, even without demonstrable physical injury. *Id.* at 213-14. Most jurisdictions now permit compensation for the negligent infliction of mental distress to plaintiffs within the "zone of physical danger," even in the absence of physical impact. Recovery, however, requires some physical manifestation of the alleged mental distress. See generally John L. Diamond, *Dillon v. Legg Revisited: Toward a Unified Theory of Compensating Bystanders and Relatives for Intangible Injuries*, 35 *HASTINGS L.J.* 477 (1984) (compiling California cases following *Dillon*, suggesting that mechanical application of the "zone of physical danger" rule results in inequitable denial of meritorious claims, and arguing for a unified compensation theory awarding out-of-pocket expenses to all foreseeable plaintiffs).

In *Dillon v. Legg*, 441 P.2d 912 (Cal. 1968), the California Supreme Court extended the scope of the doctrine of negligent infliction of emotional distress and compensated a bystander outside of the zone of danger. The court refused to engage in the "hopeless artificiality" of denying recovery to the mother "merely because of a happenstance" that placed her a few yards outside the zone of danger. *Id.* at 915.

The case embraced foreseeability of risk as the primary consideration in determining whether the defendant owes a duty of care to the plaintiff and enumerated three factors for courts to take into account:

- (1) Whether plaintiff was located near the scene of the accident as contrasted with one who was away from it.
- (2) Whether the shock resulted from a direct emotional impact upon plaintiff from the sensory and contemporaneous observance of the accident, as contrasted with learning of the accident from others after its occurrence.
- (3) Whether plaintiff and the victim were closely related, as contrasted with an absence of any relationship or the presence of only a distant relationship.

*Id.* at 920.

The *Dillon* court applied an objective standard of foreseeability, inquiring

But with respect to that legal answer, once we make the shift from asking what the difference is to wondering what made the difference, the task becomes more difficult. It is not hard to see why witnessing the maiming of one's child should be compensable. After all, parental love is primitive and deep, and witnessing harm to one's child is worse than being harmed oneself. What is not so easy to understand is why witnessing harm to a stranger is not compensable. Although there is not the same emotional attachment to the victim, it is still disturbing to see the human body lose its integrity.

I once saw a man killed in southern France. I was on a camping trip with friends, and we were driving behind a car that was going too fast. The driver must not have seen the man up ahead on his bicycle. He was thrown off his seat and sailed high into the air, landing on his head in the road. His neck snapped like a stalk of broccoli, and his skull cracked open. As soon as the *gendarmerie* arrived, they covered his body with a blanket, but until they came, we stood around and stared helplessly at the lifeless form on the road. I had never seen the human brain before, but will never forget what memories look

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"what the ordinary man under such circumstances should reasonably have foreseen." *Id.* at 921. The *Dillon* court, like jurisdictions following the majority rule, confined its holding to cases in which the plaintiff's mental distress resulted in physical manifestations. *Id.*

In 1989, the California Supreme Court clarified *Dillon v. Legg*, holding that foreseeability alone was not sufficient to support a claim for negligent infliction of emotional distress. *Thing v. La Chusa*, 771 P.2d 814, 829 (1989). To support such a claim, the plaintiff must prove three things: a close relationship between the plaintiff and victim; the plaintiff's presence at the scene of the injury-producing event and contemporaneous awareness that the victim was injured; and a resulting serious emotional distress—"a reaction beyond that which would be anticipated in a disinterested witness and which is not an abnormal response to the circumstances." *Id.* at 829-30.

See generally Peter A. Bell, *The Bell Tolls: Toward Full Tort Recovery for Psychic Injury*, 36 U. FLA. L. REV. 333 (1984) (proposing a "full recovery" rule compensating anyone for damages arising from the negligent infliction of emotional distress, to induce caution in would-be tortfeasors, to make the largest number of victims whole, and eliminate the potential for exclusion of seriously injured plaintiffs' claims by arbitrary judicial rules); Virginia E. Nolan & Edmund Ursin, *Negligent Infliction of Emotional Distress: Coherence Emerging from Chaos*, 33 HASTINGS L.J. 583 (1982) (compiling California cases, suggesting that the aftermath of *Dillon* has been marred by judicial interposition of arbitrary rules as barriers to recovery, and offering the concepts of foreseeability and seriousness of emotional injury as a construct for resolving future cases); Richard N. Pearson, *Liability to Bystanders for Negligently Inflicted Emotional Harm—A Comment on the Nature of Arbitrary Rules*, 34 U. FLA. L. REV. 477 (1982) (arguing for a reinstatement of the "zone of danger" rule on the theory that it will most frequently allow recovery by the class of plaintiffs contemplated by the rule).



like: bloody cauliflower. I guess I got over it, but I suffered a loss from witnessing the breaking of another human being. It made me experience my own bodily fragility in a way that I had never felt before or since. I have never again felt as solid or as whole or as certain of my own boundaries. I felt the loss of him too, deeply saddened, even though I had never known the face that once graced the front of his shattered head.

The legal rules about compensability for witnessing harm to others say something about the value that our culture places on love for family and love for strangers. We are expected to love our spouses and children very much, and strangers not at all. It is just a variant of the drowning baby rule. Most of the first year of law school, I wondered if I wanted any part of a legal system that imposed no duty on me to save a stranger's drowning baby.<sup>132</sup> I was given leave to watch that baby slide

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132. Prosser blames the law's refusal to impose on a stranger the duty to aid another human being in danger on the reluctance of courts to recognize "nonfeasance" as a basis for liability. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 56, at 374 (5th ed. 1984) [hereinafter PROSSER & KEETON]. The examples discussed in Prosser's treatise are, at least to me, morally repugnant.

The expert swimmer, with a boat and a rope at hand, who sees another drowning before his eyes, is not required to do anything at all about it, but may sit on the dock, smoke his cigarette, and watch the man drown. A physician is under no duty to answer the call of one who is dying and might be saved, nor is anyone required to play the part of Florence Nightingale and bind up the wounds of a stranger who is bleeding to death, or to prevent a neighbor's child from hammering on a dangerous explosive, or to remove a stone from the highway where it is a menace to traffic, or a train from a place where it blocks a fire engine on its way to save a house, or even to cry a warning to one who is walking into the jaws of a dangerous machine.

*Id.* § 56, at 375 (citations omitted); see also RESTATEMENT (SECOND) OF TORTS § 314 (1965) ("The fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action.").

For an early discussion of the failure to impose a duty to rescue, see Francis H. Bohlen, *The Moral Duty to Aid Others, Parts I and II*, 56 U. PA. L. REV. 217 and 316 (1908). For a more modern treatment of the duty to rescue, including an "economic model of rescue," see William M. Landes & Richard A. Posner, *Salvors, Finders, Good Samaritans, and Other Rescuers: An Economic Study of Law and Altruism*, 7 J. LEG. STUD. 83 (1978).

Correspondingly, there is no criminal liability for failure to render aid to another person who is in danger. WAYNE R. LAFAVE, CRIMINAL LAW § 3.3 (2d ed. 1986). The Anglo-American position on criminal omissions is not necessarily shared by certain European codes. Many of those codes impose a duty to rescue on anyone who could do so without endangering himself. See John P. Dawson, *Negotiorum Gestio: The Altruistic Intermeddler*, 74 HARV L. REV. 1073, 1101 (1961); Joel Feinberg, *The Moral and Legal Responsibility of the Bad Samaritan*, CRIM. J. ETHICS, Winter/Spring 1984, at 56, 68 (arguing in

under the surface of the water just because I did not know his name. This seemed wrong to me then, and seems wrong to me now.

But the underlying cultural value that divides family from stranger as appropriate objects of love, and therefore as sources of derivative pain, does not even seem to be invoked when it comes to the deathwatch. After all, most cases involving termination of life-support systems are brought by family members or close friends.<sup>133</sup> We are not talking about the pain of watching strangers die prolonged and difficult deaths. We are talking about the pain of watching our daughters and sons, our mothers and fathers, our sisters and brothers, and our loved ones and close friends die prolonged and difficult deaths.

On one side, the plaintiff witnesses a bloody accident in which his child is badly injured. On the other, the plaintiff witnesses his comatose child, curled up in a fetal position, main-

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favor of imposing more positive duties of assistance on bystanders in cases of "sudden and unanticipated peril to others that require immediate attention, and are such that a bystander can either make an 'easy rescue' himself or else sound the alarm to notify those whose job it is to make difficult rescues").

133. Spouses of the dying person brought the largest number of cases. See *supra* note 109 and accompanying text. Where the incompetent patient was an unmarried adult, the most common petitioners were the parents. See, e.g., *Foody v. Manchester Hosp.*, 482 A.2d 713 (Conn. Super. Ct. 1984) (father of 42-year-old incompetent patient was conservator of the person; parents sought authorization to discontinue extraordinary means); *In re Gardner*, 534 A.2d 947 (Me. 1987) (mother and guardian ad litem sought declaratory judgment regarding removal of 23-year-old incompetent son's feeding tube); *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) (parents brought action as guardians to compel hospital to comply with their request to remove feeding tube from comatose daughter); *Quinlan I*, 348 A.2d 801 (N.J. Super. Ct. Ch. Div. 1975), *modified and remanded*, 355 A.2d 647 (N.J.), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976) (action by father to terminate life support for 21-year-old daughter); *In re Storar*, 433 N.Y.S.2d 388 (N.Y. Sup. Ct. 1980), *rev'd*, 420 N.E.2d 64 (N.Y.), *cert. denied sub nom. Storar v. Storar*, 454 U.S. 858 (1981) (77-year-old mother petitioned for order terminating transfusions for mentally retarded adult son with leukemia).

In cases of incompetent minor patients, the petitioner was almost invariably a parent. See, e.g., *In re Barry*, 445 So. 2d 363 (Fla. Dist. Ct. App. 1984) (parents of brain-damaged 10-month-old baby petitioned for approval to terminate life-support system); *In re L.H.R.*, 321 S.E.2d 716 (Ga. 1984) (court enjoined hospital from interfering with parents' and guardian ad litem's wishes to have brain damaged newborn's life-support systems removed).

In some instances, a sibling or adult child served as petitioner. See, e.g., *In re Drabick*, 245 Cal. Rptr. 840 (Cal. Ct. App.), *cert. denied sub nom. Drabick v. Drabick*, 488 U.S. 958 (1988) (brother of incompetent 44-year-old patient was conservator of the person and sought approval for removal of feeding tube).

tained on a respirator or nasogastric feeding tube, suffering interminably. "What's the difference?"

Even at the level of a two-year-old, I am hard pressed to come up with an answer. Maybe there is no satisfactory answer, no intelligent way to talk about the difference between one nightmare and another. Maybe we just need there to be a difference in order to draw a line; a line beyond which the law will not go. A way for us to say with certainty: Some wishes cannot be granted. Some wishes must be made upon a star.

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There is a large bulletin board outside my daughter's kindergarten classroom. It usually serves as a surface upon which to staple recent student artwork. The pictures tend to have a seasonal theme: Sights of Summer, Winter Wonderland. Or they might reflect a class project or a field trip: Our Visit to the Seashore; Why We Wash Our Hands; Growing Beans for Fun and Profit. This spring, one of the teachers turned the bulletin board into a Wishing Wall. Each child was to make a wish, and then draw a picture of the wish as it came true. The wishes were sometimes funny, sometimes sad, and always revealing. Lots of the children wished for Porsches or other sleek machines. There were several wishes for cats and dogs. A few properly indoctrinated children wished for peace or an end to world hunger. I was somewhat abashed to find that my own daughter had wished for golden hair that touched the ground. My favorite wish was Matthew's. He wished for a magic pebble that would grant all of his future wishes.

The Wishing Wall drove me to the dictionary. A wish turns out to be a "feeling in the mind directed towards something which one believes would give satisfaction if attained, possessed, or realized." It commonly denotes a "desire for something not attainable by one's own effort," and is characterized as a "passive or inactive desire." A wish is "less emphatic than craving, longing, or yearning, but includ[es] these as particular cases."<sup>134</sup>

I began to wonder about my worry for the members of the deathwatch, and to worry about my wonder. I had been entertaining the notion of giving them some sort of legal recourse, of letting them sue the physicians and hospitals on their own behalf, of seeking to terminate life-support systems because of

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134. 2 COMPACT EDITION OF THE OXFORD ENGLISH DICTIONARY 3795 (1971).

their own pain, and not because of the fictional pain of another. Maybe that notion was nothing more than wishful thinking.

Of course, in a sense, all lawsuits are a form of wishful thinking. The plaintiff may seek some reparation, some restoration of the status quo.<sup>135</sup> Or he might ask the court to stop others from doing something, or for permission to do something to or for others in the future.<sup>136</sup> A plaintiff might express many desires: many cravings, longings, yearnings could make their way into a petition.

So characterizing lawsuits as a form of wishful thinking does not really advance the discussion. But assuming the role of the grantor of wishes does, and that is what judges do: They grant wishes. Lawsuits are expressions of a very particular kind of desire. They express desires attainable by evoking the power of the state. If a plaintiff is successful, there is an official mechanism for enforcement of the judgment. It becomes a wish come true.

What must it be like standing at the wishing wall in the role of fairy godmother?<sup>137</sup> Looking at those expressions of childhood cravings, longings, and yearnings, the discerning

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135. Restitution means the "restoration of property or money taken from the plaintiff." DAN B. DOBBS, HANDBOOK ON THE LAW OF REMEDIES § 4.1, at 222 (1973).

Punitive damages, as the name denotes, are punishment for particularly egregious conduct to discourage such behavior in the future. Punitive damages typically supplement other damage awards. *Id.* § 3.9, at 204.

136. For example, the plaintiff seeking specific performance requests the court to make the defendant actually perform according to the terms of the contract. *Id.* § 12.2, at 795-96.

The injunction provides relief by compelling a defendant to act or refrain from acting in a given manner. Failure to comply with an injunction constitutes contempt of court, and may result in fines or imprisonment. *Id.* § 2.10, at 105.

137. One interpretation of the Cinderella story, in which a fairy godmother plays a pivotal role, suggests that pagans fashioned it as an anti-ecclesiastical allegory. BARBARA G. WALKER, *THE WOMAN'S ENCYCLOPEDIA OF MYTHS AND SECRETS* 168 (1983). "Ella was Hel, or Helle, daughter of Mother Earth, the Goddess with her regenerative fires reduced to cinders. Her ugly stepmother was the new church, [and] [h]er ugly stepsisters were the church's darlings, the military aristocracy and clergy." *Id.*

Walker also relates an early German version of the story in which Cinderella's real mother was the Earth. From beyond the grave, Earth, now dead, heard her daughter's prayers and sent her a "fairy tree" that produced golden apples, and other beautiful things. This "fairy godmother" . . . seems to have been a ghost of the mother, the dispossessed Great Goddess in retirement underground." *Id.*

I do not mean to suggest that the fairy godmother in my text is a thinly disguised pagan goddess, but only offer the footnote as an aside.

fairy godmother would begin to ask: Which wishes can be granted? Not all of them can be. She might be able to bestow a Porsche, or a pet, or the means to acquire them. But unless she is a deity, her powers are probably limited. She cannot, for example, grant my daughter a head of golden hair. Neither does she have the power to stop world hunger or the ravages of war. For some wishes, we would do better not to call on her, but to use Matthew's magic pebble instead.

Besides, there may be other restraints upon a fairy godmother. Not all wishes *should* be granted. Assuming she has a conscience, granting some wishes may violate her sense of morality. And if she has tenure in her role of grantor of wishes, she may have to look to the future and consider the ramifications of granting a new kind of wish. If similar wishes start appearing on the wishing wall, there may be a drain on scarce resources: not enough Porsches or pets to go around. Or maybe she wants to protect her aesthetic sensibilities so as not to live in a world glutted with too many dogs and too many cars. A fairy godmother must think about many things if she intends to stay in her profession.

Courts, too, are grantors of wishes. Similarly, they must confront the limitations of their powers and the restraints placed upon them by, among other things, morality, and the pressures brought to bear by consistency. A court must think about many things when confronted with a new kind of wish. Such things may exceed the boundaries of the petition, like ripples that have significance to the pond way beyond that small displacement of water where the pebble dropped in.

But it is not always so easy to tell what kind of wish we have on our hands. What about my wishes on behalf of the members of the deathwatch? Are they of the kind that cannot or should not be granted?

In order to answer those questions, I would have to answer my friend's questions from that windy March day. I would have to articulate the wishes, pour them into a word mold, give them shape and definition, and give them numbers for those who need enumeration.

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Consider the following hypothetical: The patient is a silent, curled-up daughter. The petitioners are members of her deathwatch, suing on their own behalf. The request for a judicial order might be made in one of two ways:

Please order the doctors to terminate our daughter's life-support

systems because we cannot bear the pain of watching her interminable dying.

Or, in the alternative:

Please order the doctors to release our daughter to us so that we can remove her from the health care facility and terminate her life-support systems because we cannot bear the pain of watching her interminable dying.

The requests in the hypothetical are not so different from those requests that are typically made when the members of the deathwatch sue on behalf of the incompetent patient. After all, no matter whose name is on the petition, the desired result is the same: the termination of the life-support systems. But when the members of the deathwatch sue as nominal, procedural plaintiffs, the courts employ a legal fiction: a pretense that the silent, curled-up daughter is doing the asking, and not the people who file the petition.

What would we gain by dispensing with that pretense? Judicial honesty. Recognition by the courts that the members of the deathwatch are people in pain. Release from the awkwardness of fabricating intent for someone who no longer has any intent. Respect for a judicial system that confronts openly the reality of a situation, a judicial system that does not need the smoke screen of a legal fiction.<sup>138</sup>

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138. No one in the history of jurisprudence hated the dishonesty of the legal fiction more than Jeremy Bentham. Bentham was no fan of the common law, which he thought was plagued with "tautology, technicality, circuitry, irregularity, inconsistency . . . . But above all, the pestilential breath of Fiction poisons the sense of every instrument it comes near." JEREMY BENTHAM, *A Fragment on Government*, in 1 WORKS OF JEREMY BENTHAM 221, 235 n.s (John Bowring ed., Edinburgh, William Tait 1843) (1776). "[I]n English law, fiction is a syphilis, which runs in every vein, and carries into every part of the system the principle of rottenness." JEREMY BENTHAM, *Elements of Packing as Applied to Juries*, in 5 WORKS OF JEREMY BENTHAM, *supra*, at 61, 92 (1821). Bentham particularly loathed the legal fiction due to its ability to make hidden changes in the law without legislation. It gave judges too much power to determine "what shall be morality as well as what shall be law . . ." JEREMY BENTHAM, *Preface intended for the Second Edition of A Fragment on Government*, in A COMMENT ON THE COMMENTARIES AND A FRAGMENT ON GOVERNMENT 502, 511 (James H. Burns & H.L.A. Hart eds., Athlone Press 1977) (1822).

Jurisprudes of the early twentieth century took up Bentham's scathing attack on the legal fiction, although no one approached his level of rage or high concentrations of bile. Roscoe Pound classified the use of legal fiction as "spurious interpretation" which was to "make, unmake, or remake, and not merely to discover . . . . It is essentially a legislative, not a judicial process, made necessary in formative periods by the paucity of principles, feebleness of legislation, and rigidity of rules characteristic of archaic law." Roscoe Pound, *Spurious Interpretation*, 7 COLUM. L. REV. 379, 382 (1907). See also LON FULLER, *LEGAL FICTIONS* (1967) and JOHN C. GRAY, *THE NATURE AND*

But there is something more to gain from letting the members of the deathwatch sue on their own behalf: a higher likelihood that the petition to terminate the life-support systems will be granted. Increasingly, high evidentiary standards must be met in order to justify the creation of fictional intent.<sup>139</sup> *Cruzan* is a perfect example. The state of Missouri required "clear and convincing" evidence that Nancy Cruzan, before losing cognitive function, would have wanted to terminate the life-support systems had she known of her future situation.<sup>140</sup> Until new evidence was unearthed after the litigation,<sup>141</sup> the petitioners on Nancy Cruzan's behalf could not meet that burden. They could not find a residue of the right words and, as a result, Nancy Cruzan was forced to stay alive. If there had been

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SOURCES OF THE LAW 30-37 (1921), which both criticize the use of pretense in judicial decision making. For a later twentieth-century discussion on legal fictions, see Avi Soifer, *Reviewing Legal Fictions*, 20 GA. L. REV. 821 (1986).

139. *In re Conroy*, 486 A.2d 1209, 1229 (N.J. 1985) (emphasizing need for evidence of patient's former intent, including living wills, oral directives, religious beliefs, and any other information bearing on what course of treatment patient would have chosen); *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626, 631-40 (Mass. 1986) (authorizing guardian to take patient from hospital that refused to remove feeding tube, emphasizing patient's expressed preferences and religious convictions). For a discussion of a related case, *In re Westchester County Medical Ctr.*, see *infra* notes 228-44 and accompanying text. *But see Brophy v. New England Sinai Hosp.*, 497 N.E.2d at 640-46 (Nolan & Lynch, JJ., dissenting) (expressing concern that there was insufficient evidence of Brophy's former intent).

140. To effectuate the state's interest in the preservation of human life, the Supreme Court of Missouri adopted a strict standard of clear and convincing evidence for assessing the patient's former intent. *Cruzan v. Harmon*, 760 S.W.2d 408, 424-26 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990). Under this standard, no one could make the choice to terminate life-sustaining treatment for an incompetent patient absent a living will or clear and convincing evidence of her former intent. In Nancy Cruzan's case, her statements to her housemate in a "somewhat serious conversation that if sick or injured she would not wish to continue her life unless she could live at least halfway normally," *id.* at 411, were deemed "unreliable for the purpose of determining her intent . . . and thus insufficient to support the co-guardians claim to exercise substituted judgment on Nancy's behalf." *Id.* at 424-26; see *supra* notes 67-73 and accompanying text (discussing *Cruzan*).

141. Once the *Cruzan* case became a cause célèbre, three of her co-workers came forward and presented sufficient evidence of her former intent. At a hearing in November of 1990, the co-workers testified that they recalled Cruzan saying she would never want to live "like a vegetable." Tamar Lewin, *Nancy Cruzan Dies, Outlived by Debate Over Right to Die*, N.Y. TIMES, Dec. 27, 1990, at A1. This new evidence, plus new testimony from her doctor that her existence was "living hell," prompted Judge Teel of the Jasper County Probate Court to give permission for removal of her feeding tube. *Id.* Nancy Cruzan died 12 days later, at the age of 33, with her family at her bedside. *Id.*

no legal fiction, the judge who heard the Cruzans' petition might have been free to let her quietly go. As it was, the highest court in Missouri, later affirmed by the United States Supreme Court, would not, perhaps could not, let her death-watch come to an end.<sup>142</sup>

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Inherited from the utilitarian tradition, the cost-benefit analysis bids us to focus on our plans and to assess their costs and benefits should we bring them to fruition.<sup>143</sup> As lawyers, we do it every day. We look at a course of action, or at a rule, and ask, "If we decide to act one way instead of another, or if we decide to impose this limitation on our future actions, what will the upshot be?"<sup>144</sup> There is the exhilarating side of the calculation: Who will be made happier, healthier, and wealthier

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142. In a five-to-four decision, the United States Supreme Court upheld the Supreme Court of Missouri. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990). A state may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person in a persistent vegetative state. *Id.* at 2854.

143. The cost-benefit analysis focuses on the probable results of our actions or the enforcement of our rules. Hence, it is a form of consequentialism, a doctrine holding that an action's value is always determined by its consequences; that is, only by referring to an action's result can it be justified. Amartya K. Sen & Bernard Williams, *Introduction to UTILITARIANISM AND BEYOND* 1, 3-4 (Amartya K. Sen & Bernard Williams eds., 1982).

Indeed, a "quality-adjusted life-year" (QALY) is essentially a cost-benefit analysis. A QALY "is a numerical description of the value that a medical procedure or service can provide to groups of patients with similar medical conditions." John LaPuma, M.D. & Edward F. Lawlor, Ph.D., *Quality-Adjusted Life-Years: Ethical Implications for Physicians and Policymakers*, 263 JAMA 2917, 2917 (1990). According to medical scholars,

The concept of 'cost per quality-adjusted life-year,' as a guideline for resource allocation is based on six ethical assumptions: [1] quality of life can be accurately measured and used; [2] utilitarianism is acceptable; [3] equity and efficiency are compatible; [4] projections of community preferences can substitute for individual preferences; [5] the old have less 'capacity to benefit' than the young; and [6] physicians will not use quality-adjusted life years as clinical maxims.

*Id.* A QALY "attempts to combine expected survival with expected quality of life in a single metric." Thus, "if an additional year of healthy life is worth a value of 1 (year) then a year of less healthy life is worth less than 1 (year)."

*Id.*

144. There are different kinds of utilitarianism. "Act" utilitarianism deals with particular actions, or "where an agent has a choice between courses of action (or inaction)." JOHN L. MACKIE, *ETHICS: INVENTING RIGHT AND WRONG* 125 (1977). Under an act utilitarian theory, we assess the "rightness or wrongness" of each individual action directly by its consequences. J.J.C. Smart, *Utilitarianism*, in 8 *ENCYCLOPEDIA OF PHILOSOPHY* 206 (Paul Edwards ed., 1967). "Rule" utilitarianism "does not consider the consequences of each particular action but considers the consequences of adopting some general rule,"



from our decision and in what way?<sup>145</sup> Then there is the cold, dark, November side of the calculation: Who will be made sadder, sicker, or poorer from our decision and in what way? Presumably, if we remain true to the tradition, we will choose the course of action or the rule that will generate the greatest number of benefits for the largest number of people, that will maximize utility, as some are wont to say.<sup>146</sup>

As an intellectual endeavor, the cost-benefit analysis has always made me both profoundly tired and depressed. Even though my legal education was over many years ago, I still har-

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and urges its adoption if the consequences of adopting it are better than those of adopting some alternative rule. *Id.*

145. Sen and Williams characterize utilitarianism as an intersection between two different theories: consequentialism and welfarism. Under welfarism, the correct way to assess a state of affairs is to measure the aggregate welfare or satisfaction that all the individuals included in the calculation experience. Thus, utilitarianism as a moral theory recommends that we choose actions on the basis of consequences and that we assess the consequences in terms of welfare. Sen & Williams, *supra* note 143, at 3-4.

146. Although there are many precursors of utilitarianism, most histories of utilitarianism begin with Jeremy Bentham (1748-1832). By "utility," Bentham meant

that property in any object, whereby it tends to produce benefit, advantage, pleasure, good, or happiness (all this in the present case comes to the same thing) or (what comes again to the same thing) to prevent the happening of mischief, pain, evil, or unhappiness to the party whose interest is considered: if that party be the community in general, then the happiness of the community: if a particular individual, then the happiness of the individual.

JEREMY BENTHAM, AN INTRODUCTION TO THE PRINCIPLES OF MORALS AND LEGISLATION 2 (2d ed. 1823). An action conforms to the principle of utility when "the tendency it has to augment the happiness of the community is greater than any it has to diminish it." *Id.* at 3.

The word 'Utilitarian' appears to have been coined by Bentham. He used it first in a letter dated 1781, and again in a letter, dated 1801, in which he said "A new religion would be an odd sort of thing without a name", and proposed "Utilitarianism." Mill, however, seems to have been unaware that Bentham used the word, for he claims to have taken it over from John Galt's novel 'Annals of the Parish' (1821) where a character applies it to Benthamite views; and in the essay on Sedgwick's discourse to the University of Cambridge (1835) he feels it necessary to explain it in terms of adherence to the principle of Utility. The word 'Utility' was in fairly common use as a technical term considerably earlier, and is to be found in the writings of Hume.

Mary Warnock, *Introduction* to JOHN STUART MILL, UTILITARIANISM, ON LIBERTY, ESSAY ON BENTHAM, 1, 9 n.1 (Mary Warnock ed., 1962) [hereinafter UTILITARIANISM].

Sen has a much more accessible definition, taking "utility. . .to stand for a person's conception of his own well being." J.A. Mirrlees, *The Economic Uses of Utilitarianism*, in UTILITARIANISM AND BEYOND, *supra* note 143, at 63, 64 (quoting Amartya K. Sen, *Utilitarianism and Welfarism*, 9 J. PHIL. 463 (1979)).

bor resentment from the imposition of the cost-benefit analysis on my thinking processes. It undercuts enthusiasm for new ideas. It fosters conservatism. It neutralizes the passions. It sucks the juice out of one's sense of injustice, leaving the pulp and rind of a well-reasoned decision; a well-reasoned decision that may not be the right thing to do.

Even though it makes me sad and weary, however, the cost-benefit analysis is still a part of the way I look at the world. So I am forced to look at the downside of my proposal: What would we have to lose by granting the members of the deathwatch the right to terminate their daughter's life-support systems? What are the costs of dispensing with the legal fiction that the request is being made by the silent curled-up daughter, and not by her parents who are filing the petition?

The costs are high. Probably too high.

The most obvious cost would be the burden of judicial administration. I ran into that problem when I started to draw a circle of yellow chalk around the members of the deathwatch. Without a neat and tidy organizing principle like the nuclear family, the courts could spend all their time just trying to identify who the plaintiffs should be. Then there is the problem of how to deal with potential conflicts among the members of the deathwatch. What would a court do if half of the members wanted to terminate life-support systems, and half did not? Would hours of judicial attention be spent just trying to compare relative degrees of intimacy? Because the group is informal, and the deathwatch ephemeral, there would be no internal structure to deal with such disputes, just as there would be no institutional criteria to determine who qualifies to be a member and who does not.

Another cost of dispensing with the legal fiction is more difficult to put a price tag on. It is the problem that my friend alluded to when she said, "You've got to put limits on who can sue." This cost is generated by the tendency of ideas to migrate and by the unpleasant reality of human greed. If we expressly allow plaintiffs the right to assert a claim based on witnessing the pain of another, how can we prevent that idea from moving into new territory?

