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# BEYOND AUTONOMY

*Alexander McCall Smith\**

## I. INTRODUCTION

Medical law is a relatively new discipline. When Ian Kennedy published his Reith Lectures, in 1981, *The Unmasking of Medicine*,<sup>1</sup> medical law was in its infancy in Britain, despite being more advanced in the United States. Pronouncements on medico-legal issues, at that point, were often little more than speculation as to the likely view of the courts, and were commonly based not on precedent—which was scanty or non-existent—but on general legal principle. However, that changed with the ground-breaking decision in *Gillick v. West Norfolk & Wisbech Area Health Authority*.<sup>2</sup>

Now, of course, the situation is quite different. Not only is there a considerable body of case law, but also in many jurisdictions, there are statutes regulating a variety of medical matters, ranging from embryo research and artificial reproduction at the conception of life<sup>3</sup> to non-treatment decisions at the end of life.<sup>4</sup> Medical law is now a mature discipline with all the trappings of the topical specialty: institutes, conferences, and journals. But for all the interest and activity in the area of medical law, debate often seems predictable, and is dominated by a single perspective. This perspective holds that individual autonomy is the single most important value in medical law, and that in any conflict between autonomy and other values, autonomy must prevail. This Article suggests that medical law should deviate from this passive acceptance of a one-dimensional

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1. IAN KENNEDY, *THE UNMASKING OF MEDICINE* (1981).

2. *Gillick v. West Norfolk & Wisbech Area Health Authority* [1985] 3 All E.R. 402 (holding that a girl under 16 did not, by reason of her age, lack legal capacity to consent to contraceptive advice and treatment by a doctor).

3. See, e.g., The Human Fertilization and Embryology Act, 1990, Chapter 37 (England).

4. A pioneering statute of this nature was the Medical Treatment Act, 1988 (Victoria, Australia).

perspective and should be prepared, at least, to question the liberal individualist consensus which dominates so much of the current debate.

Many examples exist of the preeminent role of autonomy. Regarding reproductive medicine, numerous examples appear in the areas of mode of childbirth, surrogacy, sterilization and, most controversially of all, abortion. In each of these areas, a central and often determinative argument has been that the right of the individual to exercise autonomy outranks any other value. In relation to childbirth, asserting the autonomy of the mother undoubtedly has helped in some circumstances to wrest control of childbirth back from mechanistic medicine. However, it also has played an unduly prominent role in cases where the welfare of the infant has to be measured against the conflicting wishes of the mother. English law now shows a marked preference for the autonomy of the mother, in contrast to earlier United States decisions which placed considerable store by the interests of the viable fetus.<sup>5</sup>

In *In re MB*,<sup>6</sup> the Court of Appeal held that a woman was entitled to refuse a Caesarean section even if this resulted in the death of a viable fetus. In reaching this decision, the court observed that it was not a court of morals, thus distancing itself from the acute moral dilemma to which such an issue gives rise. In the debate on surrogacy, a common argument is that reproductive issues are a matter on which the individual may act without reference to other considerations, and if a woman wishes to conceive for the benefit of a commissioning parent, then that is a justifiable exercise of the right of autonomy. The same argument is made in relation to abortion, where the issue is often portrayed as a matter of "choice." The use of the word "choice" is significant in that choice is a central constitutive element of the concept of autonomy as it has been developed in late twentieth-century philosophical writing—by making choices one controls the shape of one's life, and thereby realizes autonomy.<sup>7</sup> For many of those engaged in the abortion debate, the exercise of choice is so morally

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5. United States cases taking an interventionist view include *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981) (holding that the State may order a mother to submit to a Caesarean section because protecting a viable unborn fetus outweighs the wishes of a mother) and *In re Madyyun*, 573 A.2d 1235 (D.C. 1986) (holding that a Caesarean section may be ordered because there is a compelling state interest in protecting the life and safety of a full-term fetus). However, a different approach was taken in *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994) (holding that a competent woman's choice to refuse to obtain a Caesarean section must be honored, even in circumstances where choice may be harmful to the fetus).

6. *In re MB*, 1997 (8) Med.Law Rep. 217.

