The Problem of Proxies with Interests of Their Own: Toward a Better Theory of Proxy Decisions

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A seventy-eight-year-old married woman with progressive Alzheimer’s disease was admitted to a local hospital with pneumonia and other medical problems. She was able to recognize no one, and she had been incontinent for about a year. Despite aggressive treatment, the pneumonia failed to resolve, and it seemed increasingly likely that this admission was to be for terminal care. The patient’s husband (who had been taking care of her in their home) began requesting that the doctors be less aggressive in their treatment and, as the days wore on, he became more and more insistent that they scale back their aggressive care. The physicians were reluctant to do so, due to the small but real chance that the patient could survive to discharge. The husband was the patient’s only remaining family, so he was the logical proxy decision maker. Multiple conferences ensued: finally a conference with a social worker revealed that the husband had recently proposed marriage to the couple’s housekeeper, and she had accepted.

The Current Theory of Proxy Decisions

Patient autonomy is the cornerstone of our medical ethics. Given this commitment to autonomy, proxy decisions will always strike us as problematic: it is always more difficult to ensure that the wishes of the patient are embodied in treatment decisions when someone else must speak for the patient. Proxy decisions are especially disturbing when we fear that the proxy’s judgment is tainted by his own interests, so that the proxy is covertly requesting the treatment he wants the patient to have, rather than the treatment the patient would have wanted. This problem of interested proxies is exacerbated by the fact that we seek out proxies who often turn out to have strong interests in the treatment of the patient. We do this for two reasons. (1) Those who care deeply for the patient are more likely than others to want what is best for the patient. (2) Those who are close to the patient are generally most knowledgeable about what the patient would have wanted. This familiarity allows us to apply the substituted-judgment standard of proxy decision making. Given a commitment to autonomy, substituted judgment is an ethically better basis for proxy decision making than the reasonable-person or best-interest standard.

The apparent alternative would be proxy decisions made by outsiders—physicians, court-appointed guardians, or ethics committees. We must learn to recognize that such outsiders also have interests of their own, and that their proxy decisions may also be influenced by these interests. The more common worry about outsiders is that they rarely know the patient as well as members of the patient’s family do, and outsiders’
concern about the individual patient does not run nearly as deep. Proxies who are members of the patient’s family have a difficult time ignoring their own interests in treatment decisions, precisely because they—unlike outsiders—are so intimately involved with the patient and have so much at stake.

Thus, it seems that our theory of proxy decisions has boxed us into a “Catch 22” situation. “Knowledgeable” about patient wishes usually means “close,” but close almost always means having interests of one’s own in the case. “Disinterested” usually means “distant,” and distance usually brings with it less real concern, as well as lack of the intimate knowledge required to render a reliable substituted judgment.

I will argue that the reservations we have about interested family members and their proxy decisions are partly of our own making. The accepted theory of proxy decisions is deeply flawed and must be recast. Our medical practice is, I believe, often better than the conventional theories of proxy decision making. Nonetheless, some of our deepest worries about proxy decision makers grow out of the morally inappropriate instructions we give them.

If the current theory about proxy decisions for incompetent patients is mistaken, the accepted view of decisions by competent patients will have to be modified as well. However, I will be able to discuss decisions by competent patients only very briefly at the end of the article.

**Case Analysis: The Husband and His Proxy Decision**

The husband in this case seemed a perfect scoundrel. The physicians involved in the case all believed that he should be disqualified as a proxy decision maker, due to his obvious conflict of interest and his patent inability to ignore his own interests in making decisions about his wife’s care. There was no reason to believe that the patient would have wanted to limit her treatment, so the conclusion seemed inescapable that the husband was not faithfully discharging his role as proxy decider.

Both traditional codes and contemporary theories of medical ethics hold that physicians are obligated to deliver treatment that reflects the wishes or the best interest of the patient, and that the incompetence of the patient does nothing to alter this obligation.1 There is similar unanimity about the responsibilities of a proxy decision maker: the proxy decision maker is to make the treatment decisions that most faithfully reflect the patient’s wishes or, if those wishes cannot be known, the best interest of the patient.2 If the proxy does not do so, commentators almost uniformly recommend that physicians reject the proxy’s requests and have recourse to an ethics committee or to the courts.

Despite this impressive consensus of both traditional codes and contemporary theories of medical ethics, I was intrigued by this case and pressed the attending physician for more details. “Why is the husband in such a hurry? Perhaps he hopes that his wife will die, but she is dying anyway. Is he afraid that she might not die?” “No,” the attending responded, “his worries are primarily financial. He is afraid that he’ll lose his house and all his savings to medical bills before she dies. Since the housekeeper has no assets, they will then be left poverty-stricken.”

