
Withholding Nutrition and Mistrusting Nurturance: The Vocabulary of In re Conroy

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Words are a lawyer's stock in trade and, as every lawyer knows, words can mislead as much as they can clarify. James Madison, in number thirty-seven of the Federalist Papers, said it best while explaining why the words of the Constitution would inevitably be difficult to interpret. "When the Almighty himself," Madison said, "condescends to address mankind in their own language, his meaning, luminous as it must be, is rendered dim and doubtful by the cloudy medium through which it is communicated."¹

Statutes or judicial opinions addressing the "right to die" are also clouded by these doubts, confused as much as illuminated by the language that is available for discussing the subject. The very words used to formulate a question can, moreover, readily contain some impetus, some bias as it were, toward an answer—a bias that not only is unintended but that can ultimately defeat the author's professed initial intention.

This paradoxical difficulty can be seen in a recent decision by the New Jersey Supreme Court, *In re Conroy*,² regarding the termination of care for seriously ill people. The central issue in that case was whether the court would authorize physicians at the nursing home where Claire Conroy lived to discontinue feeding her by withdrawing a nasogastric tube on which her continued life depended. Though Ms.

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¹No. 37, THE FEDERALIST PAPERS 229 (New American Library ed., 1961).

²98 N.J. 321, 486 A.2d 1209 (1985).

Conroy died of other causes while her case proceeded through the appeals process, the New Jersey Supreme Court nonetheless set out an elaborate framework to govern future cases like hers. Within that framework, the court held that provision of nutrition was no different in principle from other kinds of medical treatment and could be withheld on the same basis, and that discontinuance of treatment was in principle no different from initial provision of treatment. These are difficult issues to resolve, and there are no easy answers for them or answers that are obviously more correct than the court's resolution. This article will show, however, how the judges on the New Jersey Supreme Court made these questions easier for themselves—and ultimately too easy, even self-deceptively so—by the way they framed the questions, by the implicit bias in very language they used to describe what was at stake.

The essential, though unintended, bias arose from what the court identified as its “starting point in analyzing whether life-sustaining treatment may be withheld or withdrawn from an incompetent patient.”³ This starting point, the court said, was “to determine what rights a *competent* patient has to accept or reject medical care.”⁴ The court spoke as if this were a self-evident place to begin its analysis; but it is not. And, moreover, there are significant implications that follow from this choice of a starting point—implications that are contrary to the court's statement of its own intentions.

The court purported to choose this starting point in order first to identify the rights of a competent person and then to determine how the same rights could be most nearly vindicated for an incompetent person, such as Ms. Conroy, who, according to the trial record was “confused and unaware,” possibly “capable of experiencing pain” but then again possibly not capable (on this issue Ms. Conroy's physicians were confused and unaware about her true status).⁵ The Justices' professed concern here was to guard against invidious discrimination against incompetent people, and they were explicit in acknowledging the existence of an impulse in our society to impose such discriminations. They spoke particularly about abuses and discriminations against institutionalized, elderly people like Ms. Conroy.⁶ But, without realizing this, the court's own analysis itself had powerful and ultimately dispositive discriminatory implications.

³486 A.2d at 1221.

⁴*Id.* (emphasis added).

⁵*Id.* at 1217.

⁶*Id.* at 1237–38.

By invoking a competent person as its starting-point, and insisting that Ms. Conroy be given "the same rights" as if she were competent, the court implicitly revealed its devaluation of, and its invidious discriminatory attitude toward, incompetent people. In effect, the court said that competent people are the norm in this society and incompetent people should be treated as if they could attain—or at least could approximate—this highly valued norm.