7. For a useful discussion of autonomy, see GERALD DWORKIN, *THE THEORY AND PRACTICE OF AUTONOMY* (Cambridge University Press, 1988).

powerful as to exclude all other considerations. Choice, in other words, is the trumping card.

In relation to sterilization, again one sees the autonomy argument playing an important role, although in this context it acts to prevent an intervention rather than to facilitate action by the bearer of the right. The Canadian decision of *In re Eve*<sup>8</sup> provides one of the most striking examples of a court's acceptance of the notion that the autonomy of the individual outweighs any other competing interest. Indeed, it is evident in other modern sterilization decisions that courts are unwilling to give much weight to other factors such as the wishes or cares of parents or, even, the social interest in avoiding the birth of children who will be dependant upon society.<sup>9</sup>

Other areas of medicine present a similar picture. The whole edifice of the law relating to consent to treatment is constructed around a central pillar of autonomy, a fact which is neither surprising nor exceptional. But what is perhaps remarkable is the extent to which concern over autonomy has led to a gradual extension of the doctrine of informed consent to marginalize the physician's exercise of judgment as to disclosure of information. This is an unfortunate concomitant of an absolutist moral theory. The nuances of a situation and the fine moral shading tend to be obscured by rigid principles or by rules. What a doctor should disclose is an eminently contextual question. The assertion that patient autonomy is a firm rule restricts discretion and places physicians in a straitjacket. The physician, concerned that he or she should be seen as respecting autonomy, becomes a mere follower of the rule rather than a moral actor who is sensitive to the particularities of a situation.

The law of consent to psychiatric treatment similarly has been greatly influenced by the stressing of the autonomy of the individual. In some jurisdictions, this has had the effect of significantly restricting the scope of permissible non-consensual treatment, making it more difficult for psychiatrists to provide treatment in general, or to provide particular treatments such as electro-convulsive therapy. Where the treatment is radical or irreversible, this concern is particularly evident. In the United Kingdom, neurosurgical procedures for mental disorders are severely restricted under existing mental health legislation, a situation which has

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8. *In re Eve*, 115 D.L.R.3d 283 (Supreme Court of Canada, 1981).

9. For a discussion of the approach of courts to sterilization issues, see Christopher Heginbotham, "Sterilizing People with Mental Handicaps" in *Legal Issues in Human Reproduction*, 141 (Sheila McLean ed., Gower Publ'g Co. Ltd., 1989).

been the focus of some criticism.<sup>10</sup> Other jurisdictions have either outlawed the procedure altogether, or have made its performance virtually impossible.<sup>11</sup> Concern over the rights of the mentally ill is rarely misplaced, but to focus on their autonomy rather than their plight may simply have the effect of depriving them of justifiable paternalistic intervention. Cases arise where non-consensual treatment is morally appropriate, whether justification for it is provided by a paternalistic argument or by reference to the interests of others. Mental illness not only causes suffering to the individual; it causes suffering to families who must endure its effects. Family interests must be taken into account. A purely autonomy-focused analysis runs the risk of discounting these interests. It is against a background of emphasis on autonomy, even of those whose ability to choose may be radically undermined by illness, that courts have reached decisions such as *In re C*<sup>12</sup> or *In re Fleming and Reid*.<sup>13</sup> In *In re C*, an English case, the court declined to authorize treatment for a schizophrenic patient who was resisting attempts to treat a gangrenous leg and in *In re Fleming and Reid*, a decision of the Ontario Court of Appeals, a psychotic patient's refusal of treatment (expressed during a period of lucidity) was held to exclude the possibility of non-consensual treatment of that condition.

Tension between individual autonomy and social interests is equally apparent in medical research. Often, the validity of options can only be tested by selecting substantial groups of patients for particular forms of treatment and monitoring their progress over time. A doctor, then, may be unable to answer a patient's questions because he cannot predict the efficacy of the available options. The insistence on informed consent for entry into a research protocol undoubtedly drives away patients on the grounds that if the doctor cannot decide on appropriate treatment, then how can they? The result is that medicine is increasingly driven to rely on pragmatic advances, rather than on scientific investigation. An example

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10. In Scotland, for example, section 97(2) of the Mental Health (Scotland) Act 1984 prohibits psychosurgical procedures on patients who are incapable of consenting. Medical concern regarding the extent to which this limited the availability of treatment persuaded the Scottish office to establish a Working Group on the issue. This Group has recommended reforms that will enable such procedures to be performed on patients incapable of consenting, provided close monitoring and independent assessment of such cases is carried out. Scottish Office, Neurosurgery for Mental Disorder (Edinburgh: Scottish Office, 1996).