To some, this seems even worse: the husband has not only allowed his own interests to override considerations of what is best for his wife, but he has let his own crass financial considerations predominate. If his decision is not altogether self-centered, it is only because he is concerned about his fiancee’s future as well as his own. But married men are not supposed to have fiancées.

I do not necessarily want to argue that the husband made the correct decision. And I do not know enough about him to be able to judge his character. But I do think his decision should not be rejected out-of-hand, as patently inappropriate. First, I do not believe that we can just assume that the presence of another woman means that he was insensitive to his wife’s interests. I certainly know couples who have gotten divorced without losing the ability to care genuinely about each other and each other’s interests. Second, while divorcing a long-standing wife simply because she is now demented is difficult—“How can I abandon her at a time when she is so vulnerable?”—remaining married to an increasingly unreachable, foreign woman with Alzheimer’s is difficult, too. His wife’s dementia undoubtedly meant increasing isolation for him, as well as for her. And given that reality, his search for companionship does not seem unreasonable or morally objectionable. Third, the
husband also had been the patient’s primary caregiver for years without any prospect of relief or improvement. He probably longed for a chance to spend his few remaining years free of the burdens of such care. And, finally, supposing the husband to be an adherent of traditional values, he would be able to bring himself neither to simply “live with” the housekeeper, nor to consider himself no longer married while his wife was still alive, nor to accept medical care with no intention of trying to pay for it. Perhaps more “liberal” attitudes toward marriage and the payment of debts would have served his wife better. But we cannot be sure about that.

I have no doubt that the husband’s proxy decisions were influenced by his own interests. Given the reasonableness and magnitude of the interests he had at stake, it is hard to see how he could ignore them. “How can we ignore his interests?” I wondered. “And how can we reasonably ask him to ignore them?” I do not think we can.

The attending physician and I got no further on this case than my suggestion that the husband’s concern about his financial future was an appropriate consideration in deciding on a course of treatment for the patient. The physician was shocked that I thought this kind of consideration was relevant.

However, in today’s society we limit treatment all the time in an effort to save money for the government or for a health maintenance organization. We develop theories of rationing and “costworthy” medicine to justify such decisions. We regularly deinstitutionalize people, partly to limit the cost of the care that we, as a society, must provide. We limit the number of nursing home beds available for this man’s wife and other Alzheimer’s victims for the same reason. We thus force the burden of long-term care onto the families of the ill. And then we tell them that they must not consider their own burdens in making treatment decisions. I cannot make ethical sense of this.

We consider our pocketbooks, so how can we in good conscience tell proxies that they must ignore the impact of aggressive treatment on their personal financial futures? Financial considerations for a seventy-five-year-old with limited means are never trivial. We must recognize that for him, nothing less is at stake than the quality of the rest of his life, including, quite likely, the quality of his own future health care.

If we find it morally repugnant that proxies decide to limit treatment due to the burdens of long-term care on the family, then it is incumbent upon us to devise an alternative to our present system under which families deliver 75 percent of the long-term care. And until we have such an alternative in place, we dare not direct the husband to ignore the impact of treatment decisions on his own life. For we do not ignore the impact of such decisions on our lives. Moreover, the burdens of his wife’s treatment to him may well outweigh any benefits we might be able to provide for her.

**The Moral Relevance of Family Members’ Interests**

There are, of course, many cases like this, in which optimal care for a patient will result in diminished quality of life for those close to the patient. This care can be a crushing financial burden, depriving other family members of many different goods and opportunities. But the burdens are by no means only financial: caring for an aging parent with decreasing mental capabilities or a severely retarded child with multiple medical problems can easily become the social and emotional center of a family’s existence, draining away time and energy from all other facets of life. What are we to say about such cases?

I submit that we must acknowledge that many treatment decisions inevitably and dramatically affect the quality of more lives than one. This is true for a variety of very different reasons. (1) People get emotionally involved with others, and whatever affects the people we love affects us, too. (2) People live together, and important changes in one member of a living unit will usually have ramifications for all the others, as well. (3) The family is a financial unit in our culture, and treatment decisions often carry important financial implications that can radically limit the life plans of the rest of the family. (4) Marriage and the family are also legal relationships, and one’s legal status hinges on the life or death of other members of the family. (5) Treatment decisions have an important impact on the lives of others, because we are loyal to one another.