This might not pose a problem if courts limited the remedy to issuing orders to terminate life-support systems in carefully circumscribed situations. However, in recognizing new forms of harm, the legal mind likes selectively to pilfer bits and pieces of existing law to construct a new cause of action. In searching

for analogous situations, courts would inevitably gravitate toward that area of tort law in which plaintiffs have sought, and have been awarded, damages for the negligent infliction of mental distress caused by the plaintiff's witnessing harm to another.<sup>147</sup> And damages mean money, both for the plaintiff and for the plaintiff's lawyer. If courts were cavalier about making doctors and hospitals pay damages for the harm caused by wit-

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147. See *supra* note 131. In a few reported cases, members of the death-watch have asserted claims for *intentional* infliction of mental distress. In *Estate of Leach v. Shapiro*, 469 N.E.2d 1047 (Ohio Ct. App. 1984), the patient, Mrs. Leach, suffered a cardiac arrest while in the defendant's hospital. She was successfully resuscitated, but later lapsed into a coma. *Id.* at 1051. Several days later, she was placed on a life-support system. *Id.* Her husband, advised that she would never regain consciousness, petitioned the county probate court to have the life-support system removed. The court ordered the hospital to disconnect the life-support system, *Leach v. Akron Gen. Medical Ctr.*, 426 N.E.2d 809 (C.P. 1980), and Mrs. Leach finally died, almost five months after being placed on the life-support equipment. *Estate of Leach*, 469 N.E.2d at 1051.

Mr. Leach and the children then sued in state court alleging, *inter alia*, that placing Mrs. Leach on the life-support system without her consent constituted a battery. See *id.* at 1052 (discussing the court's disposition of this claim). The part of the case that is of interest to me is the claim by the husband and children for "mental anguish." *Id.* at 1055.

The court of appeals reversed the lower court's dismissal of the claim for mental anguish on two grounds. First the court held that to the extent the plaintiffs could demonstrate wrongful conduct increasing Mrs. Leach's suffering, they stated a cause of action. *Id.* Moreover, the court found that in light of Ohio precedents, the family members' claim of mental anguish presented a colorable legal claim. *Id.*

But see *Hospital Dev. & Serv. Corp. v. Leatherbury*, No. 82-22253 CV, (Fla. Cir. Ct. June 3, 1983), *aff'd*, 446 So. 2d 121 (Fla. Dist. Ct. App. 1984) (*per curiam*) (finding the defendant, admitted to the hospital after having attempted suicide, had no right to die and dismissing the defendant's wife's counterclaim against the hospital for intentional infliction of mental distress upon her by the hospital's refusal to allow her husband to die from nontreatment), discussed in A. Samuel Oddi, *The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action*, 75 GEO. L.J. 625, 646 n.94 (1986).

In a recent Louisiana Supreme Court case a member of a deathwatch sued a hospital for mental pain and anguish. *Lejeune v. Rayne Branch Hosp.*, 556 So. 2d 559 (La. 1990). *Lejeune* was not about the termination of life-support systems, however; it was about another kind of nightmare. Mr. Lejeune lay in a coma in the hospital. Shortly before his wife came into his room for her daily visit, rats had gnawed at his face. A student nurse tried to clean some of the blood away from the wounds, but the bites were still evident. *Id.* at 561. In Mrs. Lejeune's deposition she stated: "They weren't cuts; you could tell it was eaten—eaten by little rounds, and there was blood, and it was all . . . he had some on his head, his face, his neck, and his nose. Now, you know that rodent went into his mouth because they would feed him through the mouth, and he had to breathe with his mouth open." *Id.* at 571. The Supreme Court of Louisiana held that she had "sufficiently stated a cause of action" for mental pain and anguish against the defendant hospital. *Id.*

nessing the pain of another, there would be an incentive for creative plaintiffs' lawyers to look for similar situations in which to sue. The contingency fee can be a catalyst to the imagination,<sup>148</sup> and an idea like compensation for derivative pain might indeed have a tendency to wander.

Although the cost of a nomadic idea might be difficult to assess, I am confident that the speculators of doom and gloom in the insurance industry could put some sort of dollar figure on a new kind of derivative pain. Similarly, someone could probably predict the administrative costs of courts having to identify plaintiffs or deal with intraparty disputes among the members of the deathwatch. Some costs, however, do not lend themselves to quantification. They take their toll on the human body and on the human heart.

Such could be the most serious cost of dispensing with the legal fiction: the risk of potential abuse. If we take our eyes off the patient and direct our gaze towards the members of the deathwatch, we might forget to ask whether that patient still had something to say. The scenario that I have just sketched of the late-twentieth-century deathwatch assumes a patient who has substantially lost cognitive function, a Karen Quinlan or a Nancy Cruzan. The medical determination of brain function and the legal determination of incompetency, however, are both capable of manipulation.<sup>149</sup> The patient might be quite

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148. This insight I must attribute to my friend and colleague, Nicola Lee, Barrister at Law. One evening she was trying to explain to me how the practice of law in England differed from the practice of law in this country, and we lit upon the subject of the contingency fee. She contended that the institution of the contingency fee had an impact on the development of American law, providing an incentive for plaintiffs' lawyers to be creative in formulating new causes of action or in finding novel applications of the old ones. In England, where there are no contingency fees, barristers tend to be more conservative when initiating litigation. Actually, according to Nicola Lee, barristers tend to be more conservative about everything.

149. *In re Spring*, 405 N.E.2d 115 (Mass. 1980), is enough to make anyone nervous about the reliability of incompetency proceedings. The Massachusetts Supreme Court approved a lower court order permitting the petitioner, the ward's temporary guardian, to stop dialysis on a 79-year-old man thought to be incompetent due to "chronic organic brain syndrome." Two authors later pointed out:

No psychiatric testimony was heard. Two written affidavits from physicians were presented which described Mr. Spring as suffering from chronic organic brain syndrome or senility. The signature on one affidavit was completely illegible; the other affidavit was based upon an examination of Mr. Spring conducted nearly 15 months prior to the appointment of Mr. Spring's wife and son as temporary guardians and their filing of the petition to terminate his hemodialysis treatments. . . . The only medical testimony concerning Mr. Spring's com-

alive, both mentally and physically, but be too old or too annoying or too inconvenient or too expensive or too aesthetically unappealing or in some other way too much of a burden to have around. Through the use of cooperative expert witnesses, such a patient could find that her medical care has turned into her deathwatch.<sup>150</sup>

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petency, or lack thereof, came from a kidney specialist at the institution where Mr. Spring received his hemodialysis treatment. . . . Based on this evidence, Mr. Spring was found incompetent and his family was authorized to order that his dialysis treatments be withdrawn . . . .

Lee J. Dunn & Nancy E. Ator, *Vox Clamantis in Deserto: Do You Really Mean What You Say in Spring*, in *LEGAL & ETHICAL ASPECTS*, *supra* note 102, at 177, 177-78; see also Peter M. Horstman, *Protective Services for the Elderly: The Limits of Parens Patriae*, 40 MO. L. REV. 212 (1975) (arguing for the introduction of full adversary proceedings before appointing guardians for the elderly); S. Van McCrary & Terry A. Walman, *Procedural Paternalism in Competency Determination*, 18 LAW, MED. & HEALTH CARE 108 (1990) (concluding that full procedural protections—including the right to confront witnesses, an appropriate standard of proof, consideration of alternative actions, and an objective and impartial review board—are necessary to safeguard the interests of the alleged incompetent in guardian proceedings). For a discussion of recent efforts by states to revise their guardianship statutes, see Penelope A. Hommel et al., *Trends in Guardianship Reform: Implications for the Medical and Legal Professions*, 18 LAW, MED. & HEALTH CARE 213 (1990).

150. With the high cost of medical care in this country, one of the greatest risks of abuse is the sacrifice of patients because their continued treatment drains resources. Soaring medical costs have been advanced in some instances as a "valid reason for putting someone to death by the proponents of rational and assisted suicides." Joseph Richman, *Sanctioned Assisting Suicide: Impact on Family Relations*, 3 ISSUES L. & MED. 53, 61 (1987).

In the 11 years from 1976 to 1987, spending for medical care exceeded inflation by almost 80%. In 1987, national health expenditures were \$0.5 trillion, 11.1% of the gross national product. Spending for federal Medicare and Medicaid programs has grown from \$70 billion in 1982 to \$111 billion in 1987.

Many factors contribute to rising health care costs: inflation of hospital and health care provider costs, the emergence of new diseases and disorders, and the development of new diagnostic and therapeutic modalities.

Edward E. Schneider, M.D. & Jack M. Guralnik, Ph.D., *The Aging of America: Impact on Health Care Costs*, 263 JAMA 2335, 2336 (1990).

Another factor is the "aging of the aged." "An unprecedented number of individuals are entering the 9th and 10th decades of life." *Id.* This group of the "oldest old" is the fastest-growing in the United States. Things will really get tough when the "baby boomers" hit their eighties. In 2040, the average age of a baby boomer will be 85 years, and the level of Medicare spending for the population age 65 years and above could range from \$147 billion to \$212 billion, in 1987 dollars. *Id.* at 2337.

Other risks of abuse derive from prejudicial attitudes toward the elderly, the diseased, and the disabled. No one can ignore the atrocities of recent history. During the autumn of 1939, Hitler instituted his "Euthanasia Program" in which over 275,000 people were gassed in killing centers. Most who were

Even a judicial proceeding would not save her life. By the time the case reached the court's attention, the labels assessing the degree of mental capacity would already have attached. Rarely, if ever, does a judge leave the sanctuary of the courtroom to see whether the curled-up daughter in that bed is truly silent.<sup>151</sup> Instead the judge must rely on the professional training and credibility of those experts who have made the assessment. Sometimes a deposition of a doctor is a *fait accompli*.

By granting the members of the deathwatch standing to terminate life-support systems, we turn their silence into expression. My fear is that their voices would drown out whatever the patient might have left to say. After all, there is no guarantee that the members of the deathwatch will be good and true; they may have their own selfish reasons for wanting

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killed were deemed incompetent: mentally retarded, mentally ill, epileptics, senile elderly, sufferers of neurological disorders such as Parkinsonism or multiple sclerosis, and other sick and handicapped people. Dubbed "useless eaters," their sacrifice was justified by a perverse form of welfare utilitarianism that sanctioned the killing of the weak so that others could flourish. Philippa Foot, *Euthanasia*, 7 PHIL. & PUB. AFF. 85 (1977).

By focusing on the rights of members of the deathwatch, our analysis shifts from the individual to the group. Any time this shift takes place, the risk of harm to the defenseless and vulnerable members of society arises. The risk is real; hidden biases against certain forms of illness, disability, indigency, unattractiveness, or any other difference may be tacitly plugged into a utilitarian calculation that results in discrimination, or worse yet, extermination.

151. One notable exception was *In re* President & Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir. 1963). The U.S. District Court for the District of Columbia's denied Georgetown Hospital's application for permission to administer blood transfusions to a 25-year-old woman who had lost two-thirds of her blood supply due to a ruptured ulcer. She and her husband refused to consent to the transfusions on religious grounds; they were Jehovah's Witnesses. *Id.* at 1001-02. The attorneys for the hospital applied for an emergency writ at 4:00 p.m.

Judge Skelly Wright called the hospital to verify the attorney's representations, and

thereupon proceeded with counsel to the hospital, where I spoke to . . . the husband of the patient. He advised me that, on religious grounds, he would not approve a blood transfusion for his wife. I asked permission of Mr. Jones to see his wife. This he readily granted. . . . I then went inside the patient's room. Her appearance confirmed the urgency which had been represented to me. I tried to communicate with her, advising her as to what the doctors had said. The only audible reply I could hear was, "Against my will." It was obvious that the woman was not in a mental condition to make a decision.

*Id.* at 1006-07. Judge Wright signed an order to administer the blood transfusions. *Id.* at 1007.

Compare this unusual trip to the patient's room to verify her incompetence with Judge Muir's attitude in *Quinlan I*, described *supra* note 55.

the deathwatch to come to an end. The incompetent person might be killed as a consequence of some unarticulated utilitarian calculation. The court might end up sacrificing her in the name of someone else's pain.

That would diminish us all. The loss of life and dignity is not only felt by the lamb, but also by those who lead the lamb to slaughter. It is true that the use of the legal fiction may engender disrespect for a judicial system that cannot openly confront the reality of the situation. The members of the deathwatch are the plaintiffs, and not the silent curled up daughter. Furthermore, the use of the legal fiction may keep some deathwatches going interminably. But that may be the way it has to be.<sup>152</sup> Although the members of the deathwatch may end up paying for our use of that legal fiction, and that is a tragedy, the risk of abuse is a cost that I do not think we can bear.

So, once again, the cost-benefit analysis had silenced me, and I began a deathwatch on my own idea.

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"So have you given up on them altogether?" she said one day at the pool while we were doing desultory laps. "Your plaintiffs, the members of the deathwatch?"

"I guess so," I admitted reluctantly. "At least when I think of them legally."

It was several months later. I had become so disheartened by my own conclusions about granting the members of the deathwatch some form of legal recourse that I had lost faith in my original insights about their pain.

This happens to me a lot. It reminds me of picking chicory. You see something beautiful by the side of the road, a spray of periwinkle blue in the grass, and you want to pick it, to take it

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152. At the same time we make the decision of whom to burden, we also are deciding whether we want to get accustomed, whether we wish to become callous, or whether, instead, we think that as a society we would be better off if we continued to view some things as shocking, offensive, and even abominable.

GUIDO CALABRESI, *IDEALS, BELIEFS, ATTITUDES, AND THE LAW* 83 (1985).

In this instance, by clinging to the legal fiction, we have decided to burden the members of the deathwatch, and at the same time, we have decided to get accustomed to their pain. We do this because we are sufficiently worried that granting the members of the deathwatch their own cause of action might result in sacrificing innocent victims, and that as a society, we would be better off to remain deeply offended by the risks of abuse that I have described. Hence, we are willing to be callous about the pain felt by the families of Karen Quinlan and Nancy Cruzan.

home. The wildflower book has warned you not to, that chicory does not take kindly to picking, but you do it anyhow. A few hours later, the chicory has collapsed. The crisp, jagged edges are limp, and the brilliant blue has turned to a sullen gray. The same thing happens to a lot of my ideas. When I pick them and try to arrange them in a vase, they faint against their glass prison; they wither and die. In fact, I had given up on trying to squeeze the members of the deathwatch into any kind of lawsuit. They had been relegated to that class of four-in-the-morning things; things out of my control.

"Well, that's too bad." She hugged the kickboard and pushed off from the edge of the pool, her legs flailing in a blur of water and air.

"What do you mean that's too bad?" I grabbed a kickboard and followed her in the water. I was annoyed. This was not the only time that she had done this to me. I would have an idea that could not withstand her scrutiny, and then she would not let it die a dignified death. She would not let it quietly slide down into the ravine of unworthy ideas, washed away by the gentle rain of indifference and neglect. Oh no, she had to torture it to death, submit it to a public execution.

"I just think it's too bad, that's all."

"But you were the first one to say that the members of the deathwatch shouldn't have any substantive rights of their own." I was kicking furiously to keep up with her, grasping tightly on to my kickboard.

"That's right, I did." We had reached the other side of the pool, and had stopped swimming. "Look, I can disdain the solution, but still admire the problem."

"The problem being?" At that moment, in that chlorinated sea, I could not remember what there was about the members of the deathwatch that had captured my imagination. The season had changed, and the chicory now lay under the ground. I could not remember its blue beauty in the light, or its splendid verticality.

"The problem being the law's failure to include the members of the deathwatch in the frame." My friend had just taken an introductory course in photography, and it seemed to radically alter the way that she looked at the world. Not only did she now see everything through a lens of a camera, but she was leaving words behind, consumed by an unexpected passion for the visual. "Those termination of life support cases all focus on the face of someone who no longer cries, on the face of the in-



competent dying person. The lens is telephoto, and the field of vision is so microscopic that the members of the deathwatch aren't included. The ones who are really crying aren't even in the picture."

"And what do you propose as an optic solution?" It was a good thing that I had an earlier lifetime as a photographer and could hold my own in technical banter.

"Maybe a twenty-eight-millimeter lens. Something that still focuses on the face of the dying person, but captures everything else around him. It's the lens of social context."

I wondered if that expression had been her own, but did not want to offend her by questioning her authority. "How sharply in focus would you have the members of the deathwatch be?"

"Not sharp at all. I'd want them in the picture, but as soft presences. An aura of human warmth and concern around the dying person, but without any formal recognition. You know," she grabbed her kickboard in preparation for departure, "if you insist that the law face this problem head on, in the middle of the frame, then you're stuck with the old picture. But if you let the law do its work like an artist, in the shadows and on the edges of things, you might still be able to do something about their pain. Don't desert your paintiffs yet, your members of the deathwatch." And she pushed off from the edge of the pool and disappeared down the lane.

Suddenly I loved my friend, old and new. The aqua-green water that enveloped her grew still, and I floated on my kickboard without moving, finding solace in her wake. I tentatively picked up another lens, the fifty-millimeter lens of our reality, and dared to look at my problem again, through the clear glass of her metaphor.

There they were. That splash of blue. I love the way the wildflowers come back in the spring.

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*Left Hemisphere Interlude*<sup>153</sup>

Over and over, I resisted the urge to ask the question.

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153. The two halves of the human brain, called the "left hemisphere" and the "right hemisphere," resemble a walnut when viewed from above. Our nervous system connects to the brain in a cross-over fashion, so that the left hemisphere controls the right side of the body, and vice versa. BETTY EDWARDS, *DRAWING ON THE RIGHT SIDE OF THE BRAIN* 26 (1979).

In most animal brains, the cerebral hemispheres are symmetrical in function; human cerebral hemispheres, however, are asymmetrical. In the 1960s,

Over and over, I resisted the urge to outline an answer to it. I was not going to do it. I was not going to order my thoughts in a logical sequence. I was not going to make arguments, one, two, three. I was going to be a poet, not a lawyer.

And over and over, the argument kept appearing on legal pads and the backs of envelopes, written in a scrawl with a pencil, as if the illegibility and erasability of the words made them somehow less there. Worse yet, the argument kept falling into place behind those ominous numbers, one, two, three. Before I knew it, I was outlining an answer to a question, and could not stop myself from asking it.

Question: What can the law do to alleviate indirectly the pain of the members of the deathwatch?

Answer: Three things (of course, three things).

- 1) The law can redefine death.
- 2) The law can lower evidentiary standards regarding conversations about the circumstances of one's own death in recognition that the subject is a taboo in our culture.
- 3) The law can help create an environment in which a meaningful deathwatch can take place.

It is a hard fact to face: I am a lawyer, not a poet.

researchers at the California Institute of Technology, in particular a psychobiology professor, Dr. Roger Sperry, discovered that each hemisphere perceives reality in its own way. *Id.* at 26-28. The function of language and language-related capabilities is located mainly in the left hemisphere of the majority of individuals. (This is true in approximately 98% of right-handers and about two-thirds of left-handers.) The left hemisphere operates "in a more logical, analytic, computer-like fashion," and is used most of the time in individuals with intact brains. John W. Levy, *Differential Perceptual Capacities in Major and Minor Hemispheres*, 61 PROC. NAT'L ACAD. SCI., 1151, 1151 (1968). The left hemisphere plans step-by-step procedures and processes information in a sequential, symbolic, and linear manner. The right "nonspeaking" hemisphere is subjective, intuitive, and is not good at categorizing, naming or placing things in sequential order. We use the right brain to imagine how things exist in space, to understand metaphors, to dream, and to create new combinations of ideas. EDWARDS, *supra*, at 34. "[O]ur educational system, as well as science in general, tends to neglect the nonverbal form of intellect. What it comes down to is that modern society discriminates against the right hemisphere." Roger W. Sperry, *Lateral Specialization of Cerebral Function in the Surgically Separated Hemispheres*, in THE PSYCHOPHYSIOLOGY OF THINKING 209, 209 (Frank J. McGuigan & R.A. Schoonover eds., 1973).

Even if the specialization of function in the cerebral hemispheres may not be so cut and dry, it is still useful to keep in mind that each human being may have multiple ways of processing information and apprehending reality, and that how one approaches a problem will depend to a large part upon how one perceives it. And if our understanding of the psychophysiology of cognition has become more complex, the metaphor of left-brain and right-brain thinking still makes sense to me. A lawyer will typically approach life from a left hemispheric vantage point. A poet will not.

III. MOVING UP THE BRAINSTEM<sup>154</sup>

## WHAT CAN THE LAW DO TO ALLEVIATE INDIRECTLY THE PAIN OF THE MEMBERS OF THE DEATHWATCH?

This first suggestion is the most obvious, and has been made by many others who have looked at the horrors of the late-twentieth-century deathwatch: *The law can redefine death.*

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In the law, and in medicine, it has always been biological death that has commanded our attention. The cessation of the lungs and heart used to provide the definition.<sup>155</sup> Once artificial ventilation became possible, however, the medical profession had to reconsider the definition of human death. The focus shifted from heart and lung activity to activity of the brain.

The prevailing test, formulated by an ad hoc committee of the Harvard Medical School, specifies a set of clinical tests that determines whether the entire brain of a comatose person is dead.<sup>156</sup> I dutifully put them in a footnote, because I must, but

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154. In a lovely footnote that in my mind belonged in the first paragraph of his article, Raymond J. Deverette pointed out that the word "brainstem" is a metaphor borrowed from botany. The metaphor does not support a claim that we have a living human brain when we say that the stem lives, but the rest of the brain is dead: "Now we do not say that we have a living rose when the stem is alive but the blossom dead, nor do we say we have a living or edible apple or grape when the stem lives but the fruit is dead." Raymond J. Deverette, *Neocortical Death and Human Death*, 18 LAW, MED. & HEALTH CARE 96, 103 n.13 (1990). For another work discussing the significance of metaphor in our discourse about illness, see SUSAN SONTAG, *ILLNESS AS METAPHOR* (1977).

155. "The cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereupon, such as respiration, pulsation, etc." BLACK'S LAW DICTIONARY 488 (3d ed. 1951).

156. In a 1968 report, the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death specified a set of clinical tests which it maintained were sufficient for determining whether the entire brain is dead or the patient is in an irreversible coma. It recommended that, excluding cases of hypothermia and the presence of central nervous system depressants, death should be declared when a patient exhibits three traits: unresponsivity and unresponsivity to external stimuli and inner need, no movements or breathing, and no elicitable reflexes. Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 JAMA 337, 337-38 (1968). A fourth condition, a flat electroencephalogram (EEG) reading, should be used for its confirmatory value only. *Id.* at 338. Once the patient meets all three tests, the results of which must be consistent over a 24-hour period, the Committee recommended

no one has ever claimed that they tell us much about the death of a human being. They tell us when, in the words of the Munchkin coroner, someone is "not merely dead," but "really most sincerely dead."<sup>157</sup> They do not apply, however, to those patients who still have some residual nervous system function. Those people, like Karen Quinlan and Nancy Cruzan, are not "dead" because they cannot meet the current definition. Their cerebral function may be gone, but the lower brainstem function is still hanging on.

Other competing medical models provide definitions of human death. Some prefer a definition that focuses on the loss of organic function.<sup>158</sup> Others focus on whether the patient has regained consciousness.<sup>159</sup> All the medical models require doctors to prick limbs with needles, yell into deaf ears, shine lights into eyes that do not see.<sup>160</sup> All entail a medical judgment based on an assessment of physical capacity; by and large, the

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that death be declared and the respirator turned off. *Id.* The application of the report was carefully circumscribed to be concerned "only with those comatose individuals who have no discernible central nervous system activity." *Id.* at 337 (italics omitted).

157. *THE WIZARD OF OZ* (Metro-Goldwyn-Mayer 1939). The Mayor of Munchkin City called the Munchkin coroner to ensure that the Witch of the East, upon whom Dorothy's house had recently landed, was "morally, ethically, spiritually, physically, positively, absolutely, undeniably, and reliably dead." *Id.* Without his averment as to her death, the Munchkins could not launch into "traditional death behaviors." See ROBERT M. VEATCH, *DEATH, DYING AND THE BIOLOGICAL REVOLUTION* 27 (1989) (arguing that the timing of traditional death behaviors should be the impetus that drives public debate about the definition of death). In the case of the Munchkins, such behavior involved singing "Ding, Dong, the Witch is Dead."

158. "[A] human organism is dead when, for whatever reason, the system of those reciprocally dependent processes which assimilate oxygen, metabolize food, eliminate wastes, and keep the organism in relative homeostasis are arrested in a way which the organism itself cannot reverse." Lawrence C. Becker, *Human Being: The Boundaries of the Concept*, 4 PHIL. & PUB. AFF. 344, 353 (1975).

159. See David Lamb, *Diagnosing Death*, 7 PHIL. & PUB. AFF. 144, 147 (1978).

160. Physicians have proposed several other major sets of criteria to diagnose irreversible loss of brain function. For example, in 1971, the University of Minnesota Health Sciences Center published what have been called the "Minnesota Criteria." They differed from the Harvard criteria in that they required neither a confirmatory EEG nor the absence of movement in response to painful stimuli. They specified a test for the presence of spontaneous respiration for a period of four minutes at a time, and required only the absence of brainstem reflexes. In addition, the tests needed to be repeated and remain unchanged only within 12, not 24 hours. A. Mohandas & Shelly N. Chou, *Brain Death: A Clinical and Pathological Study*, J. NEUROSURGERY, Aug. 1971, at 211, 212. The Minnesota Medical Association adopted another set of

conclusion can be justified by pointing to a chart. The incredible comfort of numbers tells us that we have done the right thing, the only thing, in considering this person to be a dead one.

In contrast to the medical models, some have argued that the task of how to define death is one that requires a moral, not a medical, judgment.<sup>161</sup> The central question then becomes: When is it morally justifiable to treat a person as dead? This

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criteria in 1976. See Ronald E. Cranford, *Minnesota Medical Association Criteria: Brain Death—Concept and Criteria*, 61 MINN. MED. 561, 562 (1978).

In 1977, a study organized by the National Institute of Neurological Diseases and Stroke (NINDS), headed by Earl Walker, published another set of brain-based criteria. In addition to the deep coma with cerebral unresponsivity and apnea, the Walker group required dilated pupils, absence of cephalic reflexes, and electrocerebral silence on an EEG. A. Earl Walker, M.D. et al., *An Appraisal of the Criteria of Cerebral Death—A Summary Statement*, 237 JAMA 982, 982 (1977).

A President's Commission proposed a set of criteria that included deep coma, absence of brainstem reflexes, and apnea. Clinical indicators for the cessation of all brain functions had to be present for at least six hours. The Commission recommended confirmation by EEG, and further testing for the absence of cerebral brain flow could also aid in diagnosis. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE, *DEFINING DEATH* 159-66 (1981). For an excellent history of the brain-based definition of death, see VEATCH, *supra* note 157, at 15-58.

161. Some writers have analyzed the problem of defining death by examining the underlying notion of personhood. For example, H. Tristram Engelhardt has argued that there are at least two notions of person. The first is the moral agent, the rational individual who bears rights and duties. The second is a social concept or social role of person, individuals who may not be rational moral agents, but who can still engage in "at least a minimum of social interaction." H. Tristram Engelhardt, *Medicine and the Concept of Person*, in *CONTEMPORARY ISSUES IN BIOETHICS* 94, 97 (Tom Beauchamp & LeRoy Waters eds., 1982). Children, the senile, the mentally retarded and mentally ill would all fall into this second category, and are therefore bearers of rights, who must be treated with respect. Personal life and mere biological life can be distinguished, so that those who have deficient brain functions could be considered dead. The brain-oriented concept of death for Engelhardt is thus more directly concerned with personal life. *Id.* at 98-99.

For another philosopher's discussion of what constitutes the significant properties of a person, see Joseph Fletcher, *Indicators of Humanhood*, *HASTINGS CENTER REP.*, Nov. 1972, at 1. Some scholars also suggest that we not focus on consciousness, but rather on the capacity for social interaction. Rebecca Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373 (1986); Kevin P. Quinn, *The Best Interests of Incompetent Patients: The Capacity for Interpersonal Relationships as a Standard for Decisionmaking*, 76 CAL. L. REV. 897 (1988); Rhoden, *supra* note 74.

For a fascinating exploration of the impact of developments in artificial intelligence on our sense of what is human, see Steven Goldberg, *The Changing Face of Death: Computers, Consciousness, and Nancy Cruzan*, 43 STAN. L. REV. 659 (1991).

question implies a deathwatch. Someone must ask that question: someone who is treating the dying person; someone who loves the dying person; someone who is responsible for the dying person; someone who must justify his decision to himself and to others. Unlike the medical models that have objective criteria, here we have value judgments to which we own up. It is impossible to justify the conclusion by pointing to a chart. There are no numbers in which to take comfort. Instead, this question must be answered by an essay—an essay that recognizes dying as a two-part relation, occurring within the context of a moral community.<sup>162</sup> Such an essay would defend the be-

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162. Robert Veatch has been a leading proponents of a "higher brain death" definition. He relies upon the Judeo-Christian notion of what it means to be a whole person, affirming that a human is of necessity an integrated unit of body and mind. One is not interested in

the death of particular cells, organs, or organ systems, but in the death of the person as a whole . . . . For purposes of simplicity I shall use the phrase the capacity for bodily integration to refer to the total list of integrating mechanisms possessed by the body. A case for these mechanisms being the ones that are essential to humanness can indeed be made. Humans are more than the flowing of fluids. They are complex, integrated organisms with capacities for internal regulation. With and only with these integrating mechanisms is homo sapiens really human.

VEATCH, *supra* note 157, at 24. The other higher functions of the brain, however, such as "consciousness [and] the ability to think and feel and relate to others," are so essential that "their loss ought to be taken as the death of the individual." *Id.* at 29. Thus Veatch argues that death should be defined as the "irreversible loss of the embodied capacity for social interaction." *Id.* at 30.

Even though Veatch has focused on the human body's capacity, he is still squarely aligned with those who believe that the definition of death is a moral decision, not a medical one. "[A]ll that is at stake in the public policy debate over the definition of death is determining when death behaviors are appropriate." *Id.* at 27. Death behaviors are those that society initiates upon the death of one of its members, such as mourning. In a sense, the deathwatch is just an overture to subsequent death behaviors.

Two philosophers have criticized Veatch, arguing against basing the definition of death on moral judgments. They claim that personal identity should be critical in determining when a person is dead. Michael B. Green & Daniel Wikler, *Brain Death and Personal Identity*, 9 PHIL. & PUB. AFF. 105 *passim* (1980). Thus "a given person ceases to exist with the destruction of whatever processes there are which normally underlie that person's psychological continuity and connectedness." *Id.* at 127. They characterize their argument as "ontological," not moral. *Id.* at 106.