The court's implicit devaluation of incompetency was revealed in an almost off-handed observation in its opinion regarding the kinds of evidence that would be developed in trial proceedings that the court mandated to determine the incompetent person's intent regarding treatment. A competent person, of course, could simply announce his or her intent; an incompetent could not. But in order to draw as close an approximation as possible between the competent and incompetent person, the court called for evidence not only regarding any earlier (competent) statements by the now-incompetent person but also regarding the person's current condition. It is here that the court made this revealing aside; evidence should be gathered, the court said, about numerous aspects of the "patient's condition, treatment and prognosis," including evidence about the "degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment."⁷

There is a contradictory tension in this statement. On the one hand, the court seemed to acknowledge that there are varying degrees of "humiliation, dependence and loss of dignity" that might afflict incompetent people; it called merely for inquiry into the question without expressing any definitive judgment. But, on the other hand, the court's very formulation of the question clearly implied that "humiliation, dependence and loss of dignity" were virtually synonymous with one another. In the court's vocabulary, that is, "dependence" was inextricably linked with "humiliation" and "loss of dignity." This is the underlying meaning of, the underlying impetus that arises from, the court's analytic starting point that competency is the normal state, the valued status—because incompetency is inevitably humiliating and undignified.

This conviction is even more starkly revealed in a separate opinion in *Conroy* by Justice Alan Handler. He purported to take a different starting point from the court's. "It would be amiss," he said, "in the context relevant to Miss Conroy's situation, to stress notions of individual privacy or autonomy in measuring a person's best interests"

⁷*Id.* at 1231.

because she can neither “presently choose” nor had she ever previously “reliably indicated” her views or preferred choices in the matter.⁸ But notwithstanding his initial and clear-sighted acknowledgment that Ms. Conroy’s views could not reliably be known by anyone, at the crucial moment of choice, Justice Handler *ascribed* views to her and thereby pulled a wooly obscurity over his own analysis. Here is the crucial paragraph, which is quoted directly:⁹

The medical and nursing treatment in *extremis* and suffering from these conditions entails the constant and extensive handling and manipulation of the body. At some point, such a course of treatment upon the insensate patient is bound to touch the sensibilities of even the most detached observer. Eventually, pervasive bodily intrusions, even for the best motives, will arouse feelings akin to humiliation and mortification for the helpless patient. When cherished values of human dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough.

Justice Handler is passionate in his eloquence here, and his imagery vividly evokes hospital intensive care units or long-term nursing homes where patients lay honeycombed with tubes and wired to machinery. But for all his eloquence, there is the same underlying equation—even more openly stated than in the court’s opinion—in Handler’s opinion that “helplessness” is in itself “humiliating” and “mortifying.” Why should this be so? Why should “the sensibilities”—as Justice Handler put it—of “even the most detached observer” (even, one might thus say, a detached and impartial Supreme Court Justice) be “touched” by this course of treatment, by “the constant and extensive handling and manipulation of the body.”

One cannot resist a psychological speculation here: that the specter of “extensive handling” and the passivity implied by this handling is distasteful to someone who is accustomed only to being active, accustomed not to being *handled* but to being a *handler*—perhaps even a Justice Handler. Whatever such speculation is worth about Justice Handler himself, a deep fear of passivity and dependence pervades the court’s opinion in *Conroy*—and, moreover, is at the core of our legal system’s current response to these issues generally.

Aversion is not the only conceivable response to passivity. “Humiliation” and “loss of dignity” are not necessarily synonymous with “dependence.” Passivity, dependence, constant handling—all of this

⁸*Id.* at 1246.

⁹*Id.* at 1250.

can evoke images of childhood and infancy when passivity, dependence, and constant handling is the normal state of affairs and when, for most of us, our needs were met with loving and attentive nurturance. These images cannot be found in the *Conroy* opinions, however. They are missing because of a general phenomenon in our society: that we have no confidence in the nurturant potential in our common social life. However adequately and lovingly we were treated as children, there is a widespread belief today that no equivalent caretaking is reliably available to us as adults.