11. For a survey of the European view, see Arthur Rogers, *Legislation on Psychiatry in Europe*, 343 THE LANCET 1027 (1994).

12. *In re C* [1994] 1 All E.R. 819.

13. *In re Fleming and Reid*, 82 D.L.R.4th 298 (1991).

is the treatment of breast cancer—a major trial in the United Kingdom has had to be abandoned for want of participants.<sup>14</sup> Determining the level of information to be given to participants in clinical trials inevitably involves a delicate balancing exercise, but patient autonomy is only one of the considerations to be taken into account, even if it usually will be the most important. Social interest in medical advance, particularly in the treatment of life-threatening conditions, is a relevant factor to which at least some measure of consideration should be given. In some cases, of course, the autonomy of participants has not been given adequate consideration, with results that few would find acceptable. The much-criticized New Zealand cervical cancer project provides an instance of just the sort of situation where more attention to autonomy would have prevented significant abuse.<sup>15</sup>

It could be argued that these examples do no more than demonstrate that what medical law has achieved has been to embody, in the form of legal rules, the prevailing rejection of paternalism and the widely-held belief that people should be allowed to determine the shape of their own lives. That it does this is obvious, and, in many cases, the result is welcomed. What is perhaps less obvious, however, is just how autonomy has crowded out other values and how uncritically it is used. Autonomy has become something of a shibboleth, and it may be appropriate to pause and take stock of its limits and its relationship to other values. Before doing this, however, it is important to reflect on the way in which values have played a part in medical law and ask the question whether a clearer boundary should not be drawn between medical law and medical ethics.

## II. MEDICAL LAW AND MORAL PHILOSOPHY

Most of the issues with which medical law concerns itself are issues of moral significance. In this respect, medical law is similar to family law, which is accustomed to wrestling with the socially and morally sensitive implications of such issues as divorce, custody, and parental rights. Therefore, many of the questions which medical law must address fall outside the strictly legal realm. At one level, they are legal issues in that a legal rule needs to be applied, but the nature of the legal rule to be applied is not a technical legal question, but rather a matter of policy.

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14. Michael Baum, Kevin Zilkha, & Joan Houghton, *Ethics of Clinical Research: Lessons for the Future*, 299 *BRITISH MEDICAL JOURNAL* 251 (1989).

15. Discussed by Alastair V. Campbell, *A Report from New England: An 'Unfortunate Experiment'*, 3 *BIOETHICS* 59 (1989).

Whether or not a contract of surrogate motherhood should be enforceable is thus not a question on which the law of contract can provide anything but superficial assistance; it is a moral question which must be settled by society's moral arbiters. Who these are depends on the society. In some countries, the matter may be resolved by reference to some fundamental constitutional source, such as a bill of rights, which is then applied to the issue at hand by the courts. In others, the arbiter will be the legislature, and a political decision will be made by the law-maker.

However the issue is tackled, the important matter is that the law is but an instrument in the process of moral resolution. Ideally, lawyers should not state what the moral values of society should be; that is a task for the community itself to undertake. Lawyers can then apply the principles which the community chooses and particularize them through legal rules. In practice, this will be difficult to achieve. The courts will have to make moral choices. The task of interpretation inevitably will require moral decisions to be made, and the scope of moral discretion may sometimes be considerable. However, the basic policy issue should be settled elsewhere. Applying this point to the euthanasia debate, the issue of whether physician-assisted suicide or even voluntary euthanasia should be permissible is removed from the judicial system and left as a matter for society to determine through its legislators. It is difficult to see why lawyers should have any particular competence to pronounce on this fundamental question of life and death—the legal voice is merely one of a number of voices which should be heard.