Many excellent articles urge some form of upper brain criteria for death. See, e.g., David R. Smith, *Legal Recognition of Neocortical Death*, 71 CORNELL L. REV. 850, 879 (1986) ("the inevitability of scientific progress suggests that the limits of present medical technology are no reason to avoid addressing the appropriateness of a neocortical death standard"); Deverette, *supra* note 154, at 96 (supporting an integrated approach in which upper brain death plays a key role in defining death).

havior of one human being toward another.

When faced with the patchwork of the proposed criteria, the statutes and Uniform Acts,<sup>163</sup> and the law reviews and competing medical and philosophical opinions,<sup>164</sup> I am at a loss to make an intelligent proposal for a new definition of death. It is work better left to those more qualified, and there are plenty of talented people to thrash out a new definition of death that we can all live with, or die with.<sup>165</sup> And chances are that techno-

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163. UNIF. DETERMINATION OF DEATH ACT § 1, 12 U.L.A. 271 (Supp. 1992) ("An individual who has sustained either 1) irreversible cessation of circulatory and respiratory functions, or 2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.").

164. The literature on the issue of defining death is extensive. For an excellent bibliography on the legal definition of death see, Richard E. Leahy, *Legal Death: A Pathfinder to the Current State of the Law and Its Implications*, 9 LEGAL REFERENCE SERVICES Q. 73 (1989); see also HOWARD BRODY, *ETHICAL DECISIONS IN MEDICINE* (2d ed. 1981) (including case studies in textbook format); HANS JONAS, *PHILOSOPHICAL ESSAYS: FROM ANCIENT CREED TO TECHNOLOGICAL MAN* 132-40 (1974) (explaining that for practical purposes brain death defines death, but for higher moral reasons a brain-dead person still enjoys sacred identity); PAUL RAMSEY, *THE PATIENT AS PERSON* (1970) (providing a practical, wide-ranging discussion of death by a Christian ethicist); Joel Feinberg, *The Rights of Animals and Unborn Generations*, in *PHILOSOPHY & ENVIRONMENTAL CRISIS* 43 (William Blackstone ed., 1974) (ascribing rights to brain-dead individuals); John C. Hoffman, *Clarifying the Debate on Death*, 62 SOUNDINGS 430 (1979) (proposing that the definition of death should be a primary, rather than secondary, moral consideration).

There is an interesting debate between D. Alan Shewmon and Robert L. Barry about whether neocortical death is consistent with the metaphysics of the rationality of the soul in Aquinas. Compare D. Alan Shewmon, *The Metaphysics of Brain Death, Persistent Vegetative State, and Dementia*, 49 THOMIST 24 (1985) and D. Alan Shewmon, *Ethics and Brain Death: A Response*, 61 NEW SCHOLASTICISM 321 (1987) (asserting that the death of the brainstem provides substantial changes in the metaphysics of life) with Robert L. Barry, *Ethics and Brain Death*, 61 NEW SCHOLASTICISM 82 (1987) (arguing that, brain-dead or not, human beings retain rational souls and moral rights).

For a thorough discussion of the redefinition debate, see KAREN G. GERVAIS, *REDEFINING DEATH* 159-82 (1986). For an international perspective, see Christopher Pallis, *Brain Stem Death—The Evolution of a Concept*, 55 MEDICO-LEGAL J. 84 (1987).

165. Not everyone agrees that finding a definition of death is a worthwhile endeavor. One commentator argues that the effort expended on a search for a single definition of death is "wasted at best, counterproductive at worst." Roger B. Dworkin, *Death in Context*, 48 IND. L.J. 623, 628 (1973). The question of whether a death has occurred arises in a number of different contexts: When may an estate be probated? When does a life estate end? When is a victim of a crime dead? When can we stop medical treatment? Thus, "it would be odd indeed if all these different situations were susceptible to resolution by one definition of death." *Id.* at 631. "The simplest solution lies in recognizing that as there is no need to define death, so too there is no need for the law to use the term at all. . . . What is important . . . are the consequences, not the

logical advances will make whatever definition we settle on a temporary solution.

What I do think will happen is this: the Harvard Ad Hoc Committee criteria from the late 1960s will be discarded for a definition that includes higher brain function. Just when that will happen, I do not know, but it does not bother me that we are moving slowly.<sup>166</sup> Although I feel anguish for the members of the deathwatch, it is a definition that should only be made after deep reflection. After all, we are searching for the right words to say: This person is alive. That one is not. The consequences that flow from such a definition are profound: it tells us what it means to be a human being. We need to be wary of those words; they must say exactly what we mean them to say.

#### IV. DEATH THOUGHT, DEATH TALK, AND THE EVIDENTIARY IMPLICATIONS OF TABOO

##### WHAT CAN THE LAW DO TO ALLEVIATE INDIRECTLY THE PAIN OF THE MEMBERS OF THE DEATHWATCH?

This second suggestion is not so obvious, although several others who have looked at the horrors of the late-twentieth-century deathwatch have hinted at it: *The law can lower evidentiary standards regarding conversations about the circumstances of one's own death in recognition that the subject is a taboo in our culture.*

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Just as the members of the deathwatch hover over a dying person, so I hover over the subject of death. Death is not a subject that we meet face to face. We may talk and write around the subject of death, but we do not gather death into our arms.

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conclusory determination." *Id.* at 638. The law should only seek to describe the circumstances under which given consequences are to flow. For criticism of these views, see Alexander Capron, *The Purpose of Death: A Reply to Professor Dworkin*, 48 IND. L.J. 640 (1973).

Another writer points out that even if we redefined death to include patients in a persistent vegetative state, "it will be of no use in addressing the dilemmas of dying for patients in less fully debilitated conditions." Daniel Wikler, *Not Dead, Not Dying? Ethical Categories and Persistent Vegetative State*, HASTINGS CENTER REP., Feb.-Mar. 1988, at 41, 47.

166. It is not only probable, but highly desirable that society should proceed with the greatest caution and deliberation in proposing procedures that in any serious way threaten the traditional sanctity of the individual life. As a consequence, society will certainly move very slowly in developing formal arrangements for taking into account the interests of others in life-and-death decisions.

Robert Morison, *Death: Process or Event*, 173 SCIENCE 694, 698 (1971).



We do not feel its weight against our bodies; we do not look it in the eye. Instead, like strangers moving in and out of buildings, we brush up against death as we go about our business. Casual, unintentional encounters that do not implicate gravity. Oblique, fleeting encounters on other thresholds; silent nods in death's direction without the risk of intimacy.

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We had the conversation many years before his death.

It was one of those close nights in August when the house was too small to hold us. My father and I had escaped together to the backyard. We were sitting on deck chairs in the dark, listening to the melancholy *chchchchch* of the locusts. Our gray cat had appeared from nowhere to join us, sitting silently on the edge of the ravine, his eyes flashing green and golden from some unknown source of nocturnal light. There was no breeze, but the evening air had an edge of coolness to it, a hint on the back of the arms that summer was coming to an end. The planet had started to tip backwards, away from the sun, and we were together on that journey, my father and I, those rasping locusts, and our cat. My mother was out singing somewhere.

I do not remember what book I was lost in that summer, but it was probably Jung. It does not really matter. I think everyone has an August night in his life where some book generates questions about the soul.<sup>167</sup>

I asked my father if he believed in the human soul. His response was, as usual, Aristotelian.

"Yes," he said. "I believe in some spirit that lives and animates my body."

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167. Those who read books passionately, and survive, often have many such August nights throughout their lives. The first few are the most memorable, however, due to the tenderness of one's tissue and one's susceptibility to beauty and pain. One of my favorite accounts of growing up in the Midwest during the 1950s, or of growing up anywhere, reading books and looking at things intensely, is Annie Dillard's *An American Childhood*. Dillard describes the subversive influence of books on the young, how what she

sought in books was a world whose surfaces, whose people and events and days lived, actually matched the exaltation of the interior life. There you could live.

Those of us who read carried around with us like martyrs a secret knowledge, a secret joy, and a secret hope. There is a life worth living where history is still taking place; there are ideas worth dying for, and circumstances where courage is still prized. This life could be found and joined, like the Resistance.

ANNIE DILLARD, *AN AMERICAN CHILDHOOD* 183 (1987).

"And what will happen to that spirit when you die?" I pursued the subject, curious to hear his answer.

"What do you mean, 'What will happen'?" My father leaned over and picked up his beer that was nestled in the grass by his chair. "I don't think anything will happen. It will die when my body dies."

"That's it? You go and it goes?" I was disappointed, since I had recently come to a different conclusion and was seeking ratification.

"Yes, that's it. I am just a biological creature who lives in a body with a finite life span, and when it is over, I'll close my eyes and die. Then I suppose, my body will be cremated, and you can sprinkle me in the ravine. It'll be good for the trillium." He laughed softly and took a swig of beer. "I'll finally be useful."

"I think there's more to it." I was shy to reveal my new beliefs, even to my father, particularly to my father.

"I expect you do, sweetie girl. That's because I am an Aristotelian, and you are not."

I was annoyed. My father had picked up several theories from his undergraduate education, and one of them was that there were two kinds of people in the world: those who belonged to the Aristotelian tradition and those who belonged to the Platonic tradition. It may well have been a useful tool with which to analyze his fellow man, but my father's theory had worn thin on his family. He brought it out all the time, and much to our annoyance, it seemed universally applicable.

My brother rebelled against the theory with a countertheory designed to drive my father to distraction. There are two kinds of people in the world, my brother would say: those who believe there are two kinds of people in the world, and those who do not.

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It has been a rough century for talk about the human soul. In the early part of this century, the positivists carved metaphysics out of philosophic discourse, and devoted themselves to that which is knowable by our senses, one through five.<sup>168</sup> Nor

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168. The most famous articulation of philosophy's rejection of such metaphysical subjects as the future and past of the human soul is found in Alfred J. Ayer's *Language, Truth and Logic*. He begins by criticizing the "metaphysical thesis that philosophy affords us knowledge of a reality transcending the world of science and common sense." ALFRED J. AYER, *LANGUAGE, TRUTH AND LOGIC* 33 (1952). Metaphysicians produce sentences which are not verifia-

does the law talk much about the human soul, except in the context of one's constitutional freedom to maintain beliefs about religion.<sup>169</sup> And the medical profession is renowned for its reticence on spiritual matters, for keeping its gaze focused on the human body and not on what animates it.<sup>170</sup>

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ble by empirical evidence. While many metaphysical passages may have aesthetic or moral value,

[w]hat is important to us is to realize that even the utterances of the metaphysician who is attempting to expound a vision are literally senseless; so that henceforth we may pursue our philosophical researches with as little regard for them as for the more inglorious kind of metaphysics which comes from a failure to understand the workings of our language.

*Id.* at 45.

For a more modern treatment of the subject of the human soul see THOMAS NAGEL, *Death*, in MORTAL QUESTIONS 1 (1979). Nagel discusses the observation of Lucretius that it is irrational to fear death, since death is just the mirror image of our prenatal experience, and "no one finds it disturbing to contemplate the eternity preceding his own birth." *Id.* at 7. Nagel argues that "if death is an evil, it is the loss of life, rather than the state of being dead, or nonexistent, or unconscious, that is objectionable. This asymmetry is important." *Id.* at 3.

I am not as certain as Nagel that prenatal and posthumous nonexistence are not analogous. But then, Nagel expressly wants to "leave aside the question whether we are, or might be, immortal in some form," *id.* at 1, and assumes, for example, that "none of us existed before we were born (or conceived), but few regard that as a misfortune." *Id.* at 3. He also rather cavalierly states that "almost everyone would be indifferent (other things being equal) between immediate death and immediate coma followed by death twenty years later without reawakening." *Id.* at 2.

169. The Court first articulated the "action-belief" doctrine in *Reynolds v. United States*, 98 U.S. 145 (1878). In that case, George Reynolds, private secretary to Brigham Young, appealed his conviction under the Morrill Act for practicing polygamy in the Territories. Reynolds argued that it was his religious duty to practice polygamy, and "that the failing or refusing to practice polygamy by such male members of said church, when circumstances would admit, would be punished, and that the penalty for such failure and refusal would be damnation in the life to come." *Id.* at 161. The Court upheld the Morrill Act, announcing that the First Amendment makes freedom of *belief* absolute, but not freedom to act based on that belief. Although laws may not directly "interfere with mere religious belief and opinions, they may with practices." *Id.* at 166. Thus, the law purposefully does not discuss the substance of an individual's beliefs about such things as the immortality of the soul, except perhaps to allude to them in the presentation of the facts.

170. This probably stems from the fact that medicine in this century is viewed as a branch of science. Thus, like the positivists, the medical profession is only interested in phenomena which are empirically verifiable.

Physicians-as-scientists view their functions (observation, identification, description, investigation, and explanation of natural phenomena) within the theoretical confines of their discipline. They usually accept the notion of scientific law as a formulation of observed recurrences, order, relationships, or interactions of natural phenomena. Even the theories to which they turn, while not, by definition, based

Our collective reticence, however, does not mean that the subject is a dead one, not of vital importance to understanding the various attitudes towards the late-twentieth-century death-watch. The pressures of intellectual fashion may push our thoughts about the human soul below the water's surface, but submersion does not necessarily mean drowning. Our theory of ensoulment may still have enormous influence on our moral, legal, and medical behavior, even if those thoughts do not breathe the air.

Most of us believe in some theory of ensoulment, however inchoate, and with apologies to my brother, my father was probably right: We do each belong to either the Aristotelian or Platonic tradition. I first read the *Phaedo*<sup>171</sup> when I was seventeen. It was my season for leaving home, for shedding old beliefs and acquiring new ones, for pulling up the window shades to let the light flood in. In such a period of intellectual growth I first met Plato's theory of ensoulment. It had a great impact on me then, and although I do not embrace all of it now, his theory still represents a rough version of spiritual truth for me.

Plato viewed man as having a dual nature; he is a composite being, consisting of a corporeal element, the body, and an incorporeal element, the soul. During our temporal existence, the soul is seen as attached to or incorporated in the physical matter of the human body.<sup>172</sup> Plato always emphasized the element of control of the soul over the body.<sup>173</sup> The soul is viewed

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directly on observable phenomena, must ultimately be validated by reference to confirmed experimental law—to observably simple and definitely true statements about the nature or behavior of natural phenomena.

Joan M. Gibson & Robert L. Schwartz, *Physicians and Lawyers: Science, Art, and Conflict*, 6 AM. J.L. & MED. 173, 178 (1980).

171. *Phaedo*, *supra* note 31.

172. In the *Phaedo*, Socrates characterized the body as an "endless trouble to us." *Id.* at 120. Our souls are infected with the evils of the body, with its lusts, appetites for foods and "fancies of all kinds," and susceptibility to disease. *Id.* Worse yet, the body is "always breaking in upon us," causing turmoil and confusion in our enquiries, so that we are prevented from knowing the truth. *Id.* at 121. One can only achieve knowledge of Plato's essential forms through a separation of the soul from the foolishness of the body:

It has been proved to us by experience that if we would have pure knowledge of anything we must be quit of the body—the soul in herself must behold things in themselves: and then we shall attain the wisdom which we desire, and of which we say that we are lovers; not while we live, but after death . . . .

*Id.*

173. In the *Alcibiades*, Socrates distinguished between the user and the thing used. PLATO, *ALCIBIADES*, reprinted in *BODY, MIND AND DEATH* 34, 36

as a navigator of a seagoing vessel. Upon death, the true essential person survives because of his identification with the immortal substance of the soul. Death is seen as a liberation. Once freed from the prison of its physical form, the incorporeal soul is capable of existing on its own, in one form of immortal life or another.<sup>174</sup> For this reason, Socrates can show indifference at the end of the *Phaedo* when Crito asks him how to bury his body: "In any way you like; but you must get hold of me, and take care that I do not run away from you."<sup>175</sup> Crito is not to be sorrowful as he buries the body of Socrates, because the soul of Socrates shall not remain, but go away and depart.<sup>176</sup>

Here is where Plato and I part company. He had an elaborate theory of the transmigration of souls in which I have never been able to believe.<sup>177</sup> But it really does not matter what

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(Anthony Flew ed., 1964) Analogizing to a shoemaker or a harpist, he noted the difference between the artisan or artist and the tools or instruments that he uses. Similarly, the true essence of the artisan or artist differs from the hands and eyes he uses to carry out his work. Because a man uses his body, he must therefore be something different from his body. The user of the body, Socrates concluded, must be the soul. *Id.* at 36-37.

174. This is particularly true of the philosophic soul:

That soul, I say, herself invisible, departs to the invisible world—to the divine and immortal and rational: thither arriving, she is secure of bliss and is released from the error and folly of men, their fears and wild passions and all other human ills, and forever dwells, as they say of the initiated, in company with the gods.

*Phaedo*, *supra* note 31, at 141. If I turn out not to have a philosophic soul, and Plato's theory of the transmigration of souls turns out to be right, I can only hope that I will return to this earth as a cat in my own home. They really have it good.

175. *Id.* at 186.

176. *Id.*

177. According to Socrates, what happens to the soul after death depends upon the degree of its purity at the time of departure. The philosophical soul who has striven during life to overcome the body in its quest for knowledge of the forms will be delivered to a divine, rational and immortal world. *Id.* at 141. The impure, polluted soul who remained in love with the body has another fate, however. After death, such a depressed soul may be dragged down to the visible world and be left to wander among the graves and sepulchers, still longing for the corporeal world. Eventually these doomed souls will be imprisoned in another body. Their physical forms, Socrates warned, will be of the same nature as in their former lives. Thus, men who were gluttonous drunkards would pass into the bodies of asses and other lowly animals. The unjust, tyrannical and violent would pass into the bodies of wolves, hawks, or kites. *Id.* at 143. The temperate and just souls would pass into the bodies of social creatures, such as wasps or ants, or back again into the physical form of man. From these happier souls would spring the just and moderate men of the future. *Id.*

Milton similarly described the fate of the depressed souls of impure, lustful men:

either Plato or I believe about the afterlife. What will happen upon our deaths will happen. We will just have to wait and see. What does matter, at least with respect to how we perceive our own deaths, is that we believe something will happen when we take our last breath. We can face our deaths with some degree of equanimity and curiosity because of our belief in the soul's immortality.

But for many people who live in the late twentieth century, this is not the case.<sup>178</sup> Like my father, they are Aristotelians. Aristotle was a biologist. He did not consider the soul to be in any sense a separate substance or entity, but rather the form of a particular living body.<sup>179</sup> The soul-as-form stands in

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[B]ut when lust,

By unchaste looks, loose gestures, and foul talk,  
But most by lewd and lavish act of sin,  
Lets in defilement to the inward parts,  
The soul grows clotted by contagion,  
Embodies, and imbrutes, till she quite lose,  
The divine property of her first being.  
Such are those thick and gloomy shadows damp  
Oft seen in charnel, vaults, and sepulchers  
Lingering, and sitting by new-made grave,  
As loath to leave the body that it loved,  
And linked itself by carnal sensuality  
To a degenerate and degraded state.

JOHN MILTON, "Comus," in *THE POEMS OF JOHN MILTON* 168, 199-200 (John Carey & Alastair Fowler eds., Longmans 1966) (1634).

Plato also provides a procedure for transmigration. After death, the soul of each person would be led to a gathering place for the dead in order to be judged on its former life. After judgment, the soul would be guided into the world below to "receive their due and remain their time." *Phaedo*, *supra* note 31, at 177. Eventually, another guide would bring the soul back to the visible world "after many revolutions of ages." *Id.* Each soul would then be assigned to another physical form, a fitting habitation according to its degree of purity.

178. It is difficult to say whether this century's decline in formal religious activities in many industrialized Western nations represents both a decline in religious practice as well as a decline in beliefs. Writing about the Christian tradition in England, one commentator suggested that the crisis in religious belief belongs more to "religious intellectuals," while "[s]omething like half of British people appear to believe in an after-life." Ninian Smart, *Death and the Decline of Religion in Western Society*, in *MAN'S CONCERN WITH DEATH*, *supra* note 25, at 138, 140.

Smart attributes the intellectual crisis to three main roots, the second being "the effect of certain aspects of scientific thinking upon traditional ways of formulating Christian belief." *Id.* at 139. Scientific thinking had shaped my father's views on immortality, and I would suspect has also shaped the views of most members of the medical profession.

179. Aristotle started from the following principle, which ran through most of earlier Greek thought: the soul makes living things alive. ARISTOTLE, *DE ANIMA* 8-9 (John L. Ackrill ed. & David W. Hamlyn trans., 1968) [hereinafter *DE ANIMA*]. He was concerned, as a "student of nature," with all general

the same relationship to the physical body that the configuration of a statue stands to the materials from which it is made.<sup>180</sup> As such, the soul is inseparable from the body.<sup>181</sup> Aristotle left no room in his theory for the immortality of the soul. Once the body had lost its vitality, it had also lost its soul. Body and soul were so intimately entwined that they live and die together.<sup>182</sup>

What I have presented is a rather crude dichotomy. I have only touched upon two traditions, and at that, in a very cursory fashion.<sup>183</sup> Furthermore, I have confined myself to the frame-

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forms of life, not just with the human soul. According to Aristotle, the soul is the form of a living body, or "the first actuality of a natural body which has organs." *Id.* at 9. The first actuality seems to be some sort of potentiality. Thus to speak of the soul is to speak of "the potentialities which a living thing has for different forms of life." David W. Hamlyn, *Introduction to DE ANIMA*, *supra*, at x. These potentialities include the various faculties of living things: nutrition, reproduction, awareness, and rational thought. Aristotle believed they formed a hierarchy, with the higher functions being dependent upon those below. *Id.* at xi.

180. "Hence too we should not ask whether the soul and body are one, any more than whether the wax and the impression are one, or in general whether the matter of each thing and that of which it is the matter are one." *DE ANIMA*, *supra* note 179, at 9.

181. "That, therefore, the soul or certain parts of it, if it is divisible, cannot be separated from the body is quite clear; for in some cases the actuality is of the parts themselves." *Id.* at 10.

182. This account of Aristotle's beliefs regarding the immortality of the soul is unavoidably simplistic. True, Aristotle concluded "the soul does not exist without a body and yet is not itself a kind of body. For it is not a body, but something which belongs to a body, and for this reason exists in a body . . ." *Id.* at 14. Other passages in *De Anima*, however, suggest that personal immortality exists in some fashion due to the "eternal" nature of the active intellect. In discussing the active and passive intellect, Aristotle referred to the active intellect as "immortal and eternal." *Id.* at 60. Hamlyn suggested that the text of this passage may be corrupt. *DE ANIMA*, *supra* note 179, translator's notes at 141. Taking the "least extravagant" interpretation, "Aristotle provides no grounds here for any kind of belief in personal immortality." *Id.* at 142. Not all scholars agree, however, and there have been many conflicting interpretations of this passage. Even with these multiple interpretations of Aristotle, "it is illuminating to regard Aristotle as the archetypal protagonist of the alternative and opposite view of the nature of man, even though he was neither so consistent nor so wholehearted a monist as Plato was dualist." Antony Flew, *Introduction to BODY, MIND AND DEATH*, *supra* note 173, at 1, 9.

183. For example, I have not even alluded to Descartes, a more modern philosopher who fits squarely within the Platonic tradition. Like Plato, Descartes believed that "our soul is in its nature entirely independent of the body, and in consequence it is not liable to die with it." *RENE DESCARTES, DISCOURSE ON METHOD* (Elizabeth S. Haldane & G.R.T. Ross trans., 1931) (1637), *quoted in BODY, MIND AND DEATH*, *supra* note 173, at 129. As a student of physiology, Descartes departed from the Platonic tradition with his interest in science and mechanical principles. He equated living bodies with machines. Man-made automatons and brutes were considered pure machines, while man

work of Western culture, not even nodding above the line to the competing belief systems that exist in large parts of the world.<sup>184</sup> Thus even on the level of abstraction, what I have said about theories of ensoulment is fragmentary, and only a partial picture of how humans have come to regard the human soul and its immortality.

But the deficiencies in my discussion go even deeper than that, and they are beyond my control. I have only dealt with the matter of the soul on the level of abstraction, and there is much more to it than that. It is one thing to subscribe to metaphysics on an intellectual level, and another to believe in it con-

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was seen as a machine with a mind. What distinguished automatons and brute animals from human beings was the faculty of reason possessed by the latter. An automaton, for example, would be unable to make appropriate responses to the wide range of life events confronting even "the lowest type of man." *Id.* at 127. Brute animals reacted only from the "disposition of their organs," not from reason. *Id.* at 129. Furthermore, brute animals and automatons differed from man in their inability to arrange words and form statements by which they could make known their thoughts. This emphasis on consciousness and the ability to use language as the criterion of thought was distinctly Cartesian. "It is to Descartes and not to Plato that we owe the typically modern view . . . of the problem of body and mind as the problem of the relations between consciousness and the brain." Flew, *supra* note 182, at 24.

In this century, Gilbert Ryle challenged this traditional Cartesian dualism, which he calls the dogma of the "ghost in the machine." GILBERT RYLE, *THE CONCEPT OF MIND* 15-16 (1949). Mental and bodily activities are not separate and independent. Rather, when a person performs bodily in an appropriate way, we can regard this as a display of intelligence instead of the basis for an inference that there is some internal, invisible ghost who is running the machine. *Id.* at 22.

At least with respect to my thoughts about death, my interest in Plato's theory of ensoulment, as well as in Descartes' theory, has more to do with theology than with the philosophy of mind.

184. The Buddhist doctrine of rebirth, for example, differs dramatically from traditional Western concepts of the afterlife:

[T]he individual is regarded as virtually everlasting, unless and until he attains liberation (nirvana), when there will be no more rebirth. The individual comes through a vast succession of previous existences, and will continue thus so long as he remains in the grip of craving and spiritual ignorance. . . . the Buddhist doctrine of rebirth . . . does not involve belief in a soul. There is no permanent self underlying physical and mental states.

Ninian Smart, *Attitudes towards Death in Eastern Religions*, in *MAN'S CONCERN WITH DEATH*, *supra* note 25, at 95, 96. Nirvana means the replacement of the imperfect states which make up the individual by a permanent state in which there is no person. The death of the individual is "the most fearsome sign of the impermanence and ill-fare of the world," and the prospect facing the individual is seen "negatively as a succession of deaths." *Id.* at 97. Thus one should not hope to attain individual immortality, but to transcend it. Nirvana is sometimes described as the "deathless place," since it is "beyond the realm of change and therefore of individual existence." *Id.*



sistently. It is possible to subscribe to Plato's views about the immortality of the soul in the daylight, and break out in an Aristotelian sweat in the middle of the night.

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In fact, most of us do all right when the death talk is on the level of abstraction. We all know that death is a part of the human condition and this fact does sometimes enter into our conversations (although it is not a frequent intruder). No one invites the subject to come in, but no one denies it admission when it shows up at the back door, either.

But talk about a real death is another matter. That kind of talk is different.<sup>185</sup> And most of us never talk about our own deaths at all, except to ourselves, in the dark, in the dampness of that Aristotelian sweat. Even then, the subject of our own death usually never makes a formal appearance. It does not become incorporated in our nocturnal dialogue about undone tasks, unpaid bills, the randomness of tornadoes coming our way. Rather, the subject of our own death waits outside, and looks longingly in through the window. It casts a shadow on all our other talk, and the darkness it sheds magnifies our little worries into grave concerns. It is not really talk about our own death, but non-talk. By not letting it into our sentences, even those muttered to the self at night, we try to deny that it is there.<sup>186</sup> We cannot find the words to say that we might die

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185. Ghassan Kanafani, a modern Arabic writer, noted the difference between talking about death in the abstract and talking about an actual death:

What I want to talk to you about is death. Death that takes place in front of you, not about that death of which one merely hears. The difference between the two types of death is immeasurable and cannot be appreciated by someone who has not been a witness to a human being clutching at the coverlet of his bed with all the strength of his trembling fingers in order to resist that terrible slipping into extinction, as though the coverlet can pull him back from that colossus who, little by little, wrests from his eyes this life about which we know scarcely anything.

Ghassan Kanafani, *The Death of Bed Number 12*, reprinted in MODERN ARABIC SHORT STORIES, 28, 29 (Denys Johnson-Davies ed. & trans., Heinemann 1976).

186. Due to our narcissism and inability to conceive of ourselves not existing, "[i]n the unconscious every one of us is convinced of his own immortality." 14 SIGMUND FREUD, *Thoughts for the Times of War and Death* (1915), in STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS 273, 298 (James Strachey et al. eds. & trans., Hogarth Press 1957). "Whenever we attempt to [conceive of our nonexistence] we can perceive that we are, in fact, still present as spectators." *Id.* at 289.

For a study of Western attitudes toward death, see ERNEST BECKER, *THE DENIAL OF DEATH* (1973). "[T]he idea of death, the fear of it, haunts the

today.

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This denial of our own death, and the resulting silence that surrounds the subject, came to be of more than academic interest for me.

Richard worked in the law library at school, and while at first I did not know him very well, he had helped me on several research projects. He was a gifted reference librarian, curious and intuitive. He was also very sick. He had started out with the flu one winter, and his fever would not go away. It hung around for weeks and weeks, and when the doctor finally ran some blood tests, it turned out that Richard had lymphoma. He was thirty-one years old.

For months, Richard was in and out of the hospital for chemotherapy. During one dark period, his left lung suddenly collapsed, and he ended up on a respirator in the ICU. He recovered, however, or so it seemed, and eventually came back to work. One sticky afternoon in July, I was invited back to technical services to celebrate a staff member's birthday. It was the usual fare: Carmella's cupcakes, Hawaiian punch, matching cups and napkins from Woolworth, and a funny card signed by everyone. Richard and I sat together, perched on a cool radiator. I asked him how he was feeling.

"Fine, I guess. Tired. Okay, but really tired."

Then we talked about a movie I had just seen, and something else that I don't remember. It was crowded in the room, and festive. People were milling around, laughing, talking, juggling cupcakes on their knees. I was about to get off the radiator and get some more Hawaiian punch when I heard Richard say, "I'd like to get one of those documents you were doing re-

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human animal like nothing else: it is a mainspring of human activity—activity designed largely to avoid the fatality of death, to overcome it by denying in some way that it is the final destiny for man." *Id.* at ix. Becker devotes much of the book to showing that the fear of death is universal.