Most of us do not believe that family and friendships are to be dissolved whenever their continued existence threatens one’s quality of life. I know of a man who left his wife the day after she learned that she
had cancer, because living with a cancer-stricken woman was no part of his vision of the good life. But most of us are unable or unwilling to disentangle ourselves and our lives from others when continuing involvement threatens the quality of our own lives.

This loyalty is undoubtedly a good thing. Without it, we would have alliances for better but not for worse, in health but not in sickness, until death appears on the horizon. It is a good thing even though it sometimes brings about one of the really poignant ironies of human existence: sometimes it is precisely this loyalty that gives rise to insoluble and very basic conflicts of interest, as measures to promote the quality of one life undermine the quality of others. If the husband in the case we have been considering had simply divorced his wife when she was diagnosed as having Alzheimer’s, she would have died utterly alone. As such, only her own interests would have been relevant to her treatment. Her husband’s loyalty—impure though it may have been—has undoubtedly made her life with Alzheimer’s much better for her. But it also makes her treatment not simply her own.

Now, if medical treatment decisions will often dramatically affect the lives of more than one, I submit that we cannot morally disregard the impact of those decisions on all lives except the patient’s. Nor can we justify making the interests of the patient predominant by claiming that medical interests should always take precedence over other interests. Life and health are important goods in the lives of almost everyone. Consequently, health-related considerations are often important enough to override the interests of family members in treatment decisions. But not always. Even life or death is not always the most important consideration. Thus, although persons become “patients” in medical settings, and medical settings are organized around issues of life and health, we must still bear in mind that these are not always the most important considerations. We must beware of the power of the medical context to subordinate all other interests to medical interests. Sometimes nonmedical interests of nonpatients morally ought to take precedence over medical interests of patients.

Because medical treatment decisions often deeply affect more lives than one, proxy decision makers must consider the ramifications of treatment decisions on all those who will be importantly affected, including themselves. Everyone with important interests at stake has a morally legitimate claim to consideration; no one’s interests can be ignored or left out of consideration. And this means nothing less than that the morally best treatment in many cases will not be the treatment that is best for the patient.

An exclusively patient-centered ethics must be abandoned. It must be abandoned, not only—as is now often acknowledged—because of scarce medical resources and society’s limited ability to meet virtually unlimited demands for medical treatment. It must be abandoned, as well, because it is patently unfair to the families of patients. And if this is correct, the current theory of proxy decisions must be rejected in favor of an ethics that attempts to harmonize and balance the interests of friends and family whose lives will be deeply affected by the patient’s treatment.

**Reexamining the Doctrine of Substituted Judgment**

There is a second, related point. Arguably, there is a presumption that substituted judgment is a morally appropriate standard for a proxy decision maker. But this can be no more than a presumption, and it can be overridden whenever various treatment options will affect the lives of the patient’s family. In fact, substituted judgment is the appropriate standard for proxy decision making in only two special (though not uncommon) situations: (1) when the treatment decision will affect only the patient, or (2) when the patient’s judgment would have duly reflected the interests of others whose lives will be affected. In other situations, proxy deciders should make decisions that may be at odds with the known wishes of a formerly competent patient.

Consider again the case with which this paper began. I did not know the patient, and I have no idea what kind of a person she used to be. Let us, then, consider two rather extreme hypotheses about her character. On one hand, suppose that the patient had been a very selfish, domineering woman who, throughout their marriage, had always been willing to subordinate her husband’s interests to her own. If so, we can reliably infer
that she would now have ignored her husband’s interests again, perhaps even ridden roughshod over them, if she could have gotten something she wanted by doing so. Therefore, we can conclude that she would have demanded all the medical treatment available, regardless of costs to him. We can even imagine that she would have relished her continuing power over him and her ability to continue to extract sacrifices from him. Obviously, her husband would know these facts about her. The substituted-judgment standard of proxy decisions would have us conclude that if that is the kind of woman she was, this would increase her husband’s obligation to make additional sacrifices of his interests to hers.

Suppose, on the other hand, that this woman had always been a generous, considerate, unselfish woman, who was deeply sensitive to the interests of her husband and always ready to put his needs before her own. If that is the kind of woman she was, the theory of substituted judgment allows—strictly speaking, even obligates—her husband to sacrifice her interests once again by now demanding minimal care for her. After all, he knows that is what she would have done, had she been competent to make the decision. Even if he wanted to give her the very best treatment as an expression of love or gratitude for her concern for him throughout their lives, substituted judgment would require that he ignore those desires. Continued treatment is what he wants for her, not what she would have chosen for herself.