Yet this is not always the way in which the matter is decided. In many instances the forum for the resolution of this issue has been the legal rather than the political system. For instance, in the Canadian case of *Rodriguez v. Attorney-General of British Columbia*,<sup>16</sup> the question of whether a woman suffering from a progressively disabling disease had the right to seek medical help to end her life was resolved by the Supreme Court through the application of the Canadian Charter of Rights and Freedoms.<sup>17</sup> Needless to say, the Charter does not specifically address the issue. It could be argued that an issue of such profound importance as euthanasia is one upon which a legislature should pronounce specifically, but this is rarely done. Legislators seem content to leave these difficult issues and their resolution to lawyers and the courts, possibly deliberately hoping that the courts will relieve them of the need to pro-

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16. *Rodriguez v. Attorney-General of British Columbia*, 82 B.C.L.R.2d 273 (1993).

17. *Id.*

nounce on a matter which brings few votes and usually succeeds in raising passions. In other circumstances, courts may have the last say by virtue of constitutional arrangements. Public discussion of an issue and indeed political action may be thwarted by the restrictions which constitutions place on legislation. Even if there is a political will to decide in a particular way, constitutional challenges may emasculate political action.

As a result of the entrenchment of the law in the process of resolving moral dilemmas, it is perhaps not surprising that medical lawyers frequently fail to distinguish the moral dimension of rules from the strictly legal dimension. A legal discussion of an issue therefore frequently moves backwards and forwards between questions of policy and legal fact. Of course, lawyers are not mere technicians and should be encouraged to have a view on the morality of the legal rules which they apply, but what is important is that the moral part, which is a matter of policy, is identified and treated not as a technical legal issue but as a matter for proper moral analysis and resolution. However, this rarely happens and major policy issues are treated as if they were matters of legal principle. Moreover, because of this enthusiastic embrace by lawyers of the policy dimensions of the rules which they apply, there has been a tendency to transport the legal outlook into the moral realm and to apply legal values as if they were beyond moral challenge. It is clear that medical law has been very much influenced by this tendency and that this fact, coupled with the potency and currency of liberal individualist ideas, has resulted in the excessive entrenching of autonomy within the medico-legal debate. This is the background. The next task is to ask why lawyers, more than any other group, should seize upon autonomy and promote it to such a status. Is there anything in the legal outlook which predisposes lawyers to reduce moral issues to issues of autonomy?

If there is such a feature of the legal outlook, it is probably to be found in the way in which the common law interprets society as a series of relationships between persons in which conflict is resolved by appeal to rights, where one right usually outranks others. The legal model of society is essentially contractarian. The individual enters into legal relationships with others in which obligations and entitlements are created. This is the warp and woof of the common law, and it permeates the thinking of lawyers to a greater extent than they perhaps appreciate. It is an outlook which has traditionally relied on formal resolution of disputes rather than informal arbitration. The values it endorses tend to the individualistic. Disagreement may be resolved, in theory at least, by one right being preferred to another, rather than by compromise. It represents, in many



ways, an atomistic vision of human society, which is the perfect intellectual soil for liberal individualism and its accompanying notion of individual autonomy. It is no surprise, then, that medical lawyers have seized upon notions of autonomy developed by political philosophers and have taken them as their own. In doing so, they have helped form the relationship between doctor and patient into a mold which some might see as sterile and inhumanly formal—a mold in which the governing concept of autonomy is frankly overworked.

### III. AUTONOMY MISUNDERSTOOD

Some concept of individual autonomy is essential for any moral system which recognizes the principle of respect for persons. Autonomy is undoubtedly a central and important human good—an essential part of human flourishing—and to be deprived of it is to suffer a moral and psychological disaster.<sup>18</sup> In exercising autonomy, we allow the self to flourish and to imbue our lives with authenticity. By contrast, the non-autonomous person, the person for whom decisions are made by others, or who, for whatever reason, is unable to make decisions for himself, leads a poorer life. The moral texture of such a life is drab. It is less of a life than that of one who creates his own living conditions. It may well be a life devoid of significant suffering, but in general it would be considered a life less worth living than the life of the autonomous agent.