The fear of our own death is so great that we actually repress the idea: Therefore in normal times we move about actually without ever believing in our own death, as if we fully believed in our own corporeal immortality. We are intent on mastering death . . . . A man will say, of course, that he knows he will die some day, but he does not really care. He is having a good time with living, and he does not think about death and does not care to bother about it—but this is a purely intellectual, verbal admission. The affect of fear is repressed.

*Id.* at 17 (quoting Gregory Zilboorg, *Fear of Death*, 12 PSYCHOANALYTIC Q. at 468-71 (1943)).

search on last year. You know, one of those living wills."<sup>187</sup>

"Oh, sure." I tried to sound casual.

"You know, just in case. I don't know if you knew it or not, but last spring my lung collapsed and they put me on a respirator. I don't ever want to be on one of those things again. Ever. I would rather just die."<sup>188</sup> He said all of this rather matter-of-factly, but did not look at me. I did not know what to say, so I just rattled the ice cubes in my paper cup. "So anyhow," he said after an awkward silence, "I'd like to get one of those."

"I'm sure we can find a living will form somewhere in the collection. I don't have one, Richard, but they aren't hard to find."

"Okay, I'll look." And that was all he said.

Richard and I had many subsequent conversations during that summer, but he never again mentioned the living will. He continued to work in the law library until the middle of August, when his fever came back to haunt him. His recovery had been an illusion. He went into the hospital for more tests, and stayed for some experimental chemotherapy. One Monday

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187. The living will is a written directive, executed while the patient is competent, stating preferences about such things as termination of life-support systems and withdrawal of food in the event the patient later became incompetent. In some states, the requirements for valid living wills, including sample forms, can be found in what are called "Natural Death Acts." California enacted the first such statute in 1976. CAL. HEALTH & SAFETY CODE §§ 7185-7194.5 (West Supp. 1992). The various state acts that followed California's lead as of 1983 are listed in the PRESIDENT'S COMMISSION, *supra* note 74, app. D at 309-87.

The President's Commission suggested an alternative to natural death acts, the durable power of attorney statute. *See id.* at 145-47. With a power of attorney, the patient appoints an agent to act on his behalf. At common law, the power terminated when the principal became incapacitated. To avoid this result, many states enacted statutes allowing the agent's authority to continue if the principal becomes incompetent. This allows the agent to make medical decisions for the incompetent patient, including the decision to terminate life-support systems. Over 40 states now have some form of "living will" legislation, "right to die" legislation, "natural death acts," or "durable power of attorney" statutes. The statutes vary considerably. *See* Judith Areen, *Advance Directives Under State Law and Judicial Decisions*, 19 LAW, MED. & HEALTH CARE 91 (1991) (summarizing various statutes); *see also* UNIF. RIGHTS OF THE TERMINALLY ILL ACT, 9B U.L.A. 96 (Supp. 1989).

188. One study suggests that most patients and family members (70%) who had experienced intensive care treatment were completely certain that they would do so again to prolong life for any period, including only one month. Marion Danis, M.D. et al., *Patients' and Families' Preferences for Medical Intensive Care*, 260 JAMA 797, 800 (1988). Thus Richard may have been in the minority of patients who had spent time in an ICU.

morning I came into the library to learn that Richard was again in the ICU. On a respirator.

I called his mother to see how he was, and she said that when Richard's lungs had failed him, the doctors had put him back on the respirator. He was acutely agitated, and seemed to want to tell her something. Richard had written my name on the chalkboard that the nurses had given him to communicate. She wondered if I knew why, and I told her of our conversation of several months back, sitting on the radiator in technical services at a staff member's birthday party. She was frantic. There was nothing she could do for her son, and she wanted to do something. Anything.

Could I bring one of those living wills to the hospital?

I went to the card catalog, and within a few minutes I found a book with the living will form. I photocopied it, and brought the form to the hospital, and his mother led me into the ICU. Richard was lying all alone in a dark cubicle. From the eyes down, the respirator had taken over his face, making him look like some kind of exotic, elephantine creature.<sup>189</sup> With each pseudobreath, it inflated him over and over again, jerking him across the bed as if he were the marionette of some mad puppeteer. What I saw was violence, and a total, complete absence of control.

As far as I could tell, when I engaged his eyes, Richard seemed happy to see me, and nodded when I showed him the living will. I could get no one to witness its execution. The nurses had been instructed not to participate in the signing of any documents, and I was referred to the hospital's Legal Department. It all seemed so pointless there in the corridor of the ICU, staring at an empty form whose legal effect was dubious to begin with,<sup>190</sup> its purpose already defeated, and my friend

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189. The fact that a respirator is attached to the human face through a green plastic mask from which protrudes a long green elephantine tube is difficult to ignore. Masks transform the human body into something else. These transformations often occur in fairy tales, where animals can change into human beings, or human beings into animals. "The transformation of one thing into another is the specialty of the so-called demons." SCHILDER, *supra* note 57, at 205. Watching such a transformation of a familiar face can be a disturbing experience.

190. At the time of Richard's illness, New York had no legislation recognizing advance directives for medical treatment. The New York Court of Appeals, however, had given effect to prior oral statements where there was uncontested evidence that the patient had indicated his views regarding the removal of life-support systems before becoming incompetent. *In re Storar*, 420 N.E.2d 64, 72 (N.Y.), *cert. denied sub nom. Storar v. Storar*, 454 U.S. 858 (1981).

Richard exactly where he did not want to be. But his mother was looking at me with such expectation, as if by witnessing the signing of the living will, we could somehow make Richard live. And Richard had nodded.

So I got a pen, and we smoothed the document over the chalk board, and Richard signed the damned thing. He slipped into a coma that afternoon, and was dead before the sun went down. He never got off the respirator.

With the fierce egocentricity of a survivor, I felt responsible. I should have pursued that conversation, and have often asked myself why I did not. It would have taken just a few minutes to go to the card catalog on that sticky day in July and find Richard a living will form, the same few minutes it had taken on the day that he died.

Perhaps it was the informality of the occasion: Carmella's cupcakes and the Hawaiian Punch. Perhaps it was the tenuousness of our relationship: a friend I knew from work. Perhaps it was my own inability to deal with the request: denial of Richard's death and of my own. Perhaps I just did the wrong thing.

I have had to live with that failure for a long time. Richard died over eight years ago. Eventually I gave up blaming myself for those last few days he spent on a respirator in the ICU. If he really had felt that strongly about life-support systems, I told myself, he would have gotten the living will forms himself. After all, he certainly had the research skills. Besides, there were many times after that conversation on the radiator at which Richard could have broached the subject, and did not. It was up to him to instigate the conversation, not me. I was just a co-worker, not his lawyer or best friend. Such were my rationalizations.

I have often wondered why Richard chose me to reveal his thoughts to about the respirator. Perhaps he knew the nature of my research, and assumed that I would be able to find a living will. That seemed like a logical explanation, but just beneath the layer of words that sought to make sense of things, it

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The court authorized the removal of a respirator based on this uncontested evidence and on the ground that the common law permitted a competent patient the right to decline medical treatment. *Id.* at 70, 72. Thus, at the time Richard requested the living will, there was no statutory authority for its recognition, although common law precedent gave effect to prior statements regarding intent. Since that time, New York has passed a statute providing for the appointment of a health care agent and proxy. N.Y. PUB. HEALTH LAW §§ 2980-94 (McKinney Supp. 1992).

made no sense at all. I might be able to follow a map in the law library, but Richard was a cartographer. Perhaps he chose me because there was no risk in his revelation. It was an opportunity to speak the truth, without suffering the consequences. Speaking the truth is never cheap. It always costs somebody something.<sup>191</sup>

Why had he not told his mother how he felt about the respirator? Under almost any scenario, his mother was the one who would be there at the moment of decision; she was certain to be a member of his deathwatch. She would have been in the best position to carry out his intent.

But would she? I did not know Richard's mother well, though well enough to know something of her despair. Richard may well have calculated the cost of telling the truth to his mother and decided that it was too high. Not only would the conversation itself have been incredibly painful, with its implicit acceptance of failure, but carrying out his intent might also have been too much for her to bear. It was a heavy burden to place on a mother, instructing her not to put her son on a life-support system when she was clinging to his life. Also, Richard's request might have interrupted the flow of her prayers, and he might not have wanted to do that.

The fact was that Richard did not want to die. He found the contemplation of his own death a terrifying thing. He called me once, late at night, before his last hospitalization, and wanted to know whether I believed in God. I think he was under the misapprehension that I was a rational person, and that if a rational person could believe in God, then maybe he could too. I was not up to the task. My own beliefs were so idiosyncratic that I could not give Richard what he needed, a transfusion of faith. During the course of that conversation, however, I discovered how truly frightened he was. Here was someone who had not come to terms with his own mortality. That was probably not unusual for a man age thirty-one, but his illness had taken Richard's rather commonplace fears and elevated them into a spiritual crisis. He needed to talk to someone.

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191. I have always been leery of our enshrinement of the truth as the ultimate ideal. One of my favorite quotes comes from Otto Rank: "[F]or the time being I gave up writing—there is already too much truth in the world—an overproduction which apparently cannot be consumed!" JESSIE TAFT, OTTO RANK 175 (1958) (quoting a letter from Otto Rank to Jessie Taft (Feb. 8, 1933)).

In our culture, the subject of death—in particular, one's own death—is a taboo.<sup>192</sup> Richard was in a panic, but customary patterns of conversation did not provide him with a graceful way to initiate talk about that panic. He once made an appointment with a priest in the hospital, but it was a man he did not know, the priest was in a hurry, and Richard was very shy.

Besides, talk about our own death rarely takes place in a formal setting. It does not wear a tuxedo, the way we dress up our words in drafting a will, when we commit to writing what we want done with our property. Talk about what we want done with our bodies in the event of terminal illness and incompetency almost always wears blue jeans and a T-shirt, and is spoken softly, in casual, even haphazard, circumstances. Too much fear and superstition surround those words, and they cannot bear much scrutiny. After all, to the speaker of those words, there is a risk in saying them. For Richard, to articulate his intent about life-support systems was to ensure the inevitability of their use. To say those words was to make them come true.

Is it any wonder, given the climatic conditions, that there was no rain, that no words of intent showered down upon his mother, his doctor, or his lawyer in written form, or public, oral declarations? Is it any wonder that Richard chose to reveal himself to someone he did not know very well, at a birthday party at work, while sitting on a radiator?

Now here is the wonder: that Richard managed to crack the hard, dry surface of his silence at all.

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192. A *taboo* is

1) A prohibition excluding something from use, approach, or mention because of its sacred and violable nature. 2) An object, word, or act protected by such a prohibition. 3) A ban or inhibition attached to something by social custom or emotional aversion. 4) Belief in or conformity to religious or social prohibitions. 5) A proscription devised and observed by any group for its own protection.—*adj.*, Excluded or forbidden by use, approach, or mention . . .

AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 1236 (2d ed. 1975).

Radcliffe-Brown wrote that the English word *taboo* derives from the Polynesian word, *tabu*, which means simply "to forbid" or "forbidden" and can apply to any sort of prohibition. Thus, the word may express a rule of etiquette, a chief's order, or an injunction to children not to touch something. ALFRED R. RADCLIFFE-BROWN, *STRUCTURE AND FUNCTION IN PRIMITIVE SOCIETY* 133 (1952).

There is a direct relationship between our theory of ensoulment and our attitude toward death. If we subscribe to some version of the Platonic tradition, and truly believe in spiritual immortality, then we might welcome death, or at least face it with stoic resignation. But if we believe in the Aristotelian notion that our soul will be buried with the body, that could indeed create a dark, moist environment in which the wild orchids of desperation might grow.

These are generalizations, of course, but I make them just the same.<sup>193</sup> I am aware there are exceptions. For example, one could believe in an afterlife, and also in eternal damnation. Then, depending upon one's propensity to sin, the contemplation of death could inspire holy terror. Similarly, I have known some peaceful and content Aristotelians. My father was an example. It really did not seem to bother him that someday he might end up fertilizing the trillium. Still, I think the generalizations are more true than not. Beliefs about the soul's continuation, or lack thereof, affect our attitude towards death. This is not a very ambitious claim.

There is also a direct relationship between our attitude toward death and its status as a taboo subject. A taboo is something forbidden, and taboos come in many different forms. They may be proscriptions against certain behaviors,<sup>194</sup> or against eating certain foods,<sup>195</sup> or touching certain sacred or

193. One of my favorite essays by Joseph Epstein is about the virtues of generalizations and their importance to "civilized discourse." Perhaps I am so fond of the essay because he used as an example a variant of my father's generalization about people falling into two categories. "[T]here is something appealing in the finitude of them. If there are only two types or categories or kinds—or even if there are four or five—then the world suddenly seems so much more intellectually manageable." JOSEPH EPSTEIN, *But I Generalize*, in *THE MIDDLE OF MY TETHER: FAMILIAR ESSAYS* 189, 199 (1983).

194. Some of our behaviors, thought to be motivated by superstitions, are in fact motivated by a taboo. For example, in contemporary England, a person who spills salt is considered unlucky, but can avoid misfortune by throwing salt over his shoulder. RADCLIFFE-BROWN, *supra* note 192, at 135. "[H]e . . . takes precautions and goes through a ritual in order that he may escape the danger and be restored to his former ritual status." *Id.*

195. The biblical rules found in Leviticus and Deuteronomy are perfect examples of dietary proscriptions.

Every animal that parts the hoof and has the hoof cloven in two, and chews the cud, among the animals you may eat. Yet of those that chew the cud or have the hoof cloven you shall not eat these: the camel, the hare, and the rock badger, because they chew the cud but do not part the hoof, are unclean for you. And the swine, because it parts the hoof but does not chew the cud, is unclean for you. Their flesh you shall not eat, and their carcasses you shall not touch.

*Deuteronomy* 14:6-8.



profane objects or persons.<sup>196</sup> But taboos can also be what Levi-Strauss called "linguistic prohibitions."<sup>197</sup> In a given culture, certain words or subjects may be forbidden to be spoken of in public discourse. Someone with Victorian sensibilities, for example, may consider the mention of sexual activity or birth to violate a taboo.<sup>198</sup> Geoffrey Gorer has theorized that there has been a shift in prudery during the last century, with the subject

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196. Some cultures proscribe touching a corpse. According to Polynesian belief, the person who touches or carries a corpse is considered at risk. "[T]he misfortune of which he is considered to be in danger is illness." RADCLIFFE-BROWN, *supra* note 192, at 135. Other cultures have a similar proscription against touching a newborn baby. *Id.* at 148; see also MARY DOUGLAS, PURITY AND DANGER: AN ANALYSIS OF CONCEPTS OF POLLUTION AND TABOO 140-58 (1966) (discussing primitive sexual rituals and their role in maintaining social structures).

197. CLAUDE LEVI-STRAUSS, THE SAVAGE MIND 176 (Julian Pitt-Rivers & Ernest Gellner eds., Weidenfeld and Nicholson 1966) (1962). One example of linguistic prohibitions, found in Australia as well as in America, involves speaking the names of the dead. *Id.* at 176-77. For example, "the Wik Munkan forbid any mention of a name or names for three years after the death of their bearer, that is, until his mummified body has been burnt." *Id.* at 183. Similarly, some names, such as those of a man's dead sister or his wife's dead brother, may never be mentioned. *Id.* "An inquirer committing the blunder of asking them is supplied with a substitute name which means literally 'no name', 'without name' or 'the second born.'" *Id.* Some cultures give the dead a new proper name known as a "necronym" to avoid breaking the taboo. *Id.* at 191-200. Necronyms sound to me a great deal like the euphemisms we use, such as "passing on" or "passed away," to say that someone died, presumably to avoid a linguistic prohibition.

Freud had a lot to say about the prohibition against uttering the name of a dead person and about the "taboo upon the dead" in general. SIGMUND FREUD, TOTEM AND TABOO 51-74 (James Strachey trans., 1950) (1913). One explanation for the taboo is a fear "of the presence of or of the return of the dead person's ghost . . . to utter his name is equivalent to invoking him and will be quickly be followed by his presence." *Id.* at 57. Freud believed that the taboo had developed from our ambivalent emotional attitudes toward the dead person. *Id.* at 60. We may indeed feel an unconscious satisfaction from the death of a loved one, and this "can explain the idea that the souls of those who have just died are transformed into demons and the necessity felt by survivors to protect themselves by taboos against their hostility." *Id.* at 60-61. Eventually the ambivalence becomes apparent when, as time goes by, the demons of the recently dead disappear and are replaced by ancestors who are to be venerated. *Id.* at 65-66. Mourning performs a "psychical task . . . its function is to detach the survivor's memories and hopes from the dead" and eventually transform those demons into friendlier spirits who can be revered and appealed to for assistance. *Id.* For another discussion of "tabooed words," see SIR JAMES GEORGE FRAZIER, THE NEW GOLDEN BOUGH 107-12 (Theodor H. Gaster ed., Anchor Books 1961) (1959).

198. I have often noted that in social situations the subject of pregnancy and birth are considered inappropriate topics of conversation in "mixed company." It is deemed "girl talk," something that the women may discuss freely among themselves in the kitchen but not out in the living room where the

of death replacing the subject of sex as the forbidden topic on life's agenda.<sup>199</sup> His explanation for the linguistic prohibition on the subject of death is the same as mine: People no longer have a system of belief that includes spiritual immortality.

The reasoning goes something like this: If the predominant attitude toward death in a culture is one of fear, then death becomes the subject of a linguistic prohibition—a taboo.<sup>200</sup> There are risks in violating a taboo. Much like a formal legal system, our informal, traditional codes of conduct often

men most often reside. This has always struck me as odd, since for me, the bringing into the world of a new human being has infinite fascination.

Some recent feminist writings have pointed out that the subject of birth has seldom been held to be as profound as the subject of death. Death appears on the male agenda, but "birth [is] not and will not become, a worthy subject of male philosophy." MARY O'BRIEN, *THE POLITICS OF REPRODUCTION* 156 (1983). Symbolic representations of giving birth are rare: "Imaginative representations of birth from the point of view of a woman contemplating it, or of a woman experiencing a pregnancy . . . or of a woman giving birth, are unfamiliar cultural constructions." Virginia Held, *Birth and Death*, reprinted in *FEMINISM AND POLITICAL THEORY* 87, 95 (Cass R. Sunstein ed., 1990).

199. GEOFFREY GORER, *The Pornography of Death*, (1955), reprinted in GORER, *supra* note 44, app. 4 at 195. In the mid-Victorian decades, birth and intercourse were the "unmentionables," and the subject of death was "no mystery." *Id.* Children were encouraged to think and talk about death, and to attend the deaths of others, and it was a "rare individual who, in the 19th century with its high mortality, had not witnessed at least one actual dying." *Id.*

In the twentieth century, Gorer argues, prudery has shifted. Sexual intercourse has become more mentionable, and "death has become more and more 'unmentionable' as a natural process." *Id.* Gorer sees a connection between the shift of taboos and the shift in English religious beliefs where "belief in the future life as taught in Christian doctrine is very uncommon today." *Id.* at 196. He recommends that we "give back to death—natural death—its parade and publicity, readmit grief and mourning" in order to do away with this "modern pornography of death." *Id.* at 199.

200. In *The Magic Mountain*, Thomas Mann alluded to the taboo nature of death. A popular old man in the sanatorium, known as the "gentleman rider," died after weeks of critical illness. When a nurse "discreetly communicated the sad event" to Hans Castorp, the protagonist, he rebelled against the "prevailing system of secrecy" by insisting on viewing the gentleman rider's mortal remains. THOMAS MANN, *THE MAGIC MOUNTAIN* 291-92 (H.T. Lowe-Porter trans., Alfred A. Knopf 1951) (1924). At the dining hall, Castorp

tried to introduce the subject of death at table, but was met with such a flat and callous rebuff on all sides as both to anger and embarrass him. Frau Stroer had been downright gruff. What did he mean by introducing such a subject—what kind of upbringing had he had? The house regulations protected the patients from having such things come to their knowledge; and now here was a young whippersnapper bringing it up at table.

*Id.* at 292.

carry sanctions for the breaking of unwritten rules.<sup>201</sup> By referring to the subject of death, and in particular to one's own death, one runs the risk of conjuring up death's appearance.<sup>202</sup> In breaking the taboo, the speaker endangers himself by making himself vulnerable to the evil that prompted the taboo. If that risk is of no threat to the speaker, then the subject can be openly spoken of. In this instance, if the appearance of death does not rattle our bones, then there is no reason for silence on the subject. Simply put, the less fear we have about something, the more likely we are to talk about it. The converse is true as well: the more fear we have about something, the less likely we are to talk about it. Once again, this is not a very ambitious claim.

Anyone who does not believe me should spend some time in Ireland.

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201. Ironically, given his role in forming the tenets of liberal thought, emphasizing individual freedom to pursue one's interests without interference from the state as long as no harm is caused to others, John Stuart Mill also reminds us of the sanctions that society may impose on an individual who strays too far from the accepted path. See JOHN STUART MILL, *On Liberty*, (1859) reprinted in *UTILITARIANISM*, *supra* note 146, at 126, 205-08 (Mary Warnock ed., 1962). While the state may not have the authority to intervene and stop certain socially unacceptable behavior, the citizens do have the power to punish the offender. *Id.* at 205. Thus, society can ostracize a violator of social norms. *Id.* at 208.

For a discussion of the taboos existing in the practice of law, see WALTER O. WEYRAUCH, *THE PERSONALITY OF LAWYERS: A COMPARATIVE STUDY OF SUBJECTIVE FACTORS IN LAW, BASED ON INTERVIEWS WITH GERMAN LAWYERS* 140-43 (1964).

202. "Ritual avoidance" or "ritual prohibitions" are rules of behavior "associated with a belief that an infraction will result in an undesirable change in the ritual status" of the offender. RADCLIFFE-BROWN, *supra* note 192, at 134-35.

Many cultures have rites associated with two important occasions, birth and death, and rules of avoidance almost always accompany these rites. A baby or corpse, the object of the ritual avoidance, has "ritual value," and there may be a taboo against touching that object. *Id.* at 133. Many things can have ritual value, including "a person, a material thing, a place, a word or name, an occasion or event," or even a period of time. *Id.* at 139. The members of a given culture generally agree as to the ritual value of certain things. *Id.* at 141. If a taboo is broken, the person who broke it must restrict his behavior. *Id.* at 133. He "may not use his hands to feed himself," for he is "in a state of danger." *Id.* Nor can others touch him, because he can be dangerous to others. *Id.* He himself becomes taboo by having broken the taboo. *Id.*

I am arguing here that the very subject of death, especially one's own death, has ritual value; it is the object of ritual avoidance in that speaking of it puts the speaker in danger. The danger is that the offender may now suffer an undesirable change in her ritual status. That is to say, she may herself become vulnerable to death and put others in danger of death by having become taboo herself.

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My husband's family lives in county Wexford, and every summer we take the children and rent a house for an extended visit to the Irish grandparents, aunts, uncles, and cousins. The first time I went to Ireland I was struck by the frequency with which death, and the dead, were mentioned unflinchingly in casual conversation. On my first visit, I tried very hard to learn all the branches of the family. It was not an easy task. My mother-in-law came from a family of fourteen children, my father-in-law from a family of nine. I found that I could keep the relationships straight if I thoroughly understood the preceding generation, so I started by learning the children's names and the birth orders of both sets of my husband's grandparents. As I met each aunt and uncle, and began to have a face to attach to the name, I moved on to their spouses and children. To tell the truth, after almost ten years, I am still working on the children of their children. With over seventy first cousins to master, and many repetitions of the same name, it is a miracle that I have remained sane. A few rules have saved me. For example, when in doubt, his name is Andrew.<sup>203</sup>

The real problem for me at first was to determine which of the aunts and uncles were dead. My confusion sprang from the freedom with which death, and the dead, were talked about around the kitchen table. On that first visit, I was having trouble identifying Father Ger. Father Ger was an older brother of my mother-in-law, a Sinnott. He was obviously much-loved, a practical joker and a confidant to many. The one photograph I had seen of him showed a handsome young man in a priest's collar, hands thrust rakishly into his pockets, legs crossed, a greyhound at his feet, and an engaging smile that demanded one in return. I had heard many Father Ger stories and was looking forward to meeting him. About two weeks into the visit, I heard my mother-in-law refer to her brother Ger, and then say quietly, "God have mercy on his soul." For the first time, it dawned on me that I was not going to meet Father Ger, on this trip or any other. He had died in 1957.

In my defense, I had not been tipped off about Father Ger's

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203. There is a time-honored Irish custom of naming the eldest son after his paternal grandfather and the second son after his maternal grandfather. *HANDBOOK ON IRISH GENEALOGY* 11 (1978). The eldest and second daughters were similarly named after their paternal and maternal grandmothers. *Id.* Thus, on my husband's father's side, all the eldest boys were named Andrew, after their paternal grandfather.

death by any visits to his grave.<sup>204</sup> Many of the other deceased members of the family, including the grandparents, were buried in the village churchyard. They were visited at least once a week, on the way to or from Mass. It was as if the dead were still a part of the community. Dying marked a sort of transition, but not the kind that I had been accustomed to in my own culture. Where I come from, once a person dies, he more or less ceases to be the subject of conversation. Even in intimate family settings, where a dead person might be talked about openly, he has been relegated to the status of memory, a static position. In Ireland, however, the dead do not disappear or become frozen in the same way. Somehow they are still with us, as active, silent participants, and no one seems to find anything disturbing about their presence. On the contrary, having them around is rather comforting.<sup>205</sup>

The same thing is true about the subject of death in Ireland. While it is not dwelled upon, when it does come up in conversation, the speaker's tone of voice does not change. He maintains eye contact, and there are no awkward silences or clumsy efforts to move away from a subject that should never have been mentioned. You can talk about death over a cup of tea if you have to, need to or want to. Although I have often heard sadness expressed at the mention of someone dying, I have never heard an echo of fear or desperation.

The closest thing to trepidation that I ever heard about dy-

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204. Father Ger was buried in the parish in which he served rather than in his family's parish. This is not an uncommon practice in Ireland. Similarly, nuns are usually buried with other members of their religious order.

205. The following passage from the work of Henry Scott Holland was recently read at the funeral of one of our most beloved Irish aunts:

Death is nothing at all. It does not count. I have only slipped away into the next room. Nothing has happened. Everything remains exactly as it was. I am I, and you are you, and the old life that we lived so fondly together is untouched, unchanged. Whatever we were to each other, that we are still. Call me by the old familiar name. Speak of me in the easy way which you always used. Put no difference into your tone. Wear no forced air of solemnity or sorrow. Laugh as we always laughed at the little jokes that we enjoyed together. Play, smile, think of me, pray for me. Let my name be ever the household word that it always was. Let it be spoken without an effort, without the ghost of a shadow upon it. Life means all that it ever meant. It is the same as it ever was. There is absolute and unbroken continuity. What is this death but a negligible accident? Why should I be out of mind because I am out of sight? I am but waiting for you, for an interval, somewhere very near, just round the corner. All is well.

ROSAMUNDE PILCHER, SEPTEMBER 522-23 (1990) (quoting Henry Scott Holland (1847-1918)). I am grateful for the assistance of Rosamunde Pilcher in identifying the author of this beautiful passage.

ing was from my mother-in-law. At a family gathering, we were talking about irrational worries, and my mother-in-law confessed that she was pathologically afraid of being buried alive. As a child, she had once read about a man who had been in a coma and appeared to be dead, but in fact was not. He had been waked and buried, and later was discovered to have regained consciousness while in a coffin, under six feet of dirt. To this confession, her nephew, Father John, quipped, "Don't worry, Aunt Nan. We'll know if you've stopped talking for more than five minutes, you've got to be dead." The anecdote has become a bit of family folklore; my daughters will hear the story over and over again, long after their grandmother is gone.

What accounts for this attitude toward death in the corner of Ireland that I have come to know? My intuition is that it comes from a strong religious faith and a firm belief in the immortality of the soul. The Catholic theory of ensoulment, when embraced wholeheartedly, makes death a mundane topic, even one that can generate a joke at a family gathering. Because death has spiritual meaning and is theologically a joyous occasion, there is no reason to avoid mentioning it in conversation.<sup>206</sup> The subject is not taboo.

It is no quirk of fate that the Catholic religion has been at the forefront of articulating when it should be permissible to withhold extraordinary care from terminally ill patients.<sup>207</sup>

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206. Catholics find their beliefs about the immortality of the soul in the New Testament. "The principle of life is the spirit, the soul" and "death is the giving up of the spirit." THE CATHOLIC ENCYCLOPEDIA 154 (Robert C. Broderick ed., 1976) (citing to *Matthew* 27:50 and *Acts* 7:59). Catholics are "consoled by the many biblical assurances that we will rise with Christ to a new life in God the Father who prepared our reward from all ages." *Id.* (citing to *Colossians* 2:20, 3:1-11).

*Cf.* John J. Paris, *Terminating Treatment for Newborns: A Theological Perspective*, 10 LAW, MED. & HEALTH CARE 120 (1982) (criticizing the widespread belief that life and technology are the ultimate values, without regard to medical prognosis or cost of medical treatment); J. Stuart Showalter, *Determining Death: The Legal and Theological Aspects of Brain-Related Criteria*, 27 CATH. LAW. 112, 114-16 (1982) (explaining the Catholic view that death is not final, and therefore all possible means do not have to be used in keeping a person alive).

207. Catholicism makes a distinction between "extraordinary" and "ordinary" care when determining what care can be withheld from terminally ill patients. This distinction has a long history in Catholicism, where it was used prior to the discovery of antiseptics and anesthesia to decide whether a patient's refusal of treatment should be classified as a suicide. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 126-27 (2d ed. 1983).

*Ordinary* means of preserving life are all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient

Nor is it surprising that the Catholic tradition allows the burden on the family to be taken into account when determining whether a particular treatment is ordinary or extraordinary.<sup>208</sup> Where a belief system exists that takes away the fear of death, it is possible to shift the focus from the dying person to the members of the deathwatch. For the dying person, the journey is almost over. Those who are left behind must be ministered to. They are the ones who must contend with sorrow and pain, not the soul who is about to take flight.