But surely that is exactly wrong. The theory of substituted judgment has it backwards. Loving, giving, generous people deserve to be generously cared for when they can no longer make decisions for themselves, even if they would not have been generous with themselves. And what do selfish, domineering, tyrannical people deserve? The answer to that question depends on one’s ethical theory. Perhaps neglect, maybe even retribution, are justified or at least excusable. Perhaps tyrannical behavior releases the family from any special obligation to care for the now incompetent tyrant. But unless one believes that good people should not be rewarded for their virtues, one will agree that caring, giving individuals deserve better care than domineering, self-centered individuals.

Where did we go wrong? What led us to widespread acceptance of the theory of substituted judgment? The major mistake is the one we have been considering—the mistake of believing that medical treatment affects only the life of the patient, or that its impact on other lives should be ignored. If the patient’s interests are the only ones that ought to shape treatment decisions, those interests are best defined by the patient’s point of view. Proxy deciders are, then, obligated to replicate that point of view insofar as possible. But most decisions we make affect the lives of others. That, of course, is the main reason why we have ethics. And the present incompetence of a patient should not obligate others to perpetuate the patient’s former selfish ways.

It would, of course, be possible to modify and defend the doctrine of substituted judgment by reinterpreting the concept of autonomy. Patient autonomy is, after all, the main reason we embrace substituted judgment, and we usually define patient autonomy as “what the patient would have wanted.” But if we were to work instead with a truly Kantian notion of autonomy, we would arrive at a very different theory of substituted judgment. For Kant would insist that a domineering, selfish person would acknowledge that she deserves less generous care when she becomes incompetent than a more caring, giving person deserves. While she might not actually elect less generous care if she were able to choose for herself, the moral judge within her would recognize that she deserves less care from others due to the way she has treated them.

On Kant’s view, then, the treatment she would choose for herself is not the appropriate standard of autonomy. Rather, her judgment about what is fair or what she now deserves would be the true meaning of autonomy. Kant would insist that the selfish, domineering ways of an individual are all heteronomous (subject to external influences), despite the fact that the person consistently chose them. He would further insist that a request for medical care that requires inordinate sacrifices from one’s family is also heteronomous, even if the patient would have wanted that. This interpretation of autonomy and substituted judgment is clearly very different from the standard interpretation in medical ethics.

Barring a radical rethinking of the very concepts of autonomy and substituted judgment, the doctrine of substituted judgment must be rejected. At the very least, our standard view of substituted judgment must be replaced with a theory in which the interests of the incompetent are constrained by what is morally appropriate, whether or not the patient would have so constrained herself. Often, the patient would have been sensitive to
the interests of the rest of the family. But not always. In any case, the interests of other members of the family are not relevant to proxy decisions because the patient would have considered them as part of her own interests; they are relevant whether or not the patient would have considered them. It is simply not the patient’s regard for the interests of her family that gives those interests moral standing. No patient, competent or incompetent, deserves more than a fair, equitable consideration of the interests of all concerned. Fairness to all includes, I would add, fairness to the patient herself, in light of the life she has lived and especially the way she has treated the members of her family.

The theory of proxy decision making must be rebuilt. While proxy deciders must guard against undue consideration of their own interests, undue consideration of the patient’s interests is likewise to be avoided. Proxy decisions have been given the wrong instructions. Instead of telling them that they must attempt to put themselves into the shoes of the incompetent patient and decide as she would have decided, we must tell them that the incompetent patient’s wishes are the best way to define her interests, but what she would have wanted for herself must be balanced against considerations of fairness to all members of the family.

**Toward a New Theory of Proxy Decisions**

Fundamental changes in the theory of proxy decisions will need to be created and defended. And a view such as mine faces a host of important questions. I cannot develop an alternative theory in this article. Indeed, I cannot even fully answer the most pressing questions about an alternative. Here, I can only provide suggestions about the way I would try to approach four of the most immediate questions about the theory of proxy decisions I would advocate.

First, if proxy deciders must avoid undue consideration of either their own interests or the interests of the patient, how is “undue consideration” to be defined? A full answer to this question would require an account of the family and of the ethics of the family. We can begin, however, by noting that, prima facie, equal interests deserve equal consideration. But what defines equal interest? Norman Daniels has developed the concept of a “normal opportunity range” for the purpose of allocating resources to different individuals and different age groups. Perhaps this concept could be extended to problems of fairness within families by asking how different treatment options will affect the opportunity range of the various members of the family. If so, undue consideration could be partially defined as a bias in favor of an interest that affects someone’s opportunity range in a smaller way over an interest that affects another’s opportunity range in a greater way.

