

azine treatments for Mrs. Hier because of the reasonable expectation that this would improve the quality of her existence (and, indeed, might even lead her to reverse her unwillingness to be fed).

The possibility that failing to feed a patient will increase the patient's suffering must be considered—just as we must consider that the failure to employ a respirator may lead to an agonizing death for certain patients, though it is acceptable for others. Remembering that the word "care" is related to "lament," we should evaluate each individual's need for solicitude and comfort, without assigning an overriding symbolic role to feeding. Society must protect debilitated people, who are often old and make "uninteresting" patients, from the risk of neglect or abandonment by their guardians and caregivers. But, as the courts have also recognized, we should not be insensitive to either the real or the sym-

bolic harm that is done when patients without prospect of recovery or of human interaction are held on the cusp of death by feeding tubes.

Those who make and implement policy in this area face the difficult task of balancing the dictates of autonomy (which would often oppose feeding) with the impulse to paternalism (which would lead to feeding even resisting patients), all in the framework of community (which embodies our commitment to caring for each other). Perhaps, if we are fortunate, they will succeed in thinking boldly, clearing away the cobwebs of old confusions, while also cautiously evaluating each precious life that depends for its continuation upon their judgment.

REFERENCES

- ¹*In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976).
²Michael Novak, "The Social World of Indi-

viduals," *Hastings Center Studies* 2 (September 1972), 37.

³Kingsley Davis, *Human Society* (New York: Macmillan, 1949), p.53.

⁴*Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

⁵*In re Conroy*, 190 N.J. Super. 453, 464 A.2d 303 (App. Div. 1983).

⁶*In re Hier*, 18 Mass. App. 200 (1984).

⁷18 Mass. App. at 203.

⁸*Id.* at 204.

⁹Regrettably, the appeals court followed *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417 (1977), and treated the case as one calling for "substituted judgment," although most courts and commentators would limit that standard to situations when a patient's competent wishes can be ascertained. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* (Washington: U.S. Government Printing Office, 1983), p. 136.

¹⁰Bernard Lo and Laurie Dornbrand, "Guiding the Hand That Feeds," *New England Journal of Medicine* 311 (August 9, 1984), 402-04.

Life as a Work of Art

by ERIC J. CASSELL

In American medicine the principles that patients must consent to their care and that they have a right to refuse treatment have become firmly established over the past fifteen years. Underlying these principles are the right to self-determination and respect for autonomy. The changes in medical practice that followed acceptance of these ideas have occurred during a period in American society that stressed a *personalized* radical individualism. More than the political individualism of our heritage, and beyond the individualism of

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effort Americans cherish, radical individualism stresses characteristics arising from the interior of the person. I have a right to "be myself" and "do my own thing." Previously equality was stressed; now differences are more central.

Not surprisingly, during this same period medicine has shifted from a near-exclusive focus on disease toward a primary concern with the sick person. Indeed, I have argued elsewhere that the function of medicine is to help persons maintain or regain autonomy, which is inevitably damaged by serious illness, and which cannot be maintained without the help of a physician (or other caregiver).¹ In these last decades, then, the vocabulary of the moral—of right and wrong—has been added to the vocabulary of scientific medi-

cine—of fact and content. Without question, the publicly acknowledged joining of a moral dimension to medical practice has greatly enriched medicine.

However, neither of the two kinds of understandings—the scientific or the moral (at least in their present form)—provide adequate guidance in instances where a person under medical care refuses to eat. Consider the story of Elizabeth Bouvia. A twenty-six-year-old woman disabled since birth by cerebral palsy, but not otherwise ill, Bouvia admitted herself to a psychiatric hospital. There she refused nutrition and declared her desire to die, apparently because she found her life of total physical dependency unbearable. A more common situation might be that of an old woman who has suffered a series of strokes and can neither care for herself nor leave the hospital. Finding the inevitability of long-term custodial care intolerable, she refused further food. These persons no longer wish to live in their present state (which will not improve) but there is no disease that will soon kill them. Because they cannot otherwise act on their own, they refuse nutrition in order to die.

It is very important to emphasize that *there is no theoretical difference between the refusal to eat and the refusal of any other treatment*. That no disease is present