Ireland could teach us something about how to face our going out. If we could shatter the silence that surrounds the subject of death, we might be able to confront the taboo. Confronting the taboo would make for better deaths, and making for better deaths would help alleviate the horrors of the late twentieth-century-deathwatch. It would be an improvement in the human condition; a benefit for us all, and something to aspire to.

But for the people in power, confronting the taboo must be more than just an aspiration. Those people who orchestrate the deaths of others—who have jurisdiction over the human body,

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and which can be obtained and used without excessive expense, pain, or other inconvenience. . . . *Extraordinary* means of preserving life . . . mean all medicines, treatments, and operations, which cannot be obtained without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit.

GERALD KELLY, MEDICO-MORAL PROBLEMS, *quoted in* RAMSEY, *supra* note 164, at 122.

208. Pope Pius XII has spoken directly to this subject:

The rights and duties of the family depend in general upon the presumed will of the unconscious patient if he is of age and *sui juris*. Where the proper and independent duty of the family is concerned, they are usually bound only to the use of ordinary means.

Consequently, if it appears that the attempt at resuscitation constitutes in reality such a burden for the family that one cannot in all conscience impose it upon them, they can lawfully insist that the doctor should discontinue these attempts, and the doctor can lawfully comply.

JUDITH AREEN ET AL., LAW, SCIENCE AND MEDICINE 111 (1984) (quoting *The Prolongation of Life*, 4 THE POPE SPEAKS 393, 397 (1958)).

The Sacred Congregation for the Doctrine of the Faith endorsed this stance with its May 5, 1980, "Declaration on Euthanasia," approved by Pope John Paul II. It asserts:

It is also permitted, with the patient's consent, to interrupt these means (provided by the most advanced medical techniques), where the results fall short of expectations. But for such a decision to be made, account will have to be taken of the reasonable wishes of the patient and the patient's family, and also of the doctors who are specially competent in the matter.

*Id.*

who judge death talk, who design death spaces—have a duty to confront the taboo. This duty runs not only to the dying person, but also to those who gather around him.

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Doctors more or less run the dying show. Because of their medical monopoly on what takes place in hospitals and other health-care facilities, their attitudes toward death shape the contours of the late-twentieth-century deathwatch. Like other kinds of death talk, their attitudes will rarely be spoken of or written down, but they do not need to be. Like DNA, they encode the dying experience without expression, and obedient to the genetic command, the medicalized deathwatch unravels itself in a designated way.

The taboo on the subject of death is even more pronounced in the medical profession. There is often a conspiracy of silence about death in a hospital, a reluctance to express in words the fact that a patient is dying. In the early 1980s, there were some chilling cases in which "Do Not Resuscitate" orders ("DNRs") were conveyed by attaching purple adhesive dots ● to the patient's nursing records, or by circling the patient's name in red on the chart. Mistakes in applying dots and circles to the wrong person's name, and disputes over who should have the power to add color to those charts, resulted in much more stringent requirements for the ordering of DNRs.<sup>209</sup> It was as if the

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209. *E.g.*, Ronald Sullivan, *State Says Hospital to Revive a Dying Patient*, N.Y. TIMES, Nov. 20, 1984, at B6. A grand jury, investigating cases in which resuscitation was ordered withheld from two patients, criticized La Guardia Hospital in Queens. The hospital staff there conveyed "Do Not Resuscitate" orders by attaching a purple decal to the patient's nursing record. In an attempt to escape the legal risks of withholding CPR from dying patients, they would then discard the purple decal along with the record when the patient died.

New York Hospital identified patients whom it did not intend to resuscitate by circling their names in red on the chart. The hospital was charged in a civil suit when an intern refused, against the protests of a family member, also a physician, to resuscitate an 87-year-old patient for whom the family had not authorized DNR orders. It must have been quite a horrible scene: a family member and physician ordered a "crash cart," but was restrained by a hospital intern who refused to resuscitate the woman, pointing "to her chart, which had a red circle drawn around her name, signifying that she should not be saved." *Id.*

There is considerable literature regarding DNRs. *See, e.g.*, Mitchell T. Rabkin et al., *Orders Not to Resuscitate*, 295 NEW ENG. J. MED. 364 (1976) (discussing the method by which a decision not to resuscitate is formulated, and the need for stricter definitions of that process); Rabbi Levi Meier, *Code and No-Code: A Psychological Analysis and the Viewpoint of Jewish Laws*, in LEGAL & ETHICAL ASPECTS, *supra* note 102, at 90 (addressing a physician's de-



doctors and nurses needed another form of symbolic representation, something besides words, to communicate their orders about an impending death. I was reminded of those dots and circles when reading about a practice in a large, urban hospital. There was often a time-lag at this hospital between the death of an indigent patient and the transportation of the body to the morgue. To alert other hospital workers there was a corpse inside a room, the door would be closed, and often a slip of white paper would be taped to the door, a silent, wordless announcement that a death had just occurred.<sup>210</sup>

Another sign of the taboo nature of death, even in the medical profession, is avoidance of the dying person. Not only do health care workers not want to talk *about* a patient who is dying, but often they do not want to talk *to* a patient who is dying. Of course, this kind of avoidance behavior is not confined to health care workers; it is just a manifestation of what has come to be called "death anxiety."<sup>211</sup> An early study of avoidance behavior attempted to identify the relative degree to which college students would distance themselves socially from

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cision whether or not to write a DNR order in terms of psychology and Jewish law); see also PRESIDENT'S COMMISSION, *supra* note 74, app. I at 493-545 (compiling various policies of governmental bodies, institutions, and professional societies).

210. SUDNOW, *supra* note 37, at 44.

211. Psychological literature defines, in various ways, an empirically measurable theoretical construct known as "death anxiety." See, e.g., ROBERT KASTENBAUM & RUTH AISENBERG, *THE PSYCHOLOGY OF DEATH* 55-64 (1972). Kastenbaum and Aisenberg defined the fear of death as the "fear of extinction, annihilation, obliteration, or 'ceasing to be.'" *Id.* at 44. Choron isolated three different types of death fears: fear of the event or process; fear of what comes after death; and fear of ceasing to be. JACQUES CHORON, *MODERN MAN AND MORTALITY* 70-83 (1964).

Various measurement techniques seek to quantify the amount of death anxiety present in an individual. Ian S. Madfes, *Death Anxiety and Related Characteristics Among Hospice and Nonhospice Nurses* 18 (1990) (unpublished Ph.D. dissertation, California School of Professional Psychology (Berkeley/Alameda)). The two most commonly employed direct measures are the Templer Death Anxiety Scale and the Collett-Lester Fear of Death and Dying Scales. *Id.* at 20. The Templer Scale is a unidimensional measure which more often correlates with fears of one's own death and dying than with the death and dying of others. *Id.* "The Collett-Lester Scales attempt to independently assess four defined death fears: fear of death of self; fear of death of others; fear of self dying; and fear of others dying." *Id.* Both scales require subjects to rate statements about death and dying. *Id.* For example, the Collett-Lester Scales ask subjects to rate their degree of agreement or disagreement with a statement like, "I would not mind dying young." The Templer Scales asks subjects to respond True or False to similar statements. *Id.* at 21.

One of the major problems with these empirical techniques is their inability to measure the largely unconscious quality of death anxiety.

a dying person.<sup>212</sup> The researcher found that white subjects would avoid dying persons to the same extent that they would avoid "blacks or gamblers."<sup>213</sup> Most would not want to have a dying person as a friend. Similar studies in health care settings show that doctors and nurses are also guilty of fleeing from dying patients, perhaps due to their own anxieties about death.<sup>214</sup> They distance themselves; they express anger at the patient; they limit conversations; they avoid contact altogether, intellectualizing the patient's condition so they no longer have to deal with him as a person.<sup>215</sup> The effect on the dying person can be devastating. The abject loneliness of the situation,<sup>216</sup> the deper-

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212. Richard A. Kalish, *Social Distance and the Dying*, 2 COMMUNITY MENTAL HEALTH J. 152, 152-55 (1966).

213. *Id.* at 153.

214. Commentators have suggested that the practice of medicine itself generates a higher degree of death anxiety than is experienced in the general population. One study reported that a group of 81 physicians was more fearful of death than groups consisting of medical students, healthy persons, and terminally and seriously ill patients. Herman Feifel et al., *Physicians Consider Death*, 2 AM. PSYCHOL. ASS'N PROC. 201, 201-202 (1967). The medical student group was less fearful of death than the physician group, but more fearful than the other groups studied. *Id.* at 202. Data suggested that the "continued experience in the medical profession did not facilitate the mastery of one's fear of death, but rather appeared to enhance it." Joyce B. Cochrane, *Death Anxiety, Disclosure Behaviors, and Attitudes of Oncologists Towards Terminal Care* 19 (1987) (unpublished Ed.D. dissertation, Temple University).

215. For a summary of the various studies done on avoidance behavior by medical professionals about terminal care, see Harriet Goodman, *Death Work: Staff Perspectives on the Care of Terminally Ill Patients in an Acute Care Hospital* 15-19 (1990) (unpublished Ph.D. dissertation, City University of New York).

A patient may even be treated as *socially dead*, even though he might not yet be biologically dead. SUDNOW, *supra* note 37, at 74. Social death is "marked by that point at which socially relevant attributes of the patient begin permanently to cease to be operative as conditions for treating him, and when he is, essentially, regarded as already dead." *Id.* For example, a nurse closed the eyelids of a dying woman before she was actually dead in preparation for her status as corpse, it being apparently more difficult to close the lids after rigor mortis sets in. *Id.* This practice allowed for a more efficient wrapping of the body when the woman actually did die. *Id.*

216. In an article about group therapy with the terminally ill, researchers reported that "the most basic anxiety of many group members was not so much a fear of dying, of finiteness and nonbeing, but of the absolute utter loneliness that accompanies death." Irvin D. Yalom, M.D. & Carlos Greaves, M.D., *Group Therapy with the Terminally Ill*, 134 AM. J. PSYCHIATRY 396, 398 (1977). While existential loneliness could not be allayed by therapy, "secondary interpersonal loneliness that is a function both of the shunning of the dying person and his/her self-imposed isolation," could be handled capably in the group. *Id.*

Nurses, doctors and other medical personnel would often subtly "cue the patient" that her illness was terminal. *Id.* Dying patients experienced a

sonalization,<sup>217</sup> and the denial of any kind of significant social role,<sup>218</sup> are forms of social death which seem far more abhorrent than the biological death which the health care workers are avoiding.

There are reasons, obvious ones I suppose, why medical professionals might not deal well with death and dying. After all, most of them consider themselves in the business of saving lives,<sup>219</sup> and it is easy to see how they might perceive the death

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"hushed shrinking away, a tendency to be less intimate, a slightly greater distance." *Id.* One patient initially realized the gravity of her illness when her doctor began ending his meetings with her by solemnly shaking her hand instead of "giving her a gentle pat on the fanny." *Id.* (a remarkable observation on several different levels).

217. Just becoming a patient in a hospital, regardless of one's terminal status, can lead to the psychological phenomenon known as "depersonalization." This phenomenon, a feeling of loss of ego, has more specifically come to mean "a state in which the individual regards himself, and particularly his body, as a foreign object. He is estranged from his own body and does not experience it as belonging to himself. There are associated feelings of being without will and being like a machine." FISHER, *supra* note 60, at 114.

Depersonalization can occur chronically in severely disturbed people, but also occasionally in normal people, often as a response to stressful situations or those in which an individual must identify with a degraded role. Edith Jacobson, *Depersonalization*, 1959 J. AM. PSYCHOANALYTIC ASS'N 581, 583. One psychologist researched political prisoners in Nazi Germany who had once been substantial citizens, but were being treated as criminals. *Id.* at 581. They frequently reacted with depersonalization symptoms, such as feeling that their face or limbs did not belong to them. *Id.* at 581-82. The denial of part or all of the body was a symbolic denial of the criminal role assigned to them. *Id.* at 606-07. The same psychological phenomenon can happen to anyone who leaves his social role behind him to become a patient in a hospital. This is particularly true if one is dying, and the hospital workers exhibit avoidance behavior.

218. The denial of a social role for the dying person cannot be discussed in an historical vacuum. Erik H. Erikson argues that it is all too easy to discuss intellectual history as if it has no influence on the development of our psychological profiles, and urges us to analyze the "individual's ego identity in relation to the historical changes which dominated his childhood milieu." Erik H. Erikson, *Ego Development and Historical Change*, in *IDENTITY AND THE LIFE CYCLE* 18, 49 (1 Psych. Issues 1959). While a child has a number of "opportunities to identify himself, with real or fictitious people of either sex, with habits, traits, occupations, and ideas . . . the historical era in which he lives offers only a limited number of socially meaningful models for workable combinations of identification fragments." *Id.* at 26.

The increased medicalization of death, and the shunning of the dying person by both medical professionals and laymen, has provided no socially meaningful role for the dying person. This has caused a psychological crisis for the dying person which must be understood in its historical context.

219. In Brian Clark's play, *Whose Life is It Anyway*, Dr. Emerson treats a young sculptor who was paralyzed from the neck down in an accident and has chosen not to continue his life. When another doctor suggests that someone in his patient's situation could wish to die, Dr. Emerson categorically states:

No, Clare, a doctor cannot accept the choice for death; he's committed

of a patient to be a failure—a public, professional failure.<sup>220</sup> A recent article about heart surgeons in New York State published mortality rates as evidence of a doctor's skill.<sup>221</sup> It was a telling comment on our culture that survival rates would stand out as the sole criterion by which we would judge a doctor. There was no corresponding chart for sensitivity, tact, or a willingness to respond to not only the medical needs of the patient, but to his emotional, spiritual and social needs as well.

That should come as no surprise, however. We are all obsessed with beating death, and our own attitudes promote and perpetuate the attitudes of our healers. It is a symbiotic relationship, one in which miracles are demanded<sup>222</sup> and often delivered. When the miracle does not happen, the failure must be felt acutely by the miracle worker. There is a lot at stake in that failure, most of it having to do with the death of a patient and not the death of a human being.

It is understandable, therefore, that medical professionals would be even more vulnerable to the taboo of death talk—un-

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to life. When a patient is brought into my unit, he's in a bad way. I don't stand about thinking whether or not it's worth saving his life, I haven't time for doubts. I get in there, do whatever I can to save life. I'm a doctor, not a judge.

BRIAN CLARK, *WHOSE LIFE IS IT ANYWAY* 91 (1978).

220. Being human, the doctor can be hurt when forced to acknowledge that his patient is going to die. Perhaps as his medical experience lengthens he is less aware of the hurt he first felt earlier in his career when his patients died; but although the situation becomes bearable it can still perturb. He must admit to the person most concerned that he is now impotent to do what is desired so much, to save his patient's life. The doctor's ability to cure and bring relief usually sustain him in his work—and in his own self-esteem. He can feel very threatened at having to admit failure to a person who is depending on him.

John Hinton, *The Dying and the Doctor*, in *MAN'S CONCERN WITH DEATH*, *supra* note 25, at 30, 37.

221. David Zinman, *Heart Surgeons Rated*, *NEWSDAY* (Nassau & Suffolk ed.), Dec. 18, 1991, at 3. This was the first time that the New York Health Department had ever released, by name, adjusted mortality rates for each of the 140 New York heart surgeons. The Health Department made the disclosure under court order, ending a Freedom of Information Act lawsuit initiated by *Newsday*. The figures covered cardiac artery bypass operations performed in 1989 and 1990. *Id.*

222. Symptomatic of a "demanding" era, groups have even formed that are devoted to the goal of beating death altogether. KRANT, *supra* note 40, at 13. For example, a publication originated in California (where else?) called *The Immortality Newsletter*, whose motto was "Death is an imposition on the human race and no longer acceptable." *Id.* This philosophy generated the cryonics movement of the 1970s in which bodies of recently dead people were frozen in liquid nitrogen capsules so that the individuals could be revived in the future, when medicine will have found a cure for the fatal illness. *Id.*

derstandable, but not forgivable. The facts are that people die, and they do so while being cared for by doctors and nurses. Because the power to determine the circumstances of death resides almost entirely with the medical profession, there is a duty to chart carefully the course for a patient riding through those narrow straits, a duty not to let that patient crash into sheer cliffs, hurdle over wild waters alone, or languish in the doldrums of artificial life support. That duty runs to the family and friends of the dying person, to the members of the death-watch. The death belongs to them as well.<sup>223</sup>

Ultimately, the medical profession must confront the taboo. Words must be found to communicate the fact of the death so that a proper deathwatch can take place. Words of disclosure to the patient and his family.<sup>224</sup> Words about life-support systems that allow the patient to manifest his intent

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223. My indictment against the medical profession is, of course, general. Many nurses, doctors, and other health care professionals have spoken and written about the importance of attending to the members of the deathwatch as well as to the patient. For example, some hospitals and hospices offer what is sometimes referred to as "Bereavement Service," which includes counseling for family members both before and after the death. At St. Christopher's Hospice in London, the Bereavement Service maintains contact with the family for an average of 18 months after the death. Families and close friends are "assisted in working out their bereavement through reality assistance, emotional support, and simple talking-out." Leonard Liegner, M.D., *St. Christopher's Hospice, 1974: Care of the Dying Patient*, 234 JAMA 1048, 1048 (1975).

224. A trend has developed toward more open disclosure to patients, including disclosure of a bad prognosis. See, e.g., PRESIDENT'S COMMISSION, *supra* note 74, at 52-54. A 1961 study found that almost 90% of doctors had a "strong and general tendency" not to tell their patients of a cancer diagnosis. Donald Oken, M.D., *What to Tell Cancer Patients: A Study of Medical Attitudes*, 175 JAMA 1120, 1122 (1960). Sixteen years later, more than 97% of doctors said they routinely disclosed a cancer diagnosis to patients. Dennis H. Novak, M.D. et al., *Changes in Physicians' Attitudes Towards Telling the Cancer Patient*, 241 JAMA 897, 898 (1979). But see Alan Meisel & Loren H. Roth, *Toward an Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies*, 25 ARIZ. L. REV. 265 (1983) (criticizing the reliance placed on these studies).

A one-sided disclosure from doctor to patient may not actually do much to confront the taboo on the subject of death. Jay Katz argued eloquently for doctors and patients to move beyond the narrow confines of the doctrine of informed consent, which only requires the doctor to recite a litany of medical risks to the patient. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 85-103 (1984). Instead, the doctor and patient must have a dialogue in order to arrive at appropriate medical decisions, a dialogue which admits the inequalities of the parties. *Id.* at 101-102. The doctor knows more about the disease, and the patient knows more about his needs. *Id.* at 102. The conversation must be built on trust. *Id.* "This trust cannot be earned through deeds alone. It requires words as well. It relies not only on physicians' technical compe-

before losing competency.<sup>225</sup> Words that help to turn the fear inside out, just by virtue of their having been spoken. Words of consultation,<sup>226</sup> and of sympathy.<sup>227</sup>

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tence but also on their willingness to share the burden of decision making with patients and on their *verbal* competence to do so." *Id.*

For another plea for a conversation between doctor and patient, and in particular for the patient to take the initiative, see Michael R. Flick, *The Due Process of Dying*, 79 CAL. L. REV. 1121, 1162-63 (1991).

225. It always made me angry that my friend Richard's doctor did not initiate any conversations with him about any sort of living will or other advance directive regarding life-support systems, considering his gloomy prognosis. Apparently, it is not uncommon for doctors to fail to take the initiative in this way.

In 1976, California enacted the first natural death legislation. Diane L. Redleaf et al., Note, *The California Natural Death Act: An Empirical Study of Physicians' Practices*, 31 STAN. L. REV. 913, 917 (1979); see also *supra* note 187 and accompanying text (discussing living wills, natural death acts, and durable power of attorney legislation). A study of the effects of the Act on physician practices found that while most physicians were aware of the Act, only 22% of the respondents knew the circumstances under which directives were binding. Redleaf, *supra*, at 930. "Most physicians either did not answer or said they did not know whether the Act permits withholding or withdrawal of life-sustaining procedures only if the patient would die regardless of such procedures." *Id.* Most who did respond were incorrect. *Id.* The majority of the physicians also "did not know how long a patient must wait after being diagnosed as terminally ill before executing a binding directive." *Id.* A significant number of doctors (16%) expressed fears that the Act had increased their malpractice liability for stopping treatment, and 27% felt that the Act had made them uncertain regarding their criminal and civil liability if they did so. *Id.* at 939.

This study was done in 1979 when the Natural Death Act movement was in its youth, and doctors were probably much less sophisticated about the medical, legal, and ethical issues surrounding the termination of treatment than they are now. I know that in nursing homes, the forms for DNR orders are often pushed under the patient's nose before the suitcases are unpacked. When I put my elderly aunt into a nursing home a year ago, she was presented with a DNR form before getting to choose whether she would have jello or a Twinkie for dessert.

Doctors have also complained, probably justifiably, that the legal profession has not done a very good job in communicating the law to the medical profession. See, e.g., Flick, *supra* note 224, at 1166 n.165 ("Both what the law is and how it is applied are largely mysteries to doctors, who get their information about law from newspapers and medical journals. In the retelling of the law, commentators inevitably simplify and put a gloss on it . . . .")

226. Words of consultation are particularly critical to family members who may be bearing a large part of the burden of caring for the dying patient. See, e.g., Wallace I. Sampson, M.D., *Dying at Home*, 238 JAMA 2405 (1977) (discussing the needs to talk to family members about a patient's desire to die at home). Dr. Sampson has some excellent medical advice regarding the problems a family might run into if the family decides to bring the patient home to die. Among the subjects covered are pain control, ways to deal with bowel and bladder dysfunction, and the patient's need (or lack thereof) for food and water. *Id.* at 2406. Sampson also has some advice to doctors on how

Lawyers too must confront the taboo, but in a different way.

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It seems as if we are going to have to live with the pretense that the decision to terminate life-support systems belongs to Karen Quinlan or Nancy Cruzan. Dispensing with that pretense appears to be too costly; too much is at stake. To make the pretense palatable, however, courts have imposed certain standards of proof on the manifestations of the patient's former intent. In applying those standards, the taboo nature of death talk must be taken into account.

Consider the evidentiary standards New York and Missouri imposed on the members of the deathwatch. To prove that the patient, if competent, would have refused life-sustaining treatment, these states have adopted a "clear and convincing" standard of proof.<sup>228</sup>

Mary O'Connor was a 77-year-old woman who suffered several strokes that left her incompetent.<sup>229</sup> She was a widow,

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best to support and assist the patient and family: "People seem to want to regain control of their lives and of their deaths. Except in smaller towns, medicine has not been geared to home care, so we need to reorient ourselves to the desires of people who want to die at home." *Id.* at 2405. In a sense, Sampson's is a "how to" article on the logistics of bringing back the nineteenth-century deathwatch. See also *On Dying At Home*, EMERGENCY MED., Feb. 1977, at 136 (discussing the virtues of allowing a terminally ill patient to die at home amidst family and friends).

Anyone who can get through an article about home care for the terminally ill child or infant without crying is made of sterner stuff than I am. For a discussion of home care for terminally ill children, see Ida M. Martinson, R.N., *Why Don't We Let Them Die at Home?*, RN, Jan. 1976, at 58.

227. Occasionally a doctor will directly address the emotional needs of the members of the deathwatch. See, e.g., G.E. Burch, M.D., *Of the Family of the Sick*, 92 AM. HEART J. 405, 405 (1976). While Dr. Burch focused on the welfare of the patient, he also wrote about the fears and anxieties of family members and discussed the need for physicians to meet regularly with the family and to allow frequent and lengthy visits to the bedside of the dying person. *Id.* He suggested that doctors often appear to family members as "primarily concerned with the use and operation of complex, frightening, awful apparatus with stern, serious, and grim automatons in attendance." *Id.* Dr. Burch admitted that the additional burden of responding to concerns of the family of the sick "can annoy the doctors at times, but this is part of caring for the sick, part of the practice of medicine." *Id.* Dr. Burch may attend my deathwatch anytime.

228. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director*, Mo. Dep't of Health, 110 S. Ct. 2841 (1990); *In re Westchester County Medical Ctr. ex rel. O'Connor*, 531 N.E.2d 607 (N.Y. 1988).

229. Mary O'Connor suffered from dementia as a result of strokes. Although the condition "substantially impaired her cognitive ability," she was

with two adult daughters, Helen and Joan, both of whom were practical nurses. After her first stroke, she went to live with Helen, but, when she suffered a second stroke, she lost her gag reflex and had to be put into a nursing home. Because she could not eat, O'Connor became so ill that she had to be transferred to a hospital where her doctors wanted to insert a nasogastric feeding tube to keep her from dying of thirst and starvation. Her daughters opposed the insertion of the tube, stating that this was against their mother's expressed wishes that "she did not want her life prolonged by artificial means if she was unable to care for herself."<sup>230</sup>

At trial, James Lampasso, a former co-worker and long-time friend of Mary O'Connor, testified that he first discussed artificial means of prolonging life with her in 1969. At that time, Lampasso's father was dying of cancer and had informed him that he would not want to continue life by any artificial means if he had lost his dignity and could no longer control his bodily functions. O'Connor had wholeheartedly agreed, saying, "I would never want to be a burden on anyone and I would never want to lose my dignity before I passed away."<sup>231</sup> Lampasso also noted that O'Connor was a "very religious woman" who "felt that nature should take its course and not use further artificial means."<sup>232</sup> During two or three subsequent conversations, O'Connor stated that it was "monstrous" to keep someone alive by using "machinery, things like that" when

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not in a coma or a persistent vegetative state. *O'Connor*, 531 N.E.2d at 609. "She was conscious, and capable of responding to simple questions or requests sometimes by squeezing the questioner's hand and sometimes verbally." *Id.* She could not understand complex questions, however, such as those dealing with her medical treatment. *Id.* at 610. Her doctor "doubted that she would ever regain significant mental capacity because the brain damage was substantial and irreparable." *Id.*

In defending his court's decision in *O'Connor*, Chief Judge Wachtler distinguished the case from the later United States Supreme Court decision, *Cruzan v. Director, Missouri Department of Health*, on the basis that Nancy Cruzan was in a persistent vegetative state, and Mary O'Connor was not. Sol Wachtler, *A Judge's Perspective: The New York Rulings*, 19 LAW, MED. & HEALTH CARE 60, 62 (1991). The *O'Connor* decision was not, he protested, an earlier version of *Cruzan* because "Mary O'Connor was not a Nancy Cruzan." *Id.* Thus, according to Wachtler, the Court of Appeals of New York has not yet confronted how or whether to terminate life-support systems from someone in a persistent vegetative state who had not left clear and convincing evidence of his intent. *Id.*

230. *O'Connor*, 531 N.E.2d at 609.

231. *Id.* at 611 (quoting Lampasso's testimony about a conversation with O'Connor).

232. *Id.* (quoting Lampasso's testimony).



they are 'not going to get better'; that she would never want to be in the same situation as her husband and Lampasso's father, and that people who are 'suffering very badly' should be allowed to die."<sup>233</sup>

Mary O'Connor had been a member of two deathwatches: her husband's and her stepmother's. One daughter, Helen, testified that after her father was hospitalized with cancer, her mother said that she never wanted to be in a similar situation; "she would not want to go on living if she could not 'take care of herself and make her own decisions.'"<sup>234</sup> Helen testified that later, after O'Connor had been hospitalized for a heart attack and had finally been discharged, her mother said "that she was very glad to be out of the hospital and hope[d] she would never have to be back in one again and would never want any sort of intervention, any sort of life support systems to maintain or prolong her life."<sup>235</sup> Mary O'Connor's other daughter, Joan, gave similar testimony, describing her mother's statements on this subject as "less solemn pronouncements: 'It was brought up when we were together, at times when in conversations you start something, you know, maybe the news was on and maybe that was the topic that was brought up and that's how it came about.'"<sup>236</sup>

The New York Court of Appeals held the members of the deathwatch, in this case the daughters, to the very high evidentiary standard of "clear and convincing" evidence with regard to their mother's intent.<sup>237</sup> The usual standard of proof in a civil case is a "preponderance of the evidence"; in a criminal case, the burden is "beyond a reasonable doubt." In the mist, between the two standards of proof, floats this standard called "clear and convincing" evidence. In this context, the New York Court of Appeals described it as "proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented."<sup>238</sup>

When the New York Court of Appeals applied the evidentiary standard of "clear and convincing," the daughters' testimony in *O'Connor* could not meet the burden of proof.<sup>239</sup> The

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233. *Id.*

234. *Id.* (quoting Helen's testimony about a conversation with her mother).

235. *Id.* (quoting Helen's testimony).

236. *Id.* (quoting Joan's testimony).

237. *Id.* at 612.

238. *Id.* at 613.

239. *Id.* at 615.

court noted that Mary O'Connor had never discussed the withholding of food and nutrition;<sup>240</sup> nor had she indicated whether she would feel the same way if the refusal of medical treatment would have produced a painful death.<sup>241</sup> Both daughters admitted that their mother had never discussed what she would have done under those precise circumstances.<sup>242</sup>

Nancy Cruzan's parents ran into the same high evidentiary hurdle in Missouri when they sought to withdraw her nasogastric feeding tube. Nancy's statements, made at age twenty-five in a "somewhat serious conversation with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least halfway normally," also did not meet Missouri's standard of "clear and convincing" evidence.<sup>243</sup> Like the daughters in *O'Connor*, the members of Nancy Cruzan's deathwatch faced a familiar problem, harking back to *Quinlan*. Her statements about life support were too general, too hypothetical, too lacking in specificity.<sup>244</sup>

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240. *Id.*

241. *Id.* at 608.

242. *Id.* at 615.

243. *Cruzan v. Harmon*, 760 S.W.2d 408, 433 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990).