But even if this suggestion about the opportunity range could be worked out, it would represent only one dimension of an adequate account of undue consideration. Another dimension would be fairness to competent and formerly competent members of the family in light of the way they have lived and treated each other. Thus, as I have argued above, those who have been caring and generous to members of their families deserve more from them than those who have been selfish or inconsiderate.

Second, whose interests are to be considered? For example, what about the interests of family members who do not care for the patient or who have long been hostile to the patient? Lack of concern for the patient and even hostility toward the patient do not, on my view, exclude family members from consideration. Such family members still may have important interests at stake; moreover, we must not assume that the neglect or hostility is not merited. Neglect or hostility toward the patient would, however, diminish what fair consideration of their interests would amount to.

What of the interests of close friends or companions who are not members of the family? “Family,” as I intend this concept, is not restricted to blood or marital relationships. Close friends, companions, unmarried lovers--all of these relationships may entitle persons to consideration in treatment decisions. Those who are distant--neither emotionally involved with the patient nor related by blood or marriage--will almost never have strong enough interests in the treatment of a patient to warrant consideration. (Health-care professionals may have strong interests, but they have special professional obligations to ignore their own interests and are usually well compensated for doing so.) I see no principled way to exclude consideration of anyone whose interests will be importantly affected by a treatment decision.
Third, wouldn’t any theory like the one I propose result in unfair treatment of incompetent patients? After all, we do not require that competent patients consider the interests of their families when making treatment decisions. And if competent patients can ignore their families, doesn’t fairness require that we permit incompetent patients to do so, as well? I have argued elsewhere that if we want to insist on patient autonomy, we must insist that patients have responsibilities and obligations, as well. In many cases, it is irresponsible and wrong for competent patients to make self-centered or exclusively self-regarding treatment decisions. It is often wrong for a competent patient to consider only which treatment she wants for herself. We must, then, try to figure out what to do when patients abuse their autonomy—when they disregard the impact of their treatment decisions on the lives of others. Sometimes, no doubt, we should seek to find ways to prevent patients from abusing their autonomy at too great a cost to their families.

Still, competent patients are almost always permitted to ignore the interests of their family members, even when this is wrong. We do not force them to consider the impact of their decisions on others, nor do we disallow their decisions if they fail to do so. How, then, can it be fair to incompetent patients to develop a theory of proxy decisions that will, in effect, hold them to a more stringent moral standard by requiring them to accept treatment decisions made in light of their families’ interests? The answer to this question is, I think, that there are many actions that we are at liberty to take, but only so long as we do not need an agent to help us accomplish them. If we can file our own taxes, we may be able to cheat in ways that a responsible tax advisor will refuse to do. We may get away with shoddy deals that an ethical lawyer would not be a party to. Thus, the greater freedom of competent patients is only a special case of the generally greater freedom of action when no assistance of an agent is required.

And fourth, what about the legal difficulties of an alternative view of proxy decision making? They are considerable: it is presently illegal to make proxy decisions in the way I think is morally appropriate. The courts that have become involved in proxy decisions have almost all opted for exclusively patient-centered standards. I do not have the expertise needed to address the legal issues my view raises. My purpose here can only be to challenge the faulty moral foundations that undergird present legal practice.

However, it is possible that family law could provide a model for a revised legal standard of proxy decision making. Family law recognizes the legitimacy of proxy decisions—for children, for example—that are not always in the best interest of the person represented by the proxy. It has to, if only because there are many cases in which the interests of one child will conflict with those of others. Nor does family law require parents to ignore their own interests in deciding for a child; instead, it defines standards of minimum acceptable care, with the hope that most families will do better than these minimum standards. Perhaps we should similarly separate the legal from the moral standard for proxy decisions. If no abuse or neglect is involved, the legal standard is met, though that may be less than morality requires of a proxy decision maker.

Conclusion

All these issues—undue consideration, eligible interests, fairness between competent and incompetent patients, and the law of proxy decisions—may seem very complex. However, I do not believe they are unnecessarily complicated. Many important decisions within families are very complicated. In medical ethics, we have simplified our task by working with an artificially over-simplified vision of the interests and decisions of families in medical treatment. So, if my critique of the present theory of proxy decisions is correct, we all—medical ethicists, reflective health-care practitioners, legal theorists, lawyers—have a lot of hard work to do. The change I propose is basic, so the revisions required will be substantial.