This belief is not based on fantasy. There is regrettable confirmation for this belief in the actual conditions in nursing homes and in other bureaucratically organized caretaking institutions—hospitals, mental illness and retardation institutions and the like. These institutions are not the primary locus of caretaking for most elderly or seriously impaired adults in our society; the family network and various kinds of home care are still the most prevalent formats for long-term social caretaking arrangements. But the impersonal, bureaucratic institution has become the dominant social caretaking image of our time, and this image is more fearful than consoling for most of us.

This fear frames the New Jersey Supreme Court's decision in *Conroy* and provides its vocabulary. There are good reasons for this fear; but, as realistically based as it may be, the fear itself will tend to distort the judges' good intentions in *Conroy*. The likelihood of this distortion is the central problem arising from *Conroy* and from similar judicial decisions rendered during the past decade that authorize the withholding of medical treatment from gravely ill people.

Twenty years ago or even less, many physicians regularly acted to withhold treatment from patients in extreme states of disability like Ms. Conroy, usually by failing to administer aggressive regimens of antibiotics in response to respiratory ailments (colloquially known then as the "old person's friend" for ending lives obviously afflicted by other slowly progressive but incurable illnesses). Sometimes these physicians acted in consultation with families, sometimes wholly on their own; there is no clearly reliable documentation on the extent of or bases for this past practice.¹⁰ But it is clear that many physicians today view any such practice as legally risky, if not ethically improper, and are eager to transfer decision-making responsibility to courts.

The courts have not, however, accepted this proffered re-

¹⁰See PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 186-87 (1983).

sponsibility—or, to put the matter more precisely (and more truly confusingly), courts recently have purported to accept this responsibility but in a way that effectively denies it. This is the true import of the *Conroy* decision. It is the underlying implication of the court's premise that the starting point for its analysis was the "truly competent patient." The court thus said, in effect, "we judges do not have the authority (or responsibility) to decide whether treatment should be continued or withheld; only the patient has that authority (and responsibility)."¹¹ The court indeed relied on its ruling a decade earlier in the *Quinlan* case that the Constitution dictated that patients themselves must be the sole locus for this decisionmaking.¹² As in the *Quinlan* case, however, this reliance on constitutional principle in *Conroy* was awkward at best; because Karen Quinlan was apparently in a "persistent vegetative state" as Claire Conroy was irreversibly demented, neither could speak for herself to assert or even to define their "right of privacy" to which the court purported to defer.

Undaunted by this misfit between its invoked constitutional principle and the case at hand, the court in *Quinlan* constructed an obviously fictitious person to "stand for" or symbolize Karen Quinlan by authorizing her father to exercise "substituted judgment" for her—that is, to pretend that he was her in deciding whether to continue treatment.¹³ In *Conroy*, the court ultimately reached this same fictitious result, though by a more circumlocutory route. The court mandated inquiry into whether Ms. Conroy had directly expressed any wishes regarding medical treatment when she had been competent (its so-called "subjective test")¹⁴; or, if not, whether she had indirectly or implicated expressed views on the question (its so-called "limited-objective test," thus overruling its earlier holding in *Quinlan* eschewing this kind of speculative evidence).¹⁵

Finally, if even such bits and pieces of evidence to invent a "responsible decision-making individual" were wholly absent, the court then embraced a so-called "pure-objective test."¹⁶ But even here the Justices held back from acknowledging that they or any judge rather than "the individual patient" would be taking responsibility for the decision. Instead the court insisted that the existence of "pain"

¹¹*Id.* at 192.

¹²*In re Quinlan*, 70 N.J. 10, 39–40, 355 A.2d 647, cert. denied 429 U.S. 922 (1976).

¹³70 N.J. at 41–42. For a discussion of the impossible mental gymnastics required by this court-mandated pretense in the *Quinlan* case, see R. BURT, TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS 152 (1979).

¹⁴486 A.2d at 1231.

¹⁵*Id.* at 1232.

¹⁶*Id.*

would be the sole determinant on which a decision could be reached. The court thus ignored the fact, amply demonstrated in the extensive trial testimony in both *Conroy* and *Quinlan*, that the existence of "pain" was a subjective proposition that could not reliably be gauged by anyone regarding people in vegetative states such as Karen Quinlan or in severe demented conditions such as Claire Conroy.