244. Actually, I do not find Mary O'Connor's statements, in particular, to be too general, too hypothetical, or too lacking in specificity. Judge Simons, who dissented from the majority opinion in *O'Connor*, agreed with me. While he was willing to adopt the standard of "clear and convincing," he was also willing to accept the trial court's finding that O'Connor's family had met that burden of proof, that "Mrs. O'Connor did not wish any artificial means used to prolong her life under these circumstances." *O'Connor*, 531 N.E.2d at 622 (Simons, J., dissenting). He also noted that she had participated in several deathwatches of close family members, that she had consistently expressed her view that artificial means should not be used to sustain life, and that some of those statements had been made after a hospitalization for a serious illness. *Id.*

Similarly, the conversations that Nancy Cruzan had with a roommate, and the conversations that Karen Quinlan had on several occasions with family members and friends, do not strike me as too general, too hypothetical, or too lacking in specificity. To its credit, the Supreme Court of New Jersey later stated that Karen Quinlan's statements were "certainly relevant to shed light on whether the patient would have consented to the treatment if competent to make the decision." *In re Conroy*, 486 A.2d 1209, 1230 (N.J. 1985).

A very disturbing article has convinced me that there is a lot of hidden sexism in these appellate cases regarding the termination of life-support systems; that the moral agency of women, and thus their statements of intent, are taken less seriously than those of men. See Steven H. Miles & Allison August, *Courts, Gender and "The Right to Die,"* 18 LAW, MED. & HEALTH CARE 85, 85 (1990). Much of the article is based on the theoretical work of Carol Gilligan. She argues that women have a different approach to moral decision making than men. The male model tends to view the moral agent as an autonomous

The writers of those state appellate opinions, however, treated the subject of death just like any other subject about which a court might have to infer intent. They did not indicate that what was being talked about was any different from what kind of chickens a restaurant might want to buy, or what kind of windows an owner might want to put in his house.<sup>245</sup> Chickens, windows, death—the subject matter is all the same, in texture, in color, in density.

Justice Brennan's dissent in *Cruzan*, however, is where the taboo nature of death is dealt with honestly. Justice Brennan's dissent is also where the members of the deathwatch are acknowledged, and their pain openly recognized. After describing the physical deformation and dependency of a patient in a persistent vegetative state, he wrote, "Such conditions are, for many, humiliating to contemplate, as is visiting a prolonged and anguished vigil on one's parents, spouse, and children. A long, drawn-out death can have a debilitating effect on family members."<sup>246</sup> He opposed the standard of "clear and convincing" evidence on several different grounds, one of those being the exclusion of any testimony from family members and close friends regarding what Nancy would have done.<sup>247</sup> In fact, Justice Brennan argued that intimate conversations with those family members and close friends may be "the best evidence available of what the patient's choice would be. It is they with whom the patient most likely will have discussed such questions and they who know the patient best."<sup>248</sup>

Finally, Justice Brennan urged us all to look at the nature of death talk. While the majority suggested that only living wills or equivalently formal directives could meet the high standard of proof, Justice Brennan pointed out that most peo-

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individuated bearer of "rights," whereas the female model views the moral agent as a member of a complex, interdependent community in which decisions have an impact not only on the individual, but also on relationships among other members of the intimate group. *Id.* at 92. See generally CAROL GILLIGAN, IN A DIFFERENT VOICE (1982) (analyzing theories of human development and their shortcomings as applied to both sexes); Robin West, *Jurisprudence and Gender*, 55 U. CHI. L. REV. 1 (1988) (examining the harms of gender-patterned jurisprudence).

245. *Frigaliment Importing Co. v. B.N.S. Int'l Sales Corp.*, 190 F. Supp. 116, 121 (S.D.N.Y. 1960); *Jacob & Youngs, Inc. v. Kent*, 129 N.E. 889, 890 (N.Y. 1921).

246. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2869 (1990) (Brennan, J., dissenting).

247. *Id.* at 2876.

248. *Id.*

ple do not behave that way about their own deaths.<sup>249</sup> Ignorance about the legal requirements, denial of the possibility that such a thing could happen, and denial of their own mortality all contribute to an absence of formality about their intent regarding life-support systems.<sup>250</sup> No inference of lack of intent, Justice Brennan argued, should be drawn from the failure to write it down:

Too few people execute living wills or equivalently formal directives for such an evidentiary rule to ensure adequately that the wishes of incompetent persons will be honored. While it might be a wise social policy to encourage people to furnish such instructions, no general conclusion about a patient's choice can be drawn from the absence of formalities. The probability of becoming irreversibly vegetative is so low that many people may not feel an urgency to marshal formal evidence of their preferences. Some may not wish to dwell on their own physical deterioration and mortality.<sup>251</sup>

Justice Brennan ended his dissent by disparaging the legal fiction that the Supreme Courts of Missouri and the United States were trying to effectuate Nancy Cruzan's intent. Instead, "[t]hey have discarded evidence of her will, ignored her values, and deprived her of the right to a decision as closely approximating her own choice as humanly possible. They have done so disingenuously in her name, and openly in Missouri's own."<sup>252</sup>

Justice Brennan's remarkable dissent is followed by another, by Justice Stevens. Justice Stevens also brought the members of the deathwatch into the circle of constitutional consideration. His contribution, in my mind, is to tie their presence to the spiritual component of death. Borrowing an elegant turn of phrase from Justice Harlan, Justice Stevens made a beautiful analogy: "[J]ust as the constitutional protection for the 'physical curtilage of the home . . . is surely . . . a result of solicitude to protect the privacies of the life within,'" so too "the constitutional protection for the human body is surely inseparable from concern for the mind and spirit that dwell

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249. *Id.*

250. Several studies have demonstrated that the number of adults who have actually executed a living will remains small. The numbers range from as low as 4%, to 15% (a telephone survey of a random sample of adults conducted by the AMA) and 17.5% (a sample of older adult research volunteers). Nancy R. Zweibel & Christine K. Cassel, *Treatment Choices at the End of Life: A Comparison of Decisions by Older Patients and Their Physician-Selected Proxies*, 29 GERONTOLOGIST 615, 615 (1989).

251. *Cruzan v. Director, Mo. Dept. of Health*, 110 S. Ct. at 2875 (Brennan, J., dissenting).

252. *Id.* at 2878.

therein."<sup>253</sup> While admitting that the constitutional significance of death is difficult to describe, he explained that

not much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience. We may also, however, justly assume that death is not life's simple opposite, or its necessary terminus, but rather its completion. Our ethical tradition has long regarded an appreciation of morality as essential to understanding life's significance.<sup>254</sup>

Justice Stevens then cast his eye on the members of the deathwatch. Nancy Cruzan's interest in life included "an interest in how she will be thought of after her death by those whose opinions mattered to her. There can be no doubt that her life made her dear to her family, and to others. How she dies will affect how that life is remembered."<sup>255</sup> He argued that the state of Missouri should have deferred to the members of the deathwatch, not directly as I had originally planned, but indirectly, working in the shadows and on the edges of things as my friend had suggested:

The trial court's order authorizing Nancy's parents to cease their daughter's treatment would have permitted the family that cares for Nancy to bring to a close her tragedy and her death. Missouri's objection to that order subordinates Nancy's body, her family, and the lasting significance of her life to the State's own interests. The decision we review thereby interferes with constitutional interests of the highest order.<sup>256</sup>

As I said, those are remarkable dissents.

Do others sometimes feel, as I do, that they were born at the wrong time? That their feelings and thoughts are so out of sync with the majority opinion, whatever the issue may be, it is almost guaranteed to be alien to them? That they may as well skip the front part of the decision and go directly to the dissent? That the dissent will be the place where the truth will emerge, where wisdom will be found, where there will be resonance with what is in their hearts?

I am grateful for those dissents. It is so important for me to see Supreme Court justices acknowledge the difficult and risky nature of death talk; to address the members of the deathwatch and their pain; to dare to put the spiritual meaning of death in the same sentence with the Constitution. It is so

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253. *Id.* at 2885 (Stevens, J., dissenting) (quoting *Poe v. Ullman*, 367 U.S. 497, 551 (1961) (Harlan, J., dissenting)).

254. *Id.*

255. *Id.* at 2885-86.

256. *Id.* at 2886.

important for me to hear the argument that the standard of "clear and convincing evidence" is too high, considering that talk about one's own death is a taboo subject in our culture. It makes me feel a part of the human family, and not alone. It is like the wonder of literature, when a writer captures something that you have said to yourself in the dark silence of the night, certain that you alone felt and thought that way. A flood of relief comes from the revelation that you are not unique, that the same words have formed in other minds, that when you cannot sleep because of what happened to Karen Quinlan, Nancy Cruzan, Mary O'Connor, and their families, your insomnia is shared—and justified.

I am grateful for those dissents, and worried about my longevity. The women in my family live forever. Justice Brennan has retired, and Justice Stevens is an old man. If I stay out of sync and live long enough, what will happen to those dissents? I can bear the alienation from the majority opinion, but I will not be able to bear a silence at the end.

And so, that is how lawyers should confront the taboo of death talk. We should implicitly recognize the taboo in our application of evidentiary standards to former conversations of incompetent patients. It is not the time for rigor and heightened scrutiny. It is a time to let Richard express his concerns about life-support systems to a co-worker, sitting on a radiator, drinking Hawaiian punch. It is a time to let Mary O'Connor tell her daughters and her friends about the horrors of the deathwatches she has seen. It is a time to let Karen Quinlan tell her sisters about the nightmare of watching family friends die terrible, lingering, painful deaths. It is a time to let Nancy Cruzan tell her roommate that she does not ever want to die that way. It is a time to defer to the members of the deathwatch and to give credence to their words about words whispered to them in the night.

## V. LAW AND THE ARCHITECTURE OF RITUAL SPACE

WHAT CAN THE LAW DO TO ALLEVIATE INDIRECTLY THE PAIN OF THE MEMBERS OF THE DEATHWATCH?

This third suggestion is not like the other two. While language is always the law's contribution, this suggestion has less to do with the manipulation of written symbols and more to do with how human beings inhabit space.<sup>257</sup> It also has to do with

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257. "The distinctions of language cut the world into bits . . . into catego-

the function of behavior known as ritual:<sup>258</sup> how does the deathwatch serve to send a member of the community on his way; how does it fortify the survivors against the threat of change; how does it conquer the anarchy of death and restore order to the universe and to the community? The third suggestion is this: *The law can help create an environment in which a meaningful deathwatch can take place.*

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The deathwatches of the nineteenth century, as portrayed by Munch's painting, took place in the bedroom of the dying person. What had once been the private domain of the individual was turned into a place for community<sup>259</sup> and consecration.

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ries, classes, oppositions, and contrasts. It is in the nature of language to search out all differences and to turn them into distinctions which then provide bases for boundaries and barriers." ROY RAPPAPORT, *ECOLOGY, MEANING AND RELIGION* 206 (1979). Rappaport contrasts conceptual language with the function of ritual "to unite, or reunite, the psychic, social, natural, and cosmic orders which language and the exigencies of life pull apart." *Id.*

258. "Ritual" has been defined in a number of different ways. Sir Edmund Leach, a cultural anthropologist, suggested an expansive definition, applying it to all stereotypical, symbolic behavior that serves to communicate information about a culture's cherished values. Edmund R. Leach, *Ritual*, in 13 *INTERNATIONAL ENCYCLOPEDIA OF THE SOCIAL SCIENCES* 520, 524 (David L. Sills ed., 1968). Another commonly encountered definition of ritual, one favored by psychoanalytic theory, refers to all nonrational or formalized symbolic behavior as "ritual," as distinct from pragmatic behavior that is rationally related to the achievement of some end. Evan M. Zuesse, *Ritual*, in 12 *THE ENCYCLOPEDIA OF RELIGION* 405, 405 (Mircea Eliade ed., 1989). These very broad definitions eliminate the religious component of ritual.

Other anthropologists are interested in the religious meaning of ritual symbolism. Victor Turner defines ritual as "prescribed formal behavior for occasions not given over to technological routine, having reference to beliefs in invisible beings or powers regarded as the first and final causes of all effects." VICTOR W. TURNER, *FROM RITUAL TO THEATRE* 79 (1982). Evan M. Zuesse defines ritual as "those conscious and voluntary, repetitious and stylized symbolic bodily actions that are centered on cosmic structures and/or sacred presences." Zuesse, *supra*, at 405. Does it matter which definition of "ritual" we adopt for purposes of the deathwatch? I do not think so. The behavior exhibited in a deathwatch qualifies for the more expansive definitions. It is formalized behavior that has social meaning, in that it transmits the culture's values and unifies individual participants into a genuine community. But the behavior exhibited in the deathwatch qualifies for the more narrow definitions as well. There is no getting around the fact that a member of the community is dying, that a life force is waning, or transmuting, or moving on. In recognition of that fact, certain rituals are performed during a deathwatch that refer to invisible beings, cosmic structures, or powers that are regarded as the first and final causes; someone or something in the transcendental realm is invoked or addressed.

259. I use the term "community" here rather loosely:

Secular ceremony certainly often takes place outside of community in

The bed would be moved to a central location, and chairs would be placed around the bed to permit visitation. The curtains would be closed,<sup>260</sup> and candles would be lit. The sick-room was transformed.

Dying is a rite of passage. In his seminal work, *The Rites of Passage*, Arnold van Gennep distinguished among three phases in a rite of passage.<sup>261</sup> The first phase, known as "separation," clearly demarcates sacred time and space from profane or secular time and space.<sup>262</sup> With formal institutions, separation is accomplished by the construction of a special building, such as a church or a temple, and by the holding of religious services that are beyond or outside the time that measures our everyday lives. Since the timing of death in the nineteenth century could not be controlled, the decline of the human body dictated when the deathwatch began.<sup>263</sup> Similarly, since dying took place in

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the sense of "corporate group" and outside of community in the sense of "common culture." There are secular ceremonies invented and produced for persons who have come together just for one particular occasion. The participants even may be of different cultures.

Sally Falk Moore & Barbara G. Myerhoff, *Introduction to SECULAR RITUAL 3*, 9 (Sally Falk Moore & Barbara G. Myerhoff eds., 1977). The members of the deathwatch may in fact, and more than likely will, be part of a larger, more permanent community. They may also form one of these more ephemeral communities, however, that Falk Moore and Myerhoff refer to here.

260. Closing the curtains creates an enclosure, a demarcation between profane and sacred space. Mircea Eliade writes that all sacred spaces are enclosed, one reason being to preserve the "profane man from the danger to which he would expose himself by entering it without due care. The sacred is always dangerous to anyone who comes into contact with it unprepared, without having gone through the 'gestures of approach' that every religious act demands." MIRCEA ELIADE, *PATTERNS IN COMPARATIVE RELIGION* 370-71 (Rosemary Sheed trans., Sheed & Ward 1958) (1948). The sacred enclosure is also analogous to city walls, originally used as a "magic defence, for they marked out from the midst of a 'chaotic' space, peopled with demons and phantoms . . . a place that was organized, made cosmic, in other words, provided with a 'centre.'" *Id.* at 371.

261. ARNOLD VAN GENNEP, *THE RITES OF PASSAGE* (Monika B. Vizedom & Gabrielle L. Caffee trans., Univ. Chicago Press 1960) (1908). Van Gennep noted that different people, engaged in different ceremonial patterns, place varying degrees of importance in each of these phases. *Id.* at 11.

262. *Id.*

263. Although the timing of death cannot be controlled in the way a periodic, religious occasion can be scheduled, Eliade would still argue that sacred time, as well as sacred space, is implicated in a deathwatch. Death is an event, and as such, "every event (every occurrence with any meaning), simply by being effected in time, represents a break in profane time and an irruption of the Great Time." ELIADE, *supra* note 260, at 396. Profane time is "the time in which meaningless actions come and go." *Id.* Not all sacred, religious time is reproduced periodically, since "any time may become a sacred time." *Id.* at 397. Just as any space can become sacred, "so too sacred time, generally estab-



impromptu, informal settings, there were no special buildings devoted to the deathwatch. However, the rituals of moving the bed and chairs, the closing of the windows, and lighting of the candles accomplished the same thing—the creation of sacred space.<sup>264</sup>

This sacred space was created in preparation for the next stage of a rite of passage, known as “transition.”<sup>265</sup> During this intervening phase, which van Gennep referred to as a “margin,” or *limen*, meaning “threshold” in Latin, the ritual subject, the dying person, passes through a period of ambiguity in which normal social relations are discontinued, rights and obligations are suspended, and cosmological concerns become of central importance.<sup>266</sup> During this phase, in the nineteenth-century

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lished by communal feasts set by the calendar, may be attained at any time and by anyone, simply by repeating an archetypal, mythical gesture.” *Id.* at 397-98.

264. A sacred space can be described as “a defined place, a space distinguished from other spaces. The rituals that a people either practice at a place or direct toward it mark its sacredness and differentiate it from other defined spaces.” Joel Brereton, *Sacred Space*, in 4 *ENCYCLOPEDIA OF RELIGION*, *supra* note 258, at 526, 526. The functions of sacred space are dual: first, to provide places of communication with divinity, i.e., places where people can go to meet the gods; and second, to be a locus of divine power. *Id.* at 528-29. See generally ELIADE, *supra* note 260, at 367-87; MIRCEA ELIADE, *THE SACRED AND THE PROFANE: THE NATURE OF RELIGION* 20-67 (Willard R. Trask trans., Harcourt, Brace 1959) (setting the agenda for recent scholarship on sacred spaces).

Since so many rituals in the deathwatch go beyond just communication with divinity, I will use the term “ritual space” from here on, except when directly referring to van Gennep’s theory.

265. VAN GENNEP, *supra* note 261, at 11.

266. *Id.* at 147-48 (discussing mourning as a “transitional” period for both the deceased and the survivors). Victor Turner built upon van Gennep’s theory of liminality, extending it far beyond its original sense of an intermediate stage in a rite of passage. For Turner, liminal personae could become an enduring category of people who inhabit the edges of social boundaries: poets, clowns, shamans, and monks.

The attributes of liminality or of liminal personae (“threshold people”) are necessarily ambiguous, since this condition and these persons elude or slip through the network of classifications that normally locate states and positions in cultural space. Liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremony] . . . Thus, liminality is frequently likened to death, to being in the womb, to invisibility, to darkness, to bisexuality, to the wilderness, and to an eclipse of the sun or moon.

VICTOR W. TURNER, *THE RITUAL PROCESS* 95 (1969).

Some people live their lives in these liminal positions. (In the legal profession, the academic plays the court jester, “betwixt and between.”) During a rite of passage, however, all participants are in a sense liminal; by engaging in ritual activity, they separate themselves from their everyday roles and statuses.

deathwatch, dying words would be said, old grievances forgiven, property distributed, promises extracted, and confessions made. It was a time for extraordinary utterances, words said outside the normal boundaries of social intercourse, a time of change and of confusion. By its very nature, the liminal stage of a rite of passage is threatening to the community; certainly this was true for the members of the nineteenth-century deathwatch. The constituency of the group was about to change: A member was on the verge of departure, and in the vacuum he left behind, there was chaos, a lack of order and definition.<sup>267</sup>

The third and final phase of a rite of passage, "reaggregation" or "incorporation," also involves symbolic behavior; in this circumstance, the closing of the eyelids, the covering of the face, the recitation of prayers that send the soul on its way.<sup>268</sup> This third phase places the ritual subject in a new, well-defined position in the total society. In the nineteenth-century deathwatch, the new position was that of ancestor;<sup>269</sup> his body became a corpse and was subject to a new set of rules for its handling and final disposition.<sup>270</sup>

The rituals of the nineteenth-century deathwatch, the sym-

267. Any change in membership in a small group, whether that change is the birth of a child, marriage, or the death of a member, strains its internal cohesion. A change such as a death "inevitably affects the group as a whole and the relationships among the participants. Every relationship within the group must be readjusted, and the newly formed group as a result is not identical to the original conjugal group." Weyrauch, *supra* note 103, at 166.

268. VAN GENNER, *supra* note 261, at 164-65.

269. When I refer to the dying person's new status as "ancestor," I have of course picked a term that has familial connotations. I do not mean to limit my remarks to familial deathwatches. The new status might just as easily be described as that of "deceased friend or loved one."

In many cultures, however, ancestor worship plays a significant role. Death rituals "which revolve about the departed are designed to remove pollution and other evil consequences and to propitiate the deity and thus obtain the favor of the spirit of the deceased." JOACHIM WACH, *SOCIOLOGY OF RELIGION* 66 (1944). "Either the departed is considered to have gone and is therefore prevented by a series of rites from returning and upsetting the newly achieved equilibrium of the surviving group, or he continues even after death to be regarded as a highly revered, howbeit invisible, member of the group." *Id.* at 67. It is possible that the high regard in which his family holds Father Ger is just another version of ancestor worship. See *supra* notes 203-08 and accompanying text.

270. Under Jewish law, a person moving from life to death actually has an interim status. *Goses* is the name given to a dying person, and in the Talmud, different rules apply to a *goses* than to a living person. For example, the *goses* should not be touched in the event that his departure might be inadvertently hastened. Furthermore, a *goses* should not be left alone, and it is a great *mitzvah* to be present at the departure of the soul. Candles are usually lit in the

bolic behavior engaged in by the entire community, provided a framework in which this change of status could take place. Those prescribed, regular formalities performed around the dying person represented some sort of constancy to a community that was threatened by change.<sup>271</sup> The deathwatch gave the members of the community an excuse to gather, and once in each other's presence, it gave them something to say and do, a way to express grief and a way to deal with the burden of one's own body at an awkward time.<sup>272</sup> Each participant knew his

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presence of a *goses* to symbolize the flickering out of the human soul. 5 ENCYCLOPEDIA JUDAICA 1426 (1972).

Once the *goses* achieves the status of corpse, a different set of rules apply. For example, someone, preferably the firstborn son, should close the eyes of the dead. For the laws and customs regarding the treatment of the sick, dying, and the dead, see CODE OF JEWISH LAW §§ 192-94 (Rabbi Solomon Ganzfried, ed. & Hyman E. Goldin trans., Hebrew Publishing Co. 1991); see also *supra* note 24.

For a general discussion of the Talmudic sources and various codes of Jewish law on the treatment of the *goses* and related ethical issues, see FRED ROSNER, MODERN MEDICINE AND JEWISH ETHICS 197-203 (1986); see also JEWISH BIOETHICS 266-316 (Fred Rosner & J. David Bleich eds., 1979) (confronting ethical issues surrounding death and the dying); JEWISH MEDICAL LAW 148-54 (Avraham Steinberg, M.D., ed. & David B. Simons, M.D., trans., 1989) (outlining Jewish ethical codes and principles concerning medical care, the treatment of the dying, and procedures after a patient's death).

I am grateful to my friend and colleague, Jeffrey I. Roth, for his assistance in the research on Jewish law.

271. Rituals, rigid procedures, regular formalities, symbolic representations of all kinds, as well as explicit laws, principles, rules, symbols, and categories are cultural representations of fixed social reality, of continuity. They represent stability and continuity acted out and re-enacted: visible continuity. By dint of repetition they deny the passage of time, the nature of change, and the implicit extent of potential indeterminacy in social relations. Whether rituals, laws, rules, customs, symbols, ideological models, and so on, are old and legitimated by tradition, or newly forged and legitimated by a revolutionary social source, they constitute the explicit cultural framework through which the attempt is made to fix social life, to keep it from slipping into the sea of indeterminacy.

SALLY FALK MOORE, LAW AS PROCESS: AN ANTHROPOLOGICAL APPROACH 40-41 (1978).

272. One function of a deathwatch is to prepare the survivors psychologically for the death and attendant grief. One nursing study investigated the relationship between the expectancy of death and adaptive behavior after death. Families who were psychologically prepared for the death of a member made earlier arrangements for removal of the body, manifested less overt emotional behavior, and verbalized fewer expressions of guilt. Rosemary J. McKeighen, A Study of Expectancy and Family Grief Reactions 21 (1967) (unpublished M.S. thesis, University of California, Los Angeles). Also investigated was the function of a hospital "quiet room," located on the same ward but apart from the deceased patient's room, to which the family could go to be alone after the death. The room provided "an appropriate place and the needed time for per-

role before entering the dark, candlelit room, and that certainty of script was more than just a consolation. The deathwatch represented to its members a promise of order and a restoration of normal social relations. It became a polar star to focus upon, a steady, unblinking point of light in the swirling, dark maelstrom of impending death.

Except for the rules about testamentary dispositions, the law did not have much to do with the substance of these rituals. As we have seen, however, the law does help define the temporal limits of the deathwatch. In this century, and in the past, we have tacitly agreed to gather together for this rite of passage, to stop looking at the clock. But no ritual can go on forever; we must eventually return to ordinary time. By redefining death and by recognizing that death talk is the subject of taboo, the law can help bring the attenuated deathwatch of the late twentieth century to an end.

The law can, however, do something more to alleviate the pain of the members of the deathwatch. It can help create an environment in which a meaningful deathwatch can take place. This the law cannot do alone. Lawyers have to talk to members of the medical profession and to the architects of ritual space. There is a logistical problem to such a conversation, however. It is difficult to talk to people who are not there.

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Every semester, after several weeks have gone by and I have begun to recognize the faces that look out at me, I give a speech about the importance of coming to class. It is not a very inspired speech, but it is heartfelt. I always feel a bit silly at its end,<sup>273</sup> since the speech was given for the benefit of those stu-

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sonal reflection, reaction, further clarification, and emotional expression." *Id.* at 22. Families who had engaged in a deathwatch and had a high expectancy of death used the room less. Those families who had not engaged in a deathwatch, or for whom the death was a surprise, displayed extreme emotional behavior, such as "vomiting, screaming and fainting," and often refused to accept the reality of the death pronouncement. *Id.* at 21. Families psychologically unprepared for the death used the quiet room more frequently. *Id.* at 22.

In part, the study concluded that family visits should be encouraged since they build "expectancy via exposure to the situation and increased opportunity for acquisition of information." *Id.* at 75. The author also recommended the hospital hire a "grief therapist," a nurse or family counselor who would help the "family to enter into or continue through the grief process." *Id.* at 77. Such a "grief therapist" would arguably serve the same function as a spiritual leader in a nineteenth-century deathwatch.

273. On days when I am feeling formidable, I admit to my students that I feel a bit silly, and on days when I am feeling fragile, I do not. Feeling fragile is a virus that attacks women law teachers in particular. *See generally*

dents who are not there. The students who share my views about the importance of coming to class are already sitting before me. I suppose an analogue is the spiritual leader who admonishes his flock about the wages of sin, knowing full well that those sheep inside the gate are already convinced. The real sinners are out of earshot, wandering the fields untended, bleating their way straight to ovine hell.

It is all a problem of audience. How do you convince others to take a certain course of action if they are not there to hear your words? In this instance, their absence is not due to truancy or sin, but to intellectual isolation. I propose that lawyers and doctors and architects get together to help alleviate the pain of the members of the deathwatch, but only one-third of my audience is present. Although I often wonder who reads law reviews, I am almost certain that most of the readers are lawyers. I know there are a few curious souls who read outside of their discipline. After all, I am one myself. But my participation is that of an eavesdropper. I like to perch on the edge of other professions because I am nosy and lonely. I like to know what they are thinking about, mostly to see if they are thinking about what I am thinking about, since so often when I stay at home I have to think alone.

But eavesdropping is solitary and passive, and does nothing to bridge the gaps between the professions. Even with the occasional exchange of footnotes, the fact remains that doctors talk and listen to doctors; lawyers talk and listen to lawyers; architects talk and listen to architects. And no one talks or listens to poets. We are very insulated from one another. Indeed, one of the goals of professional education is to provide its students with a vocabulary that ensures that what they have to say will be understood only by other members of the guild.

The problem goes deeper than that, however. We learn a way of looking at the world that makes it difficult to see things through any other prism. We also begin to believe that our pro-

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Deborah Waire Post, *Reflections on Identity, Diversity and Morality*, 6 BERKELEY WOMEN'S L.J. 136, 150 (1990-91) (discussing the challenges and biases women law professors face). While Deborah has given me many insights, and we do swim together, she is emphatically not the woman in the pool. Actually, the woman in the pool is a composite of several friends with whom I share ideas, including the more lawyerly portions of myself. This confession is dedicated to my husband, Daniel P. Jordan Jr., who has a historian's respect for the truth. He would also like me to confess that I have never taught Civil Procedure, but I refuse to on the grounds that it is never advisable to do everything your spouse wants.

fession has a monopoly on solutions. No matter what the problem is, most doctors believe that the solution lies hidden in the secrets of nature, in attaining a perfect understanding of the human body. Most lawyers believe that the solution lies hidden in the secrets of language, in finding the perfect words to address the situation. Most architects believe that the solution lies hidden in the secrets of design, in conceiving of the perfect space. All poets know that the solution, if there is one, lies hidden in the secrets of the human heart, where perfection is unheard of.

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We were expecting as visitors for the weekend an old friend from Columbus, Colin Fink, his wife Nancy, and their two children. Colin is an architect in upstate New York. Here was an opportunity to talk to someone who was not a lawyer, to someone who designs spaces for a living. Maybe we could discuss what our respective professions could do about the horrors of the late-twentieth-century deathwatch; what lawyers and architects might do together to alleviate the pain of its members.

With four small children under one roof, it was not easy to find an island of silence upon which to embark on an adult conversation. When such an island finally appeared on the horizon, I found Colin sitting on a lawn chair in our living room, reading. He put his book down and asked me what I had been working on, and I tentatively started in on the deathwatch.

Colin was interested. The firm with which he had once been associated, the Research and Design Institute (REDE), had been hired in the late 1960s as a consultant for the design of a thirty-bed extended care unit to a county hospital.<sup>274</sup> The premise that bed rest is essential to post-operative care had been replaced by a theory of early ambulation and "self-therapy."<sup>275</sup> The hypothesis was that patients would heal better

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274. The Research and Design Institute (REDE) was located in Providence, Rhode Island. It consisted of a group of architects, designers, and social scientists who sought to create "superior configurations for institutional facilities." Ronald Beckman, *The Therapeutic Corridor*, 45 HOSPITALS 1, 2 (photo. reprint) (1971). Because funding dried up, the firm is now defunct. Colin W. Fink is presently a partner with the firm, North Country Team, Inc. of Essex, New York. The hospital was South County Hospital in Wakefield, Rhode Island.

275. Ruth M. Fitzgibbons, *Open-plan Community Clinic*, INTERIORS, Dec. 1974, at 72, 74. The medical jargon of the early 1970s referred to this as progressive patient care ("PPC"). *Id.*

and faster if they were actively involved not only in their own recovery but also in the recovery of others.