Autonomy, then, resembles a most attractive value which it would seem perverse to question. Indeed, that is the case if autonomy leads, as it often does, to the living of a good life. But what if the exercise of autonomy leads not to the making of good choices but to the making of bad choices? Enthusiasts of autonomy have sometimes talked themselves into an almost existentialist position, portraying the value of autonomy as lying in the mere capacity to make the choice rather than in the capacity to make a fulfilling choice. They have, therefore, depicted autonomy in a neutral light, as being desirable in itself, and not for what it can bring to a life.<sup>19</sup> Autonomy is seen in this view as being valuable in itself, irrespective of the use to which it is put, and any measure which is designed to

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18. LAWRENCE HAWORTH, *AUTONOMY: AN ESSAY IN PHILOSOPHICAL PSYCHOLOGY AND ETHICS* (1986).

19. An exponent of this position is David Richards, who has espoused the neutral view of autonomy in works such as his *SEX, DRUGS, DEATH AND THE LAW* (Totowa, N.J.: Rowman and Littlefield, 1982). See also the same author's *Rights and Autonomy*, 92 *ETHICS* 3 (1981).

facilitate the exercise of autonomy, sometimes irrespective of purpose, is endorsed.

The acceptance of autonomy as a desirable end in itself, rather than as a means to the attainment of the good, has recently been called into question by Robert George and John Kekes, both of whom oppose, from different perspectives, the liberal individualism which has so stressed the value of autonomy. George, who provides the most impressive defense of morals legislation of recent times,<sup>20</sup> argues that there is no value in autonomy if it is exercised in the pursuit of evil. In George's view, autonomy is important because it enables us to create our own good and fulfilling lives. Kekes, like George, does not deny the value of autonomy, but argues that it has been promoted to a privileged position in liberal theory.<sup>21</sup> If autonomy is given this protected position in which it so markedly over-shadows other values, then there is every possibility that it will be exploited in such a way as to increase the amount of evil. This, however, is not what liberal theory presupposes. In fact, it holds exactly the opposite—that facilitating the exercise of autonomy will result in less evil and greater good.

What is striking in examining a great deal of medico-legal debate is the fact that it seems to be conducted in an intellectual universe in which autonomy and self-realization are simply not subject to substantial challenge from rival visions. What the individual wants is the final value. Whether this is objectively reasonable or whether it affects a community interest or a moral value seems to be of secondary importance. I would argue that autonomy should be removed from its privileged position and, although taken into account as an important value, should be seen as a means of facilitating the good rather than constituting the good in itself. To do this, however, requires that one address the problem of pluralism and inquire whether medical law can embrace moral pluralism.

#### IV. MEDICAL LAW AND MORAL PLURALISM

In looking more critically at autonomy, the obvious question is: how are people to approach a whole range of issues where there is moral disagreement as to the appropriate legal response? In an important sense, autonomy provides the easy way out of such dilemmas. If we take, as our guiding principle, the proposition that we should be free to make our own

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20. ROBERT P. GEORGE, *MAKING MEN MORAL: CIVIL LIBERTIES AND PUBLIC MORALITY* (1993).

21. JOHN KEKES, *AGAINST LIBERALISM* (1997).

choice and to do as we wish to do, then the solution is always clear. So, in dealing with abortion, if the courts or the legislature say that the question of whether to have an abortion is a matter of choice for the individual, then the moral problem is simply shelved. There is no longer a pressing moral issue, at least for the law, which has referred the matter to the exercise of individual autonomy. Similarly, in relation to euthanasia, if the law recognizes a right in each individual to decide whether or not to seek an end to life, then again the matter is conveniently solved, without the law having to pronounce that a particular course of action is morally right for all. In this way, we reduce morality to an individual level—an ideal course of action for the moral subjectivist.

Allowing the law to recognize a right in each individual to decide whether to seek an end to life is also an ideal way of keeping the moral peace. In this respect, it appeals to those pluralists who argue that the only way in which complex and pluralistic societies can be maintained in tolerably pacific conditions is to recognize a plurality of moral spheres.<sup>22</sup> This may be so empirically—some form of moral tolerance may be the only chance that such societies have of social peace. However, the technique undoubtedly also could have the effect of steadily reducing the area of common morality