Justice Handler, in his separate opinion, clearly identified this fallacy in the court's reasoning.¹⁷ He then, however, immediately embraced an equivalent fallacy by opining that Ms. Conroy's treatment should be discontinued because her "extensive handling" and "pervasive bodily intrusions . . . arouse[d] feelings akin to humiliation and mortification for the helpless patient."¹⁸ Handler thus made explicit what was only implicit in the majority's opinion—that helplessness, that extreme dependency, was in itself "painful." Though Handler came closer than the majority to admitting that this was *his* viewpoint rather than the inevitable attitude of every helplessly dependent person, at the last moment he based his decision, as he put it, on "cherished values of human dignity and personal privacy" even though the person in question had not indicated that she cherished or construed those values as this judge would.¹⁹ Handler thus constructed a fictitious Claire Conroy to be the embodiment of the social values and the underlying mistrust of dependency and he purported to defer to "her."

All of the Justices in *Conroy* thus followed the same evasive maneuver that Claire Conroy's physicians had initially embraced: to deny direct personal responsibility for making a treatment decision regarding a person who was unable to decide for herself. It seems moreover, that the judicial denial of responsibility was most likely motivated by the same mistrust of institutionalized caretaking that apparently has led so many contemporary physicians to yield decision-making authority to the courts. The judges in *Conroy* were skeptical that the best interests of seriously ill people would be adequately protected by our society's formally institutionalized caretaking arrangements (especially, as they explicitly noted, the interests of elderly nursing home residents). They were also skeptical of their own capacity to protect the interests of such people. Thus the court majority held tightly to the proposition that, if a person's wishes could not be discerned, the only justified basis for a judicial order terminating treatment in the ostensible service of that person's "best inter-

¹⁷*Id.* at 1247–48.

¹⁸*Id.* at 1250.

¹⁹*Id.*

ests" would be in response to that person's demonstrated "recurring, unavoidable and severe pain."²⁰

There is an admirable caution and modesty in the Justices' refusal to accept authority to withhold treatment based on an open-ended judicial declaration of a seriously ill person's "best interests" and in their insistence that any such decision be narrowly constrained by some such standard as "recurring, unavoidable and severe pain". It is their obvious cautious modesty that leads one to conclude that the Justices were motivated by skepticism about their own caretaking capacities—a realistic skepticism amply confirmed by long experience, for one example, of judicial failure adequately to protect vulnerable people under civil commitment laws.²¹ But much as one may admire the Justices' modest disclaimers in *Conroy*, they were not sufficiently rigorous or sufficiently self-critical in their skepticism.

Though the Justices tried to constrain themselves, the standards they invoked are inadequate instruments for any assured self-constraint. The standards of "pain" or of "individual privacy" and "dignity" have no reliably objective content; they are virtual invitations to paste fictitious subjective attributes on a "person" who never existed as such. By virtue of this attribution, moreover, medical treatment will be withheld and this nonexistent person will thus vanish in the very act of its fictional creation. All of this will transpire so smoothly, with such elaborately judicialized due process, that no one—neither judges, physicians, and families immediately involved nor more detached social observers—will see the essential fictitiousness of the entire transaction.

All of the "competent" participants, both immediate and more remote, will thus make decisions for the "incompetent" that will obscure the continued and even more urgent reasons for mistrusting institutionalized caretaking. Though this mistrust pervades *Conroy*, the basic concern is that the court's result will be viewed as a *solution* to the problem that formally institutionalized caretakers cannot be trusted. If the Justices had been more rigorous in their appreciation of the bases for this mistrust, they would have understood that it cannot be resolved and that the very effort to do so will most likely exacerbate the problem.

There are hints of the way this exacerbation will occur in the

²⁰*Id.* at 1232.