This hypothesis proved to have a profound effect on the design of the Borda Wing, as it came to be called. The REDE team was concerned that conventional hospital corridors would not support the practice of early ambulation; there just was not enough room in the narrow hallways for people to move around. The team recommended that the corridors be used not only for getting from one room to another, but also as communal areas, capacious enough to accommodate any combination of recuperating patients, some of them in wheelchairs or stainless steel exoskeletons. The architects went to work, and instead of designing the hallways for solitary nurses, they made them wide enough so that patients could congregate in groups, share experiences, and give support to one another while bodies were on the mend.<sup>276</sup>

The communal spaces in the Borda Wing included two nourishment centers available for staff and patients, and patients could eat whenever and with whomever they pleased. There were game tables, reading and writing stations, alcoves for private telephone conversations, and sunny dayrooms at either end of the corridors to provide a "destination point," otherwise known as someplace to go.<sup>277</sup> Privacy was respected, but the therapeutic emphasis was on collaboration. Everyone was encouraged to live out in the open as active members of a healing community.

It was an interesting conversation, but too short. Colin's presence was required in the backyard, and I never really got to ask him how he would design for the deathwatch. It was too short, but long enough to give me a flash of insight: architects approach problems differently from doctors and lawyers.

First, architects are obsessed with function: What is it this building is supposed to do?<sup>278</sup> Usually the answers are quite simple. For example, this building is supposed to provide shelter for a family; or this building is supposed to provide a place

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276. *Id.* The standard hospital corridor is six to eight feet wide. In the Borda Wing, they were 18 feet wide. *Id.*

277. *Id.*

278. One scholar has argued that this obsession with function ("What is it this building is supposed to do?" e.g., provide shelter, comfort, or safekeeping), has confused architects about the status of architecture. "Some have regarded architecture as chiefly utilitarian; others have treated it as an 'applied art.'" Others, such as Louis H. Sullivan, Laszlo Moholy-Nagy, and Frank Lloyd Wright, have "tried to meet the prosaic demands of utility by making function

to learn; or this building is supposed to provide a place to care for the sick and restore them to health.

Armed with a concept of what the building is supposed to do, architects start out with some expectations about how the human beings who will use the building are going to behave. This requires them to focus not so much on the behavior of any given individual, but on the behavior of a group of individuals. While it is true that the basic unit is still the human body, most buildings are designed with the idea that more than one human body will use the space, and that the patterns of use are predictable. In homes, for example, at least in our culture, people usually sleep in bedrooms that are located towards the back of the house, and gather together in larger rooms towards the front. In schools, teachers usually stand up and talk in the front of the room, and pupils sit down and listen.<sup>279</sup> In hospitals, sick people usually lie down in beds, more or less grouped

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paramount, believing that genuinely appropriate forms are always beautiful." SUZANNE K. LANGER, *FEELING AND FORM* 92-93 (1953).

Architecture does more than just provide shelter. It creates an "ethnic domain," an image of a culture and a

physically present human environment that expresses the characteristic rhythmic functional patterns which constitute a culture. Such patterns are the alternations of sleep and waking, venture and safety, emotion and calm, austerity and abandon; the tempo, and the smoothness or abruptness of life; the simple forms of childhood and the complexities of full moral stature, the sacramental and the capricious moods that mark a social order, and that are repeated, though with characteristic selection, by every personal life springing from that order.

*Id.* at 96.

Colin Fink has quarreled with my use of the word "obsessed" in the noted sentence. "In defense of architects, a good architect should not be obsessed with anything. The beauty of good architecture is the beauty of poetry—the ambiguity, multiplicity, and flexibility of a design." Letter from Colin Fink, partner, North Country Team, Inc., to Louise Harmon, Associate Professor, Jacob D. Fuchsberg Law Center, Touro College (May 9, 1992) (on file with the *Minnesota Law Review*).

279. It has always bothered me that the architecture of law schools seems to demand that classrooms be designed like large, fixed-focus cameras, with the teacher occupying the focal point at the bottom of the pit, and the students placed on ascending tiers in seats invariably screwed to the floor to assure the maintenance of this unpleasant status quo. When I first started teaching at Touro, we had just moved into an old junior high school building, and my first classes were held in a large, level room which had been the cafeteria. The students sat in folding chairs, and we moved them around a lot. The balance of power was always changing, as was the way in which we saw the world and each other. As we remodeled the building and struggled toward accreditation and acceptance in the academy, the ABA required us to screw the chairs to the floor. Now we eat bad hot dogs in that room, and I find myself teaching at the bottom of a pit.



together by disease, and their family and friends sit down to visit them. Most of these expectations are culturally determined.

At a deeper level, there are hypotheses about how best to achieve the maximum function of a building that embrace a certain view of human psychology. All of these hypotheses depart from the premise that people are affected by their environment; that the dimensions, floor plan, orientation, light, colors, and textures, all of the attributes of any given building, will have an impact on how people think and feel and interact in that environment.<sup>280</sup>

How people think and feel and interact in a hospital or other health care facility became relevant when Norman Cousins, among others, convinced us that healing is dependent on the patient's state of mind.<sup>281</sup> Cousins further insisted that a patient's environment has a "large part to do with getting the best out of health care."<sup>282</sup> These ideas had an impact on hospital design.<sup>283</sup> It became a shibboleth in the architectural litera-

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280. Consider the following statement regarding the design of environments for special groups of people such as the elderly, disabled children, or homeless people: "Architects of such facilities agree that the most important aspect in designing for any special population is the creation of an environment that is sensitive to the needs, feelings, and dignity of the people who will use the space." Lynn Nesmith, *Designing for "Special Populations,"* ARCHITECTURE, Jan. 1987, at 62, 62. While such a statement seems almost trite in an architectural journal, it is difficult to imagine articulating the goal of either a legal or medical task in this way.

281. Interest in the relationship between a patient's mental state and the healing process, with its implications for the design of hospitals, hardly started with Norman Cousins. For example, the Austrian visionary, Rudolph Steiner (obit. 1925), developed something called "Anthroposophy," the "science of the spirit." Karin Tetlow, *Healthy Color,* INTERIORS, Dec. 1989, at 94, 94. Danish-born Eric Asmussen has concentrated on anthroposophical architecture in hospital design since 1960. Asmussen designed the hospital that is part of the Rudolph Steiner Seminary at Jarna, near Stockholm. He strove to create "a stimulating environment which inspires the healing activity for which the building was intended. Windows, for example, are shaped as keyholes suggesting connections with the 'spiritual in the universe.' The resulting harmony brings equilibrium to the patient, who by being sick, is out of balance." *Id.* The architecture itself serves as therapy, on the theory that the environment can have a positive impact on healing.

282. Carleton Knight III, *Designing for the Health Care Process and Marketplace,* ARCHITECTURE, Jan. 1987, at 49, 49 (quoting Norman Cousins).

283. Cousins's book, *Anatomy of an Illness*, was one of the most popular expressions of a holistic approach to incurable illness. After its publication, "several hospitals developed special facilities within their cancer treatment centers based on his ideas." The first was St. Joseph's Hospital in Houston, which created a living room for patients, an "airy open space with comfortable furniture, a television with video cassettes of old comedies . . . a place to paint

ture that the design had to promote the healing process, as the architect struggled to come to terms with his obsession: What is it this building is supposed to do?

Architects started asking questions like these: Does it matter how many doors a patient must open in order to be out in the world?<sup>284</sup> Does it matter if a patient has another human being to make eye contact with when he enters a health care facility?<sup>285</sup> Does it matter if there is room on the maternity ward for the father to sleep?<sup>286</sup> Does it matter whether the

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or play the piano." *Id.* Cousins reported that at least "a dozen hospitals . . . have taken similar steps to reduce the institutionality of a medical environment and make it more homelike for patients and families alike in recent years." *Id.*

284. A relationship exists between a patient's vulnerability to death and changes in physical environment. Studies of transfers of the frail elderly from one setting to another show that such a move may threaten their health; they need stability. JOSEPH A. KONCELIK, *DESIGNING THE OPEN NURSING HOME* 14 (1976).

One of the most reliable predictors of death among the elderly who have been transferred is the loss of desire to penetrate the social and physical environment. The number of times a person needs to go beyond his or her boundaries—or have someone penetrate theirs—in order to remain alive can be fixed. These numbers of penetrations become the most accurate predictor of death among the aging who have been transferred from one setting to another.

*Id.* (citing Leon A. Pastalan, *Privacy Preferences Among Relocated Institutionalized Elderly*, in EDRA5 (Environmental Research Ass'n, Inc. ed., 1974)).

285. One problem with the architecture of spaces designed to house new medical machines is the tendency of architects to want to "celebrate the technology" by exposing the hardware. For example, the architects of the Center for Non-Invasive Diagnosis at the University of New Mexico in Albuquerque had to fight the urge to "express the building as a giant machine (which it actually is)." Michael Crosbie, *Reassuring Setting for High-Tech Medicine*, *ARCHITECTURE*, Jan. 1987, at 43, 43. Instead, the Center is "quite domestic in scale," reflecting the architecture of the American Southwest. The architect, Glade Sperry Jr., felt it was "important to have human contact on entering the center, and the receptionist's desk is positioned so that one immediately makes eye contact." *Id.* While the exterior reflects "the palette of the desert, the interiors are cool and restful—rose, gray, mauve, and tan." The goal is to minimize the "frightening experience" of "being pushed through a magnet and emitting radio signals." *Id.*

286. Until recently, maternity units in hospitals were judged on clinical efficiency. In Wythenshawe Hospital, an older hospital in Manchester, England, there was "no attempt to provide a domestic atmosphere or to make unobtrusive the clinical equipment such as gas outlets, cot, scrub-up trough." *Wythenshawe Hospital Maternity Unit*, *ARCHITECTS' J.*, March 30, 1966, reprinted in *BRITISH HOSPITAL AND HEALTH-CARE BUILDINGS* at 192, 199 (Peter Stone ed., 1980). There was space for about five witnesses, such as pupil midwives, the husband, and, later, medical students. While the husband could witness the birth, his extended stay was not anticipated. *Id.*

Compare this to a maternity unit in the Stirling Royal Infirmary, which seeks to provide "every amenity for the patient." *Paisley and Stirling Mater-*

lighting is diffuse in the ICU? Does it matter whether the pulsating life-support systems hang naked from the walls?<sup>287</sup> Does it matter if a bed-bound patient can see a tree?<sup>288</sup>

Even questions of power are raised in projects like the hospital wing that Colin's firm helped design. The hypothesis there shifted part of the responsibility for the healing process

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nity Units, ARCHITECTS' J., Nov. 4, 1970, reprinted in BRITISH HOSPITAL AND HEALTH-CARE BUILDINGS, *supra*, at 205, 212. The labor suite has a lounge where the patient may remain during the early phases of labor. Later on, in the first stage delivery rooms, the husband is not only welcome, but an over-night room is provided for him. *Id.*

In another new design for a birthing room, a Chicago-based architecture and interior design firm created suites at West Suburban Hospital in Oak Park that serve as labor/delivery and recovery/postpartum care rooms (LDRP) for normal and high risk births. The suite also serves as a "homey living/dining/bedroom for visiting, and even family sleep-overs in a reclining lounge chair." Judith Davidsen, *Birthing Center*, INTERIOR DESIGN, Nov. 1990, at 190, 192. The medical equipment needed for the birth, such as oxygen, air, and suction vacuum, for use in case of emergency, and an examining light, all disappear after the baby is born. The bed converts into a labor table, then a delivery table and then back to a bed. The family is invited to participate in the birthing event, and the room's design helps to "bridge the gap between pregnancy and parenthood." *Id.*; see also Margaret F. Gaskie, *Making Special Care Special*, ARCHITECTURAL REC., June 1990, at 98, 98-101 (describing another birthing center design in Miami).

287. "The Intensive Care Unit Initiative was presented to the Third Symposium on Health Care Interior Design at San Francisco's Contract Design Center" in the fall of 1990. The designer, Orlando Diaz-Azcuy, was aware that there were four essential elements to consider: "the medical staff; the patient; the family; and the technology." Karin Tetlow, *Design Heals*, INTERIORS, Dec. 1990, at 61, 61. Diaz-Azcuy hid most of the ICU equipment in "office style cabinets" in the wall when it was not in use. He also provided for a private toilet and sink that were hidden from sight, and calculated where the window should begin so that the patient could see the outside world from his bed. There was something called the nurses' "Observation Wall," which was "built from Varilite panels that change from clear to water-white at the patient's discretion to ensure privacy." *Id.* at 64. Instead of having lighting installed in the headwall, Diaz-Azcuy provided for soft, ambient lighting, with several additional lighting sources that could be operated by dimmer according to either the patient's or medical staff's needs. The curtains were a yellow stripe, and the wood paneling was made of white oak. His overall goal was to create "humanistic and sensitive designs." *Id.* at 62, 64.

288. A geographer at the University of Delaware has suggested that trees can actually reduce costs in hospital care. He examined the post-operative care records of two groups of patients who were virtually identical except that some looked out onto a brown brick wall, and some looked out onto a small stand of deciduous trees. On average, patients who could see the trees spent nearly 24 hours less in the hospital, needed less attention from nurses, and took fewer doses of expensive drugs. Ulrich argues that hospital design and siting should take into account the quality of the patients' views from the windows. Roger S. Ulrich, *View Through a Window May Influence Recovery from Surgery*, 224 SCIENCE 420, 420 (1989).

from the medical professionals to the patient himself. By shifting that responsibility, there was a corresponding shift in power; how the therapy and course of treatment was going to proceed became more a joint enterprise than a dictatorship. In the Planetree Model Hospital Project in San Francisco, to give another example, a designer challenged the traditional nursing station with its high counters and lack of accessibility, claiming that such bastions emphasize "territoriality and convey a strong 'us versus them' mentality."<sup>289</sup> The nursing work areas were therefore located informally along the perimeter walls, and in the middle of this area, tables were provided for patients to look over their charts and discuss them with nurses, doctors, or family members. A patient library in the twenty-five-bed unit "symbolically convey[ed] the importance of openly exchanging medical information."<sup>290</sup> As the space was redesigned, the power relationships were redefined.<sup>291</sup>

As I said before, architects approach things differently from doctors and lawyers.<sup>292</sup> Unlike architects, most doctors do

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289. Michael Wagner, *Healing Revolution*, INTERIORS, Dec. 1990, at 96, 97. The interior designers of the Planetree Model Hospital Project were Victoria Fay & Associates and architects Kaplan, McLaughlin, and Diaz. The Planetree Project opened in 1985 in the Pacific Presbyterian Medical Center in San Francisco. *Id.* at 96-97.

290. *Id.* at 97.

291. To me, the most radical innovation in the Planetree unit did not have to do with design, but with time. The power to set the schedule for waking and visiting was returned to the patient. Every evening the nursing staff asked the patient when he would like to be awakened, instead of rudely waking him at 6:00 a.m. to take his temperature. Similarly, the patient was the one to determine who would visit him and when. *Id.* These seem like such little things, but anyone who has spent time in a hospital knows that these little things are what get you down. They are what diminish you as a human being.

292. I realize that I may be speaking of only a handful of progressive architects. Probably just as many are designing hospitals in the more traditional style. Furthermore, some new movements in design strike me as a step backwards. I felt a chill run down my spine when I read about the new phenomenon of "medical malls." One such mall is in Tucker, Georgia, a suburb of Atlanta. The mall has 120 licensed beds, with "an inpatient care area connected to the administrative and business office by an open atrium." The mall is very cost effective, since the offices did not have to meet the stringent hospital codes. Margaret Sanders, *Hospitals: The Prognosis*, CONSTRUCTION SPECIFIER, Aug. 1991, at 46, 52.

Dr. Roger Panther, president of Quorum Health Resources, Inc., has been instrumental in developing several medical malls. "The core of the mall has an outpatient entrance leading to a central reception area," Panther says. "More than simply an open area for traffic, the reception area doubles as functional space for waiting, reception, admitting, information, and dining. The multi-purpose atrium design stresses natural lighting and an airy atmosphere

not deal with patients as members of a community. There is one human being, and only one, at the end of the stethoscope. Even then, in light of the specialization within medicine, it is sometimes difficult to get a doctor to see that one human being instead of just the body part in which he is interested.<sup>293</sup> Lawyers deal with humanity in the same way; the tenets of liberalism have forced upon us the unit of the individual, and our procedural apparatus has reinforced that limitation by making it difficult to listen to more than one voice at a time.

Because architects do not look at human beings in isolation, they have given a lot more thought to the deathwatch and how to alleviate the pain of its members. We have a lot to learn from them.

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What does it mean to be at home? I looked up the word in the dictionary, and to me the first six competing definitions looked like a piece of poetry:

HOME (hom) *n.* 1) A place where one lives; residence; habitation. 2) The physical structure or portion thereof within which one lives, as a house or apartment. 3) One's close family and one's self; a person's most personal relationships and possessions: house and

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with interior landscaping, skylights, and on-the-mall eating areas for visitors and staff." *Id.*

Unfortunately, I have had a recurrent nuclear holocaust dream in which I always find myself living out the last few days of my life, with my small children, in the Walt Whitman Mall in Huntington, New York. I was not happy to see that medical malls are on the horizon. Maybe I will someday die in a room next to an escalator, with indoor trees, a phony roaring fountain, and the malevolent hum of muzak in my ears.

293. A monologue in *My Dinner With Andre* comments on the narrow focus that a medical specialist can have with respect to the part of the patient's body he is interested in. Andre's mother had been dying in the hospital, and a specialist who had been consulted about a minor problem with her arm failed to see the rest of the patient:

You know, we had gone to the hospital to see my mother, and I'd been in to see her, and I saw this woman that looked as bad as any survivor in Auschwitz or Dachau, and I was out in the hall sort of comforting my father, and this doctor who was a specialist in a problem she had with her arm went into her room and came out just beaming and said to us, "Boy, don't we have a lot of reason to feel great? Isn't that wonderful how she's coming along?" Well, all he saw was her arm. That's all he saw. And I mean, here's another person who's existing in a dream. Who on top of that is a kind of butcher who's committing a kind of familial murder, because he comes out of that room, and he psychically kills us by taking us into a dream world, you see, where we become confused and frightened, because the moment before, we saw somebody who looked already dead, and now here comes the specialist who tells us that everything is great.

WALLACE SHAWN & ANDRE GREGORY, *MY DINNER WITH ANDRE* 61-62 (1981).

home. 4) An environment or haven of shelter, of happiness and love.

5) Any valued place, original habitation, or emotional attachment regarded as a refuge or place of origin. 6) The place where one was born or spent his early childhood, as a town, state, or country.<sup>294</sup>

Such a lot of work for one small word, and each definition is beautiful in its own way. With so many meanings, it explains how I can feel at home in my little blue house, or at home with my family, or at home at work, or at home in Columbus, Ohio, or even at home in my own mind.

But at the moment, I am thinking more about a home space, an actual place in which to live, and ultimately to die. A book by Gaston Bachelard got me thinking about home space; what it means to have one and what it means not to have one. In *The Poetics of Space*, Bachelard writes, "All really inhabited space bears the essence of the notion of home."<sup>295</sup> The phenomenologist of the home has his task set out for him: He must

say how we inhabit our vital space, in accord with all the dialectics of life, how we take root, day after day, in a 'corner of the world.' For our house is our corner of the world. As has often been said, it is our first universe, a real cosmos in every sense of the word. If we look at it intimately, the humblest dwelling has beauty."<sup>296</sup>

What does it mean to take root, day after day, in a corner of the world? For me, it means waking up in my own bed by the dim light of the dawn, making the solitary journey to the kitchen to put the kettle on, the cats at my feet, music from the radio humming in the background, knowing that the people I love the most in the world will soon join me in the kitchen, with their clatter and clutter and morning demands. For a brief, precious moment of time, we will inhabit our home space together before we all go out the door.

That door. We all go out of it in the morning, and come back through it at the end of the day. That door means everything to the definition of my home space. It creates a boundary between my family and the outside community. It keeps in our family secrets, our rituals, our words of love, and our words of

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294. THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 629 (William Morris ed., 1973).

295. GASTON BACHELARD, *THE POETICS OF SPACE* 5 (Maria Jolas trans., Orion Press 1964) (1958). I would also like to thank Peter Bentell of the architecture firm of Bentell and Bentell, in Locust Valley, New York, for his invaluable assistance in steering me toward some of the more thoughtful literature about architecture and its relationship to the human body and to society as a whole.

296. *Id.* at 4.

frustration. It houses both our dreams, and sometimes our fears. That door defines the outer edges of our intimacy.<sup>297</sup>

That door. We all go out of it in the morning, and come back through it at the end of the day. Not only does it keep things in, it also keeps things out. Each of us who inhabits the home space within has control over the use of that door; it provides the power to exclude. Even though it is only a piece of wood, hanging tenuously at times from two hinges, it is a symbol to all who stand before it that permission must be granted before entering.<sup>298</sup> And when we open that door to a friend, we do so knowingly and willingly, because of our decision that, for a time, we do not mind redefining the boundary of our private domain.

Without that corner of the world, that vital space to take root in day after day, the world would be, and is for many, a cold and heartless place.

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The only good place to be sick is at home.

Once I was trapped on my back in a hospital for four

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297. Examining the significance of the human body in architecture, two scholars have discussed the symbolic meaning of "the house." KENT C. BLOOMER & CHARLES W. MOORE, *BODY, MEMORY AND ARCHITECTURE* 45-49 (1977). At the "edges of the house," where the house dweller leaves and enters, a reorientation from a place of one or a few people to a place of many people is necessary:

Even as the primary body boundary exists between the world of the individual and the community, the house boundary exists between the family and the community. The entryway, therefore, becomes an extraordinarily sensitive region of the house boundary, a landmark which must respect and reinforce the feelings and identity of both the inside and outside communities.

*Id.* at 46. Society needs articulate and dynamic boundaries. "The architectural boundary exists to encourage and ritualize activities which are sacred to the family, and its destruction or exaggeration can sap the vitality of both the family and the public domain in which it resides." *Id.* at 47.

298. Let us only say a few words about the 'essence' of the house. To find a common denominator for all houses (buildings) may seem futile. If it makes any sense to talk about the 'level of houses,' however, it ought to be possible. In fact, all treatises on architecture from Alberti to Venturi in some way or other have attempted to solve the problem. It was pointed out above that essentially the house brings us 'inside.' The essence of the house as architecture, therefore, is interior space. In the city we are still 'outside,' although we have left the open landscape. In the house we are alone with ourselves, we have withdrawn. When we open our doors to others, it is our free decision: we let the world come to us, rather than looking at it outside. 'Domestic peace' has been a basic right since remote times.

CHRISTIAN NORBERG-SCHULTZ, *EXISTENCE, SPACE & ARCHITECTURE* 86, 88 (1971).

months, and I can still remember my incessant yearning to return to my home space. Day after endless day, I would say to myself and to others, "All I want to do is go home." I wanted my own bed, my own window looking out on my own tree, my own sheets, my own cats, my own tea cup, my own bathroom, my own door. That door.

I hated having no door to close in the hospital, being subjected to the unannounced entrances and exits of strangers.<sup>299</sup> I hated the nurses coming in and out, those constant bodily invasions, perpetrated against me according to someone else's schedule. I hated visiting hours, when sometimes people I did not choose to see chose to come see me. I hated having other very sick human beings in beds eight feet away, with their own parade of visitors, their own medical traffic, and their very different universe on the television. I hated having always to be pleasant, since I knew too well the price for petulance: a decline in the quality of nursing care. For anyone with a chronic illness, the mentality must be that of a survivor; in a conscious act of will, the prickly parts of one's personality must be wrapped in the velvet of submission.<sup>300</sup> Day after day, night after night, all I wanted to do was to go home, and unlike many times when wishes come true, when I finally did go home, there was no sense of disappointment. All I had yearned for were little things, and the little things were all still there, waiting patiently for me: my bed, my cats, my tea cup, my tree, now leafless from the winter winds.

Sickness brings with it a vulnerability of spirit, a fragility that makes us want to turn away from the world and crawl into our own beds. It is a great irony to me that our need to be at

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299. A room in an institutional setting like a hospital will always be subject to intrusions by others since it is one small unit in a much larger public space. Not only does the occupant of a hospital room lack the power to exclude others, but he also lacks the power to inhabit the public space beyond the few square feet allotted for his body. A hospital room therefore probably qualifies as a "cell." The distinction between a house and a cell is fundamental. With a house, a family expects to be able to occupy all its parts. A cell denies the occupant "access to the whole of the place which contains the cell. The front door of a prison, for example, is not accessible to the occupants of its cells, nor are the attics, cellars, and grand interior meeting places available to the tenants of most modern apartment 'complexes.'" BLOOMER & MOORE, *supra* note 297, at 47.

300. See A. Strauss et al., *The Hospital and its Negotiated Order*, reprinted in MODERN SOCIOLOGY 394, 400-02 (Peter Worsley ed., 2d ed. 1978) (discussing the hospital as a "locale where personnel, mostly but not exclusively professionals, are enmeshed in a complex negotiative process," and how the chronically ill patient gets what he wants in the "negotiated order").



home is greatest when we are sickest, yet that is the time in our culture when we are bodily removed from our homes. Just consider what it means to crawl into your own bed.<sup>301</sup> My Irish mother-in-law, for example, when she goes to bed at night, goes to the bed that she was born in, to the bed that her brothers and sisters were born in, to the bed that her mother died in, to the bed that her great-grandmother died in. My babies, her grandchildren, have many times crawled into that dark wooden bed to read books with her, to be near her soft, sweet skin that always smells of roses. Someday, she herself will die in that dark wooden bed.

Does it matter where we conceive our children? Where we give birth to our children? Where we lie down to sleep? Where we lie down to die?

Just consider what it means to crawl into a hospital bed. The mattress is enclosed in thick, brittle plastic that resists the weight of a human being.<sup>302</sup> It is a hot, sweating thing, made bearable only by the intervention of rough, white cotton that only stays in place if the envelope is not opened. Its frame is

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301. The history of where we lay ourselves down to sleep, or to die, is interesting. In Europe, until the late Middle Ages, most people slept on loose bedding or on the ground. Beds were a luxury, often serving as a symbol of wealth and rank. For example, the ranking individual in a household slept in a bed with elaborate accouterments, in particular a canopy. This "Bed of Estate," much like the Chair of Estate, would be used only when official visitors were received. A simpler bed would be used for less momentous sleeping. CHARLES BOYCE, *DICTIONARY OF FURNITURE* 26 (1985).

In the eighteenth century, beds became smaller, less elaborate, and more accessible to the average man. In England, the general type of bed was a simple four-poster bearing draw curtains. A smaller canopy known as the "field bed" became more popular in America. Beds of the Empire periods tended to be low, chunky blocks, usually undraped. The "sleigh bed" was of this type. Modern springs and mattresses have removed the need for heavy wood framing, and most contemporary bed designs use only enough framing to raise the bed from the floor. Canopies, if they are used at all, have become merely decorative. JOSEPH ARONSON, *THE ENCYCLOPEDIA OF FURNITURE* 37-43 (3d ed. 1965).

302. Those horrible mattresses are intentional, and supposedly serve laudable goals of sanitation and patient hygiene.

One guidebook to the design of long-term care facilities states as its "main thrust" the "creation of an environment which promotes a feeling of well-being, of independence, of individual worth, and an atmosphere which engenders the continued growth of the resident." LASZLO ARANYI & LARRY L. GOLDMAN, *DESIGN OF LONG-TERM CARE FACILITIES* 24 (1980). On a previous page under "Odor Control," the book states: "Proper selection of furnishings will also go a long way toward eliminating this disagreeable problem. Mattresses should always have waterproof ticking. Seating used by residents should also be covered in materials that shed or repel liquids." *Id.* at 20. The authors even suggest, "Some mattresses are also available with a germicide im-

metal, and it is not committed to any certain place, but migrates on wheels at the whim of someone other than its occupant. It has that terrible potential of becoming a prison, with shiny parallel bars that wait poised below the mattress line. They brush against your calves when you get up to roam around, a chilling reminder of their function, to capture and retain. The crime committed: illness. The theory of punishment: isolation.

Although few of us crawl into the bed that bore us, those of us who are lucky enough to live in a home space have a place to lie down at night to call our own. I want to die in that place, if I can. But if I must die in a bed that belongs to another, I do not want it to be in one of those hospital beds. I do not want my body lifted from a plastic platform to a plastic bag. I do not want to be rendered untouchable by a barrier of chrome.

To me, the answer to those questions is obvious: It matters where we crawl into bed, whether we are sleeping, making new life, healing, giving birth, dying, or just having a nap. It matters a lot.<sup>303</sup>

And the only good place to be sick is at home.

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pregnated in the ticking, the value of which may be subject to question." *Id.* at 24.

All this may be well and good for patients who are incontinent or highly contagious. However, for the dying patient who is neither, it seems a shame to force him to live out his last few days afloat a rubber mattress. Are comfortable, disposable mattresses that more closely resemble a normal bed an impossibility? During my own lengthy hospital stays, I would gladly have paid for my own mattress, if the hospital would have permitted it. As it was, I had to fight for the privilege of keeping my own pillow. If the goal of long-term care design is truly to promote the resident's feeling of well-being and individual worth, some attention ought to be paid to treating a reclining human body as something other than a generator of odor causing fluids and germs.

303. Norberg-Schultz explored the "lowest level of existential space, that of furniture and objects-for-use." NORBERG-SCHULTZ, *supra* note 298, at 31-32. The fireplace, which has since ancient times been the very center of the dwelling, and the table, the place "where the family joined to form a 'ring,'" are extremely important. However,

[T]he bed represents the centre even more convincingly, being the place from where man starts his day, and to which he returns in the evening. In bed, the circle of the day, and of life, is closed. The bed, therefore, *par excellence*, is the place where man 'comes to rest,' where his movements find their goal. Bollnow also points out that man's active relationship to the world is characterized by his vertical position; he takes a 'stand'. To sleep means to give up this position and return to the very 'point of departure'. When the Chateau de Versailles was centralized on the bed of Louis XIV, it symbolized more than a mere demonstration of power.

*Id.* at 32.

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What is the relationship between a home space and the ritual space that is needed for a meaningful deathwatch?