I close now with a word of caution and a word of encouragement. The word of caution: we must recognize that even the necessary revisions in our moral and legal theories of proxy decisions would not resolve all the problems of proxy decisions. Proxy deciders with interests that conflict with those of the patient do face serious moral difficulties and very real temptations to give undue weight to their own interests. Although the concepts of both “overtreatment” and “undertreatment” will have to be redefined in light of the considerations I have been advancing, pressure from proxies for inappropriate treatment will remain. I do not wish to minimize these
difficulties in any way.

But we should not give proxies the morally erroneous belief that their own interests are irrelevant, censuring them for allowing their interests to “creep in” to their decisions. Instead, we must deal forthrightly with the very real difficulties arising from interested proxy decisions, by making these interests conscious, explicit, and legitimate. Then we must provide guidance and support for those caught in the moral crucible of proxy decisions. Not only would this approach be more ethically sound, but it would, I believe, decrease the number of inappropriate proxy decisions.

Finally, an encouraging word. The Alzheimer’s case that I have cited notwithstanding, the practice of medicine is often better than our ethical theories have been. It has generally not been so insensitive to the interests of family members as our theories would ask that it be. Indeed, much of what now goes on in intensive care nurseries, pediatricians’ offices, intensive care units, and long-term care facilities makes ethical sense only on the assumption that fairness to the interests of the other members of the family is morally required. To mention only the most obvious kind of case, I have never seen a discussion about institutional versus home care for an incompetent patient that did not attempt to address the interests of those who would have to care for the patient, as well as the interests of the patient.

Current ethical theory and traditional codes of medical ethics can neither help nor support health-care professionals and proxies struggling to balance the patient’s interests with those of the proxy and other family members. Indeed, our present ethical theory can only condemn as unethical any attempt to weigh in the interests of the family. Thus, our ethical theory forces us to misdescribe decisions about institutionalization in terms of what is physically or psychologically possible for the family, rather than in terms of what is or is not too much to ask of them. If we were to acknowledge the moral relevance and legitimacy of the family’s interests, we would be able to understand why many treatment decisions now being made make sense and are not unethical. And then we would be in a position to develop an ethical theory that would guide health-care providers and proxies in the throes of excruciating moral decisions.

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NOTES


2 Beauchamp and Childress, Principles of Biomedical Ethics; Buchanan and Brock, Deciding for Others; Hastings Center, Guidelines; Pellegrino and Thomasma, For the Patient’s Good; President’s Commission, Making Health Care Decisions; R. M. Veatch, Death, Dying and the Biological Revolution: Our Last Quest for Responsibility (New Haven, CT: Yale University Press, 1989).


4 There are a few scattered references that acknowledge that the interests of the patient’s family may be considered. At one point, the President’s Commission states that “the impact of a decision on an incapacitated patient’s loved ones may be taken into account,” *President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: Ethical, Medical and Legal Issues in Treatment Decisions* (Washington, DC: US Government Printing Office, 1983), 135-36. The Hastings Center *Guidelines* counsels consideration of the benefits and burdens to “the patient’s family and concerned friends,” but only in the special case of patients with irreversible loss of consciousness (p. 29). Buchanan and Brock devote one page of their impressive work, *Deciding for Others*, to the “limits on the burdens it is reasonable to expect family members to bear” (p. 208). But these are only isolated passages in large, systematic works and they do not inform the overall theory developed in these works. The discussion of neonatal care is the only place I know where the interests of members of the patient’s family have received systematic attention. A good example is C. Strong, “The Neonatologist’s Duty to Patients and Parents,” *Hastings Center Report* 14 (August 1984): 10-16. The fact that many ethicists seem willing to consider family interests in the case of newborns but not in the case of older patients suggests that we may not really consider newborns to be full-fledged persons.

5 I owe this point to an anonymous referee.

6 Thus, I am in substantial disagreement with even the one paragraph from the President’s Commission’s *Deciding to Forego Life-Sustaining Treatment* that goes farthest toward something like the position I embrace. For the President’s Commission would allow proxies to consider the interests of family members only if there is substantial evidence that the patient would have considered their interests. But on my view, this is not the reason that the interests of the members of the patient’s family are relevant. If the patient was a selfish, inconsiderate person, this does not mean that the interests of her family somehow become morally illegitimate or irrelevant.