²¹*Cf.* *Parham v. J.R.*, 99 S.Ct. 2493, 2508 & n.17 (1979) ("the supposed protections of an adversary proceeding . . . (in civil commitments) may well be more illusory than real", citing studies of judicial hearings that reveal a mean hearing time ranging from 3.8 to 9.2 minutes).

Conroy opinions themselves. The first hint obliquely appears in the majority opinion's reference to the New Jersey Supreme Court's prior decision in the *Quinlan* case. In the course of appearing simply to describe the factual background of that case, the majority said, "Ms. Quinlan had been placed on a respirator. . . . The unanimous opinion of all the doctors was that Ms. Quinlan would die if the respirator were removed."²² In fact, after the court authorized it and the respirator was removed, Karen Quinlan did not die but survived in her persistent vegetative state for almost nine years. The court's indirect and seemingly casual reference to this diagnostic error has an aura of special pleading, as if the court were saying, "It wasn't *our* fault. We simply relied on the 'unanimous opinion of all the doctors'." This is, however, a false reading of the case; there was in fact conflict in the testimony of the physicians at the original trial on the question whether Ms. Quinlan could survive once removed from the respirator.²³ The trial judge chose to believe the testifying physicians who were, as it turned out, wrong.

The physicians' error might have been reasonable, and the judge's reliance on their erroneous testimony might similarly have been reasonable, but the New Jersey Supreme Court misremembered—in their eagerness to absolve themselves from responsibility for a faulty caretaking decision. In one sense, this small deception by the Justices (a self-deception, it would appear) reflects the same flight from responsibility based on the same underlying mistrust of their caretaking capacities found elsewhere in their opinion. But, in a further sense, this particular deception reveals a specific responsibility-avoidance technique that will become generalized in future cases: an uncritical deference to physicians that obscures from the judges themselves that such deference is unjustified because the physicians have no firmer basis for confidence in their caretaking capacities (in their diagnostic and treatment skills or their underlying motives) than judges who have reluctantly found themselves thrust into these matters.²⁴ In this small but eloquent descriptive error regarding the *Quinlan* case, it is as if the Justices are saying to the medical profession, "You have come to court for us to make these treatment decisions because you doubt society's trust in you. But we judges will continue to rely on you; we judges have no choice but to trust you, even when you are wrong."

This same attitude is more directly revealed—though still hidden from casual discovery—by Justice Handler in his separate opinion. In

²²486 A.2d at 1227.

²³See Burt, *supra* note 13, at 153–54.

²⁴See J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 165–206 (1984).

a prefatory observation, Handler stated that, because "the fundamental interests of helpless persons . . . are at stake, . . . it becomes a judicial responsibility to intercede. . . ." ²⁵ He then cited a recent California appellate court decision, *Barber v. Superior Court*, ²⁶ for its presumed recognition of this responsibility. That court, Handler stated, "recognized that it would be derelict in [its] duty if [it] did not provide some general guidelines for future conduct in the absence of . . . legislation to protect the best interests of incompetent helpless, terminal individuals." ²⁷

There is considerable and revealing irony in Justice Handler's citation of this California decision. In that case, the court dismissed a criminal prosecution brought against two physicians for discontinuing tubal feeding from a patient two days after he had been removed from a respirator and five days after he had suffered cardio-respiratory arrest while in the hospital recovery room immediately following surgery for an unrelated condition. These physicians had advised the patient's wife and children within three days of his post-operative cardiac arrest that he had suffered severe brain damage that would most likely leave him in a permanent vegetative state and these family members drafted a document requesting discontinuance of "all machines . . . that are sustaining life." ²⁸ The local prosecutor subsequently obtained criminal indictments based on the following concerns: that the time lapse between the cardiac arrest and the termination of treatment was too short to make any definitive diagnosis of irreversible brain damage, that the physicians' willingness to act so swiftly raised a suspicion that they were trying to mask the possible misfeasance of their hospital colleagues in providing postoperative care to the patient, and these suspicions were compounded by the fact that the patient, on entering the hospital, had appeared to designate his sister-in-law as a surrogate decisionmaker, but she was never consulted regarding treatment withdrawal. ²⁹

The California trial court sustained the indictment on the grounds that there was sufficient reason to suspect a criminal offense, but the appellate court reversed. The basis for this reversal was set out in the court's opinion directly following the passage cited by Justice Handler regarding judicial duty to provide "some general guidelines for future conduct." But contrary to Handler's account of

²⁵486 A.2d at 1246.