We cannot create the ritual space needed for a meaningful deathwatch without a home space. Ritual requires the demarcation of ritual space from secular space, and there can be no demarcation without the power to transform. Ritual also requires a community, and there can be no community without the power to include and exclude. Those powers can only be exercised in a home space. If there is no home space, there can be no ritual space, and if there is no ritual space, then the deathwatch lacks meaning.

Having a home space means, among other things, that those who inhabit it have control over what transpires within. This includes the power to transform the environment. If for whatever reason the inhabitants of the home space wish to make a room which is normally light, dark, they can do so. If they wish to change the configuration of the furniture, they can do so. If they wish to unplug the telephone and turn off the television, they can do so. If they wish to fill the room with music or prayer, they can do so. In a home space, there are no institutional impediments to the creation of ritual space. There is a door, and behind that door the members of the deathwatch can gather. There is freedom behind that door.

That door. Having a home space also means that its inhabitants can shut that door, or they can choose to open that door selectively, to invite in friends and family. That door defines the community; it draws the circle around the members of the deathwatch, not some arbitrary legal category. Control over that door, and who goes in and out, allows the inhabitants of the home space to create their own circle of intimacy, without which ritual cannot take place. There is a relationship between a home space and the ritual space needed for a meaningful deathwatch, all having to do with that door.

Recognition of that relationship is something that the law could do to alleviate indirectly the pain of the members of the deathwatch. There is this obvious suggestion: If possible, we should help those people who want to die at home, or who want to care for their dying family members or friends at home, to do so.

The idea is not new; no wheels need be invented. There is already an institution in place to facilitate such a home death. It is known as a hospice. Although the words "hospice" and

"hospital" share the same etymology,<sup>304</sup> and the institutions share the same history, they have come to mean very different things. In the ancient civilizations of India and Egypt, as well as in early Greece and Rome, the public facilities for the care of the sick were located in temples.<sup>305</sup> Bodily and spiritual health were regarded as the same thing.

In Western Europe, during the medieval period, religion was again the dominant influence in the establishment of healing institutions. During the Crusades, "hospices" or "hospitals" sprang up all over Europe alongside monasteries to provide food, temporary shelter and medical care for travelers and pilgrims. A number of military facilities provided for the care of sick and exhausted crusaders.<sup>306</sup> In the early medieval period, monks and clerics performed the role of healers, because they were the only ones with a semblance of education and were bound by vows of charity. In 1163, a Church edict forbade clergy from performing any operation that necessitated the shedding of blood. The result was a sharp curtailment in the

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304. The word *hospital* ultimately comes from the Latin *hospes*, meaning "a guest." The French *hospice* developed from the Latin *hospitium*, which meant the location where a guest was received, and the English words *hospital*, *hostel*, and *hotel* come from the old French *hospitale*. Thus, the words *hospital*, *hostel*, *hotel*, and *hospice* were all originally used in the same sense, but now have very different meanings. KENNETH P. COHEN, *HOSPICE: PRESCRIPTION FOR TERMINAL CARE* 13 (1979).

305. Both ancient India and Egypt had crude facilities that we might characterize as hospitals. In "the sixth century B.C., Buddha appointed a physician for every ten villages and built hospitals for the crippled and the poor." *Id.* at 14. His son also built shelters for the pregnant and the ill. In early Egypt, medical treatment was usually dispensed in the home, but some therapy was also available in the temples. Often the Egyptian doctor was a priest, since science and magic were often viewed as the same thing. *Id.*

In ancient Greece, sanctuaries were dedicated to Aesculapius, the Greek god of medicine. In these sanctuaries the sick were ministered to for both their physical and spiritual woes. These Aesculapia had large spas, *gymnasia*, for "gymnasiotherapy," amphitheaters for entertainment, libraries, and rooms for patients, visitors, attendants, priests, and doctors. Aesculapia spread throughout Greece and into the Roman empire. *Id.* at 14-15.

306. Pestilence and disease were particular problems during the Crusades, and there were a number of monastic and military hospitals and hospices for the care of sick and exhausted pilgrims and crusaders. The first reference to beds being provided for patients was in the foundation charter of the Knights Hospitallers, dated 1113, which set up seven resthouses for sick or wounded pilgrims on their way to the Holy Land. *Id.* at 17-18.

Leprosy was another motivating factor in the establishment of hospitals in the twelfth and thirteenth centuries. "Lazar houses" were developed to treat those afflicted with leprosy. These were generally crude structures, located on the outskirts of town, which served to segregate lepers and to check the spread of the disease by isolation and proper hygiene. *Id.* at 19.

medical activities of religious leaders, and the barbers took over surgery.<sup>307</sup> Centuries later, even though the hospitals are still dominated by the successors of the barbers, religious leaders have returned to the hospice, to treat the spiritual ills of the weary travelers within.

The "modern concept of hospice care dates back to the late 19th century, when an associate of Florence Nightingale opened a home for the terminally ill in Dublin."<sup>308</sup> It is not easy to define a "hospice," because it is often not a place, but an out-patient program for the terminally ill and their families. In 1978, the National Hospice Organization adopted the following definition of hospice, which is as good as any:

Hospice is a medically directed, nurse coordinated program providing a continuum of home and inpatient care for the terminally ill patient and family. It employs an interdisciplinary team acting under the direction of an autonomous hospice administration. The program provides palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement.<sup>309</sup>

One of the greatest virtues of hospice care is that it takes care of the terminally ill person in his home space.<sup>310</sup> In fact, the hospice takes care of everyone who inhabits the home

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307. *Id.* at 20.

308. Paul M. Sachner, *Heroes in Our Own Backyard*, ARCHITECTURAL REC., Nov. 1988, at 82, 104.

309. The National Hospice Organization ("NHO"), formed in 1977, consists of various institutional and individual members. NHO provides for the exchange of information between hospice groups, informs the public about hospice care, and establishes and maintains standards for hospice care. JACK M. ZIMMERMAN, *HOSPICE: COMPLETE CARE FOR THE TERMINALLY ILL* 17 (2d ed. 1986).

The NHO and the Joint Commission on Accreditation of Health Care Associations ("JCAHCA") are fighting a jurisdictional battle over the setting of standards and the accreditation of hospices. Both are voluntary, nongovernmental bodies. *Id.* at 26. Government involvement began in 1982, when Medicare began to provide hospice benefits to certified institutions. See the Health Care Financial Administration regulations governing hospice care under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, section 122 of Public Law 97-248, which set forth elaborate requirements for an organization to meet in order to be certified for the purposes of participating in the Medicare hospice benefit program. 96 Stat. 324, 356-63 (1982). In addition to federal legislation, state legislative and regulatory requirements began to affect hospices in the mid 1980s. ZIMMERMAN, *supra*, at 27.

310. Most hospice care in this country is delivered in the person's home. Jacqueline Shaheen, *New Jersey Q & A: Making the Decision for Hospice Care*, N.Y. TIMES, Mar. 24, 1991, § 12, at 3. There are 1,700 hospices in the United States. Frank Spencer-Molloy, *Hospice Brings Dignity*, HARTFORD COURANT, Aug. 21, 1991, at c1. Formal in-patient facilities, however, are rare.

space.<sup>311</sup> This is one instance where the architect's approach of looking at human problems in social context prevails. The patient is not seen as an isolated, autonomous individual, but as a member of a family and a community. The pain of the members of the deathwatch is not only expressly recognized, but addressed. Most hospices provide counseling for friends and family members before and after the death of the patient, sometimes for longer than a year,<sup>312</sup> and there is evidence that bereaved survivors of hospice patients experience much less painful and protracted periods of mourning.<sup>313</sup> The patient too does not suffer the isolation and loneliness that often comes with a hospital death. He is restored to the center of the circle, in his own home space, and his dying and his deathwatch once again have social meaning. He does not die alone.

Sometimes hospice care takes place outside the home, for a variety of reasons,<sup>314</sup> and it is in the design of in-patient care

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Amy Dunkin, *Tender Care for Terminal Patients*, BUS. WEEK, Mar 25, 1991, at 107.

311. The National Hospice Organization's Standards of a Hospice Program of Care lists the "unit of care" as the "patient/family." ANNE MUNLEY, *THE HOSPICE ALTERNATIVE* app. A at 320 (1983).

312. Most states have licensing requirements that include the provision of year-long bereavement counseling for family members following the death of the hospice patient. Danni Sabota, *Hospice Becomes a Business as Well as an Approach*, HOUSTON BUS. J., Aug. 6, 1990, § 1, at 17.

313. In a recent study of bereaved survivors whose family members had received hospice care from a hospital based hospice program, survivors reported that "routine, pre-death, work of the hospice team had a noticeable and positive impact on their subsequent well-being in bereavement." Ruth Huber & John W. Gibson, *New Evidence for Anticipatory Grief*, 6 HOSPICE J. 49, 65 (1990). The study included a new clinical tool called the "10-Mile Mourning Bridge," which represents the grief process. Conceptually, bereaved individuals successfully crosses the bridge when "they are able to reinvest their emotional energy into new interests or relationships." *Id.* at 55; see also Linda L. Steele, *The Death Surround: Factors Influencing the Grief Experience of Survivors*, 17 ONCOLOGY NURSING F. 235 (1990) (finding that survivors of terminally ill people who had participated in a hospice program prior to the death showed "decreased feelings of guilt, dependency, loss of control, despair, numbness, shock, and disbelief").

314. While home care may be an ideal way to care for a dying family member, one doctor noted that the ideal may not be possible for many patients. Many patients do not have the financial means to afford home care. Many patients do not have family, and for those patients who do have a family, "work or other obligations may restrict the time a family can spend on the patient." Morris D. Kerstein, M.D., *Caring for the Terminally Ill: A Hospice*, 129 AM. J. PSYCHIATRY 237, 237 (1972) (letter to the editor). Dr. Kerstein urged more hospice care, recommending that hospices be affiliated with major universities so they could be used to teach and provide research data in sociology, nursing, and theology, as well as undergraduate and graduate medicine. This "combi-

hospices that architects have shown themselves to be light-years ahead of doctors and lawyers in their concern for members of the deathwatch.<sup>315</sup> St. Christopher's Hospice in London was the model. Consider the following description of St. Christopher's:

There are mainly wards, with few private rooms. Each bed has a colorful curtain around it, and there are some transparent partial panels. Personal touches, such as flowers, paintings, comfortable lounge chairs, and wood, give a feeling of warmth. In addition to the wards, there are family rooms for visits and a large room for group activities . . . . Each patient brings his own personal belongings. Hospital gowns are not used. Bedside cabinets are of wood. The beds are simple and low enough for easy egress and ingress. Five huge, down pillows are supplied each patient . . . . Children of all ages, including infants, are permitted to come and go freely in all wards, hallways, and dayrooms . . . . The actual event of death is managed with dignity. The dying patient is not isolated behind curtains. All patients in the ward area are aware of what is transpiring. The lack of suffering, in fact the absolute absence of patient distress, is the unique factor permitting the staff and other patients to overcome their fear of death.<sup>316</sup>

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nation of disciplines would allow this supportive group to be more realistically aware of the patient and of his family life-style." *Id.* at 238.

315. Despite the hospice movement, it is not clear that the medical profession has truly changed its attitudes and practices toward the dying patient. One study reviewed medical charts to study the terminal care practices at a hospital and two in-patient hospices. While the hospital patients had more diagnostic tests and laboratory charges, the physicians' notes about the patients' families or nonmedical aspects of the illness were infrequent at all three institutions. Henry S. Perkins, M.D. & Albert R. Jonsen, M.D., *Dying Right in Theory and Practice: What Do We Really Know of Terminal Care?*, 145 ARCHIVES INTERNAL MED. 1460, 1460-63 (1985).

The study distinguished between "curative" therapy and "palliative care." *Id.* at 1462. "Palliative care" has become a euphemism for "hospice" in American hospitals. When my great-aunt was dying of cancer last year in St. Luke's hospital in New York City, she told me that she had received a call from a nurse in the "palliative care" unit. She then asked me where in the body the "palliative" was located.

316. Liegner, *supra* note 223, at 1047-48. But see David K. Reynolds, Ph.D. & Richard A. Kalish, Ph.D., *The Social Ecology of Dying: Observations of Wards for the Terminally Ill*, 25 HOSP. & COMMUNITY PSYCHIATRY 147 (1974) (describing how dying occurs in three extended care wards in a Veterans' Administration Hospital).

Reynolds and Kalish found almost no social interaction among the patients: "Many patients lie mute in bed; others, sitting in wheel chairs by their beds all day, say little or nothing to their roommates." *Id.* In the solarium, the researchers found "seven wheel chairs facing in seven directions, no one facing anyone else, no one talking or even watching the jumping and unclear images on the TV screen." *Id.* at 148. Many patients had no visitors, even at the time of their death, and many others had guardians or socially distant relatives who only showed up when they died. There were no chairs at the patients' bedsides, and ambulatory patients sometimes used wheel chairs to assure themselves of a place to sit down. The staff controlled the temperature

The first freestanding hospice in the United States was a project of Hospice, Inc., a New Haven, Connecticut, nonprofit group.<sup>317</sup> Lo-Yi Chan was the architect, and he was particularly challenged by the maintenance of a proper balance between isolation and privacy. Experience in English hospices had shown that the dying patient actually needed other people around him more than privacy, since privacy came to signify isolation and abandonment.<sup>318</sup> Chan found that the space requirements for hospices differed from those of an acute care facility or a nursing home because of the importance of "interdisciplinary care and family participation."<sup>319</sup> Thus, Chan designed the rooms in the New Haven Hospice to have approximately twenty feet around each bed to accommodate visitors and family members.<sup>320</sup> Here was an architect who recognized the importance of the deathwatch, and offered its members a legitimate space to stand in. Perhaps I make too much of twenty feet of floor space, but on a symbolic level, those twenty feet represent for me a glimmer of hope that the horrors of dying alone in the late twentieth century might come to an end.<sup>321</sup>

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and lighting. Lights were turned on at 2:15 a.m. to change incontinent patients, and all patients were awakened at 4:00 a.m., even though breakfast did not arrive until 8:00 a.m. The smell of the ward was "objectionable at first, although one becomes adjusted to it in a few minutes." *Id.*

317. Lo-Yi Chan, *Hospice: A New Building Type to Comfort the Dying*, AM. INST. ARCHITECTS J., Dec. 1976, at 42, 42.

318. *Id.* at 44.

319. *Id.* at 43.

320. Judith Kohn, *Hospice Building Speaks on Many Emotional Levels to Patients, Family*, MOD. HEALTHCARE (SHORT-TERM CARE), Oct. 1976, at 56, 57.

321. Lo-Yi Chan is one of many architects who have turned to the problems of hospice design. William Bregner, the architect of an addition to St. Mary's Hospital in Bayside, Queens, a palliative care unit or hospice for dying children, has also been sensitive to the needs of the members of the deathwatch. The unit accommodates ten terminally ill patients aged 2 to 16 with life expectancies of up to one year. At a washer/dryer area, families could "meet and share their thoughts." Monica Geran, *Hospice for Children*, INTERIOR DESIGN, Feb. 1986, at 192, 194. There was ample space for visitation, and relatives could place convertible chairs next to the beds so they could "stay overnight and maintain hand-to-hand contact with the child." *Id.* Grieving parents could retreat to a lounge on another floor so their behavior would not upset the patients. In hindsight, Breger would have expanded these facilities. *Id.*

When the University of Michigan overhauled its health-care facilities in 1980, it studied the use of the hospital by the "forgotten users," the patients and their families. Not only did the researchers look into the nonmedical needs of the patients, but they were also concerned about visiting friends and family:

While the inpatient is whisked from admitting to the cocoon of his room, his illness, and his treatment, it is his companions or visitors



How could the legal profession help people who want to die at home, or who want to care for their dying family members or friends, to do so? First, they could get involved in projects that would create more hospices. Despite the desirability of hospice care, and even its cost effectiveness,<sup>322</sup> there simply are not enough hospices to go around. For many, if not most, terminally ill patients in this country, hospice care is not available; in particular, there is a scarcity of in-patient hospice beds.<sup>323</sup> Lawyers are often involved in the development of health care facilities, and recognition by the legal profession that a hospice is an option for the care of the terminally ill could go far in promoting the hospice movement.<sup>324</sup>

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who brave the confusions and complexities of the establishment to find the patient's room, the nearest telephone, restroom, or cup of coffee, or a place to await medical verdicts.

ARCHITECTURAL REC., June 1986, at 116 (reviewing JANET R. CARPMAN ET AL., *DESIGN THAT CARES: PLANNING HEALTH FACILITIES FOR PATIENTS AND VISITORS* (1986)).

Many in-patient hospices have open visiting hours and permit overnight guests. Space for extra beds in the patient's room is provided, and extra chairs can be brought in when the deathwatch finally takes place. MUNLEY, *supra* note 311, at 63, 66.

322. Hospice care is gradually being recognized as more cost-effective in cases of terminal illness than hospital care. Rob Mosbacher, chairman of the Texas Board of Human Services, estimated, "It's costing roughly half as much for hospice care as it is for institutional care or hospitalization. In fact, it's probably the low end, conservative. We think it is probably upwards in many cases, of perhaps four to one." Sabota, *supra* note 312, § 1, at 17. For example, the average daily hospital stay in 1988 cost \$950. Inpatient hospice care averaged a daily charge of \$346, and home care hospice costs ran about \$80 per day. Since many patients are covered by Medicare/Medicaid, insurance companies are now providing the hospice package established by Medicare. Under that program, the daily cost of \$361.35 for inpatient care and \$81.63 for home care covers all services, medication, and equipment. *Id.*

323. The scarcity of hospice beds is a serious problem in this country. Most formal inpatient hospice services are geared for patients with a prognosis of less than six months' survival, and who consider themselves in a "palliative treatment mode, with no desire for cardiopulmonary resuscitation." J. Cain, M.D. et al., *The Quality of Dying: Financial, Psychological, and Ethical Dilemmas*, 76 OBSTETRICS & GYNECOLOGY, 149, 151 (1990). In one large metropolitan county with a population of 1.5 million, there were only 12 beds; they were available at a cost in excess of \$300 a day. Insurance coverage was based on skilled care needs; patients who needed extensive custodial and comfort care, but not skilled care, had to pay more than \$9000 per month. Nevertheless, there was long waiting list for these 12 beds. *Id.*

In a nursing home, the average costs are \$2500 per month, and again insurance does not cover costs unless skilled care is needed. Beds in nursing homes are also scarce, since many homes do not have the skilled staff or the psychological support necessary to provide terminal care. *Id.* at 151-52.

324. Lawyers could be more aggressive in recommending hospice care to clients for whom it would be appropriate. Close to three-fifths of the families

Second, the legal profession could be instrumental in developing a national system to make hospice care available to those who cannot afford to pay. As it now stands, there are gaps in Medicare coverage for hospice care; dying younger adults and children are not eligible.<sup>325</sup> Thus, even if there were a hospice available, many of the patients who might benefit from its services are too poor to bear the cost alone. Perhaps amending the existing federal scheme is not the answer. After all, the hospice movement was in many ways a reaction against the dehumanizing experience of a hospital death. The tradition in England was a free-standing hospice facility unaffiliated with a hospital. That tradition did not survive the journey across the Atlantic, however. Most hospice care in this country is affiliated with a hospital,<sup>326</sup> and there have been instances in which the existing funding system and criteria established by third party payers have forced the hospice to fit the hospital mold.<sup>327</sup>

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interviewed in one study received no information about hospice care after terminal cancer had been discovered. David S. Gochman & Gordon S. Bonham, *The Social Structure of the Hospice Decision*, 6 HOSPICE J. 15, 30 (1990). Data from physicians confirmed that they were not communicating information about hospice care to terminally ill patients and their families. The study did not even mention lawyers, presumably because they were not identified by families as a source of information. As a group, "friends" most often communicated information about hospices. *Id.* at 32.

325. One gap in the insurance coverage for hospice care involves younger people who are dying and not eligible for Medicare. Although some private insurance companies provide hospice benefits, and hospice programs frequently try to provide services on a sliding fee scale, the expense can still be prohibitive. Shaheen, *supra* note 310, § 12, at 3.

Until recently, children have had very little in the way of hospice care, despite the fact that approximately 100,000 children die annually in the United States. Most hospice programs in the early 1980s could not accept children as patients. Ann Armstrong-Dailey, *Children's Hospice Care*, 16 PEDIATRIC NURSING 337, 339 (1990). Children's Hospice International ("CHI") was formed in 1983 to improve the availability and quality of hospice care for children. CHI serves as a training and conference center, publishes training manuals, and supports efforts to expand awareness of the benefits of children's hospice care. A children's hospice in Alexandria, Virginia was scheduled to open in 1991. The facility was "designed to feel like home, complete with playrooms and toys. It will have 14 beds for children and space for visiting parents." *Id.*

326. Janet Plant, *Finding a Home for Hospice Care in the United States*, HOSPITALS, July 1, 1977, at 54, 57.

327. For example, St. Luke's Hospital Center, a teaching facility in New York City, was one of the first to establish a hospital-based team that provided a combination of home care and in-patient services. St. Luke's did not group the hospice inpatients together in a special unit. Instead, it assigned them to various floors in the hospital, fearing that the hospital might otherwise lose its standing with third-party payers as an acute-care facility. *Id.* at 58, 61.

Hospicizing the hospital may end up hospitalizing the hospice. Instead of building upon the structure that generated the problem in the first place, we may need to get out a shovel and break new ground.<sup>328</sup>

Third, the legal profession could help develop licensing standards for the various professionals who work in hospices to ensure quality care and to avoid the risk of abuse by greedy and exploitative individuals who might want to get rich quick from the death racket.<sup>329</sup>

Fourth, lawyers could help fashion creative solutions that combine some form of hospice care with already existing health care facilities. The Mayo Clinic, for example, has recently purchased a hotel across the street from its surgical facility, and discharges patients to spend a few days there. The family can then come and stay with the patient, administer medication, and care for him, but if complications arise, immediate medical attention is available across the street.<sup>330</sup> Such a move across the street to an environment that is more like a home space might be a possible solution for families who cannot care for the dying person in the home. It would allow a meaningful

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328. See Sandra S. Ikuta, *Dying at the Right Time: A Critical Legal Theory Approach to Timing-of-Death Issues*, 5 ISSUES L. & MED. 3, 65 (1989).

329. Most states have licensing requirements for hospices. See *supra* note 309 and accompanying text. However, there are not always licensing requirements for the professionals who work in hospices. Nurses are a perfect example.

The nursing profession has seen proposals to educate and certify nurses in hospice care. These nurses would receive special training in such things as pain management, home pain management, instruction of family members in home care, crisis management, and bereavement counseling. One article proposed two levels of hospice education. The first level would certify the nurse as a "hospice nurse certified" who would deliver patient/family hospice care; the second level would certify him as a "hospice nurse advanced" who would educate and administer hospice care programs. Marjorie C. Dobratz, *Hospice Nursing: Present Perspectives and Future Directives*, 13 CANCER NURSING 116, 116 (1990).

330. See Sanders, *supra* note 292, at 48. The University of Texas M.D. Anderson Cancer Center in Houston, Texas, is currently building a new patient-family facility, the Jesse H. Jones Rotary House International. Unlike the Mayo Clinic arrangement, patients will not be discharged to Rotary House; rather, it will operate as a hotel. The facility has been specially designed to provide a comfortable, home-like atmosphere for patients and their families while also taking into account the patients' physical needs. Guest rooms will be larger than industry standards to accommodate wheelchairs and medical appliances. Furthermore, a resource center will offer education programs for patients and family members on how to care for themselves and cope with their disease. Office of Public Affairs, M.D. Anderson Cancer Center, University of Texas, Press Release 1, 1-2 (Oct. 12, 1990).

deathwatch to take place, yet the medical services of a hospital would be only a few steps away. In New York State, to cite another example, there has been a move recently for hospices to enter into contracts with individual nursing homes to provide care for terminally ill nursing home residents.<sup>331</sup> These kinds of creative solutions require complicated negotiations, exchanges of promises and expectations; in short, they require the skill and imagination of legal minds.

So lawyers do have something to contribute: setting up the legal relations that create a space in which a meaningful deathwatch can take place. We are professional wordsmiths, and our words are instrumental. We can make things happen with our words: words of contract, words of legislation, words of persuasion and legitimation. Our law words can help carve out of the universe a warm space in which our fellow human beings can gather upon the death of one of their own.

That warm space is called home.

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There was one other thing Colin said that keeps ringing in my ears. It is a high pitched sound, and unpleasant, like tinnitus.

He said this:

In a way, the inability to have a meaningful deathwatch in a hospital is your own fault. I don't mean you personally, but the fault of lawyers. Most doctors I know are panicked about being sued. If the doctor opens the door and lets a lot of people into the room to watch the patient die, somebody's cousin is going to be a lawyer, and before you know it, the doctor will end up in court. I wouldn't want to open that

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331. This move results from a 1989 federal law permitting Medicaid reimbursement for hospice patients living in nursing homes. Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, § 101(b)(2), 103 Stat. 1979, 1980 (1989). In May 1991, the New York Department of Social Services implemented an interim system whereby hospices could be reimbursed for care inside nursing homes in New York. Before this, nursing home residents in New York were not eligible for hospice care. Mary Baker, *Hospice Contracts Seen Cutting Health Spending*, CAP. DIST. BUS. REV., May 27, 1991, § 1, at 1.

One local health-care industry analyst estimated that the new law could more than double New York hospice business in the state's 80 hospices. The state would reimburse hospices with patients in nursing homes at 95% of the nursing home rate. At that point, the contract between the hospice and the nursing home would determine how the nursing home would be reimbursed for its care of the patient. If the patient were eligible for Medicare coverage, the federal government would pay the cost of hospice care in the nursing home. This would prevent the transfer of terminally-ill nursing home residents to hospitals where "they are likely to be subjected to aggressive and costly life-extending medical procedures." *Id.*

door either. It's like inviting an audience in to witness your failure, your inability to keep out the ultimate uninvited guest, the specter of human death.

Those words are still humming in my head, disturbing my equilibrium. There is some truth to them. Although I like to think the law could alleviate indirectly the pain of the members of the deathwatch, the lawyer might just bring the deathwatch to an end. After all, his relationship with human failure is parasitic; he needs someone to stumble in order to survive. And as long as the doctor perceives death to be such a failure, he is never going to let the lawyer into the room.

Perhaps as lawyers we could make a small gift to the members of the deathwatch—a small gift, but one from the heart. Just as judges should be generous to those who engage in death talk, so should we be generous to those who take care of them. When we ourselves become members of a deathwatch, when we enter that ritual space to attend, we should leave our law words behind.

There are times in life, and in death, when no one needs our dutiful prose. Only our prayers and our poetry.

### *Right Hemisphere Coda*

#### *Mourning Shore*

For some reason  
I come into the day  
a little sad.  
I always have.  
At night we drift  
in black waters of  
some foreign sea.  
Elemental simplicity,  
no structural demands,  
no boundaries,  
wetness binds the gases  
and molecular integrity  
is easy to maintain.  
The moon is our pilot  
on that journey  
dark and deep  
and of such beauty  
rough earth words  
could never tell  
of our collective sleep.  
On sand hot white  
I crack  
and suck the air  
in crude exchange.

The ends of hands,  
of tongue, of feet,  
begin the definition,  
the solitude  
of finite form,  
the sickness of gravity.  
For some reason  
I come into the day  
a little sad.  
I always have.

### *Solidity*

From salty water,  
wordless we come in,  
wrapped in white cotton  
by the hands of others.  
Horizontal, heavy headed,  
all mouth and tongue,  
unaware that we begin  
or that we end,  
searching with eyes that look  
but do not see  
for interpreters  
of our infancy,  
to give meaning where  
there is no meaning  
beyond pain and need,  
and dependency.

Slowly we come into our words,  
words that yield boundaries:  
The carapace of self,  
the mystery of other,  
the tyranny of corners,  
and edges of things.  
Vertical, head erect,  
we shed white cotton and  
the hands of others,  
and construct a world of words,  
words that make water  
turn into ice.  
And though we think  
that what we name  
stands still,  
it does not.  
Solidity is a cheap  
word trick.  
What is named is really  
just slow water.

Wordless, we go out,  
wrapped in white cotton,  
by the hands of others.  
This time, there is a text,  
the text of memory,

to yield an interpretation  
of our senility.

Old words, our old words,  
lying around in random patterns,  
on the sand,  
words of laughter,  
thrown out at the sea,  
on some nameless day  
of sun and dogs and levity.  
Or whispers dropped softly  
in the dark  
at the bottom of sea pools,  
left along the beach,  
when the tide ran out,  
and the moon  
cast its cool light  
on our discovery:  
The transiency of sun,  
of surf,  
and our solidity.

Those who wrap white cotton,  
be wise about those words.  
The detritus of expression.  
Solid waste.  
The meaning they bear belongs  
to those who do the interpretation,  
not to the author of the text  
who floats out to sea,  
silent, free  
in saline liquidity.

### *Mistakes About Water*

That dark night  
I was pulled out to sea,  
it was just a mistake  
about water.  
They called it the East River  
which led me to believe  
I could dance on its shores  
with impunity.

But when I lost my footing,  
I tasted salt,  
and felt the power  
of the moon,  
and quickly apprehended:  
They were wrong.  
It was a tidal estuary  
and no place to dance  
at all.  
It was just a mistake  
about water.

Beckoned by those  
who saw me fall,

and rescued my identity  
when they could not  
rescue me,  
you arrived:  
The members of my deathwatch.  
One by one,  
in solemn procession,  
you descended  
that dangerous  
brown bank  
to witness my departure,  
to attend,  
to stay with me.  
I would not  
be alone in my  
going out to sea.

Your presence  
so startled me,  
those sad eyes,  
and outstretched hands,  
those words of sorrow  
and supplication,  
my body found  
the will to swim  
toward beauty,  
and love,  
and terror  
on the shore.

Even though  
the decision  
was unilateral,  
made without consultation,  
I do not begrudge  
my body's domination.  
It cannot help itself;  
it is just a poor  
living thing.

But someday,  
I will make another mistake  
about water.  
And when you arrive,  
one by one,  
in solemn procession,  
the members of my deathwatch:  
Do not make a mistake  
about water.  
Let me go,  
for I have seen  
the green glory  
of the sea,  
and known the freedom  
of not being me.