²⁶147 Cal.App.3d 1006, 195 Cal.Rptr. 484 (Ct. App. 1983).

²⁷486 A.2d at 1247.

²⁸195 Cal.Rptr. at 486.

²⁹*Id.* at 493 n.2.

this passage, the California court did not purport to act in order "to protect the best interests of incompetent helpless, terminal individuals." The California court acted, by its own account, for the following purpose:³⁰

[T]here must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients. We would hope that this opinion might be serviceable to some degree in ameliorating the professional problems under discussion.

Thus, contrary to Justice Handler's bowdlerized version, the California court did not claim to act "to protect the best interests of incompetent helpless, terminal individuals." That court acted "to free physicians" from threats to their "self-interest or self-protection" that might arise if they were held accountable in criminal prosecutions for their possible misconduct in terminating treatment of "incompetent, helpless, terminal individuals." (There is, moreover, the further irony that the California court's statement ignored by Justice Handler was a direct quotation from the opinion of the New Jersey Supreme Court in the *Quinlan* case.)³¹ By thus unmasking Justice Handler's description of the California court's motivation, we have a vivid depiction of the dynamic that lies beneath the surface verbiage of the *Conroy* decision and that threatens to undermine its supposed beneficent purposes. In the ostensible service of incompetent, helpless people, the courts will in fact act to protect physicians.

Justice Handler made the point in yet another distorted citation of a sister state court opinion. The judicial task, he said, "can be viewed as 'establishing a framework in the law on which the activities of health care personnel and other persons' can be guided so as to act in the best interest of the patient."³² Handler was quoting here from a Massachusetts Supreme Judicial Court decision, *Superintendent v. Saikewicz*,³³ approving the withholding of cancer treatment from a retarded man notwithstanding that all mentally normal people would have opted for such treatment. In fact, however, in the passage cited by Justice Handler, the Massachusetts court did not claim to *guide* the activities of health care personnel; that court conceived its "task of establishing a

³⁰*Id.* at 491.

³¹355 A.2d at 668.

³²486 A.2d at 1247.

³³373 Mass. 728, 370 N.E.2d 417 (1977).

framework . . . on which the activities of health care personnel . . . can find support".³⁴

These variations between Justice Handler's citations and the actual court decisions may seem to be small matters. But these verbal differences reveal the deep tensions beneath the surface assurance of the Justice's opinion. The issue of trust in caretakers is the key. Justice Handler and his colleagues in *Conroy* revealed, in their equation of "helplessness" and "humiliation," their mistrust of the nurturant capacity of social caretaking institutions. But in Handler's disguised "support" for physicians (in the ostensible service of "guiding" them and protecting "helpless" patients), the Justice further showed an impulse to override, to disregard, his mistrust. There is here the same impetus toward uncritical deference toward physicians, and the same suppression of doubts about whether this deference is truly deserved, that was revealed in the same small way in the *Conroy* majority's reliance on the supposed "unanimous opinion of all the doctors" in Karen Quinlan's case.

These small hints in *Conroy* of uncritical and undeserved deference, and of suppressed doubts, regarding physicians as caretakers were greatly magnified in the California and Massachusetts decisions that Justice Handler cited. It is of course possible that the physicians in *Barber*, the California case, acted with adequate deliberation and were guided solely by the incompetent patient's interests and his immediate family's wishes rather than acting with unseemly haste to protect their professional self-interest; it is possible that the physicians in *Saikewicz*, the Massachusetts case, acted to save their retarded patient from needless and otherwise unavoidable suffering rather than because they valued his life less than a mentally normal person. The quick foreclosure of judicial scrutiny in both cases, however, raises rather than resolves doubt on these scores. In the California case, the foreclosure was obvious in the dismissal of the indictment without any trial. In the Massachusetts case, the foreclosure was less obvious since the court conducted an inquiry before authorizing nontreatment, but the desultory character of that inquiry was nonetheless apparent.³⁵ For reasons that I have set out in an earlier work, moreover, the very format of advanced judicial or administrative review of decisions to withhold treatment will most likely serve to suppress rather than to resolve doubts, so long as these advanced review processes guarantee absolute immunity to physicians from any subsequent sanction.³⁶

³⁴370 N.E.2d at 422 (emphasis added).

³⁵See Burt, *supra* note 13, at 155-58.

³⁶*Id.* 164-69.

The critical difficulty in *Conroy*, as in these other state cases, does not arise from the judges' underlying mistrust of caretaking institutions but rather from the judges' attempts to solve "the problem" of mistrust, an attempt which may well arise from the intensity of that mistrust that the judges perceive and fear. This same central difficulty also afflicts the solution advanced by some who would advocate a rigid rule that physicians may never withhold nutrition or hydration from any person under any circumstances. Such a rule cannot be justified on the ground that every conceivable person would always be benefitted from the prolongation of life by such means; the justification is rather that permission to withhold such treatment in some cases must necessarily lead to abuse in many other cases. The premise for this rigidity is mistrust of the bureaucratized network of social caretaking institutions. As sensible as this mistrust may be, the adoption of this rigid rule to "solve the problem" of mistrust will most likely lead to greater problems, to more subtle but pervasive abuse of helpless, dependent people. This is because such a rule would force caretakers to provide treatment in individual cases that appears to them both pointless and cruel. Adherence to this rule would, that is, mirror the heartless, nonnurturant implications of the bureaucratic organization of our health care system. This rigid rule would quickly become a reiteration and reinforcement of the very problem it intended to address, and it would breed other cruelties, other retaliatory inflictions, in its wake. Adoption and enforcement of such a rule would disregard the age-old wisdom that the spirit of a law can be life-affirming while adhering to its letter can be deadly.

What then is the solution to the problem posed by Claire Conroy's case? My preference is for courts and legislatures to avoid both promulgation of clear-cut rules and construction of formal bureaucratized procedures either of which, when followed "by the book," would immunize caretaking professionals from any prospect of later sanction. The customary regime should be relied on in which the immediate parties must act subject to the risk of subsequent public scrutiny, based on general standards of "good practice" and "ethical conduct," in civil, criminal, or professional license-revocation proceedings.

Arguments are elsewhere for this preference.³⁷ It is enough here to say that, however unsatisfying the refusal to provide direct substantive answers and exonerating procedures might be, there are greater risks for increased abuse inherent both in the formal rules and procedures set out in *Conroy* and in alternative proposed clear-cut "solu-

³⁷*Id.*

tions" to the problems of treating incompetent, medically dependent people. All of the currently espoused solutions rest on a deep mistrust of the possibilities for nurturance in our society which inevitably tends to imply a corresponding aversion to dependence and to dependent people.³⁸ In the very intensity of our contemporary mistrust of social caretaking, we have created an impossible bind for ourselves—a bind in which our traditional caretakers, whether physicians or judges, find themselves driven repeatedly to demonstrate the true depths of our predicament by proving how unreliable they themselves are as caretakers. An image keeps recurring: that we have dug a deep hole for ourselves and that every time we grasp some implement to find a way out, the tool turns out to be another shovel. Honest acknowledgement of the predicament seems at least the first, best step.

³⁸See Burt, *Legal Reform and Aging: Current Issues, Troubling Trends*, in *WHAT DOES IT MEAN TO GROW OLD?* 108–110 (T. Cole & S. Gadow eds., 1986).

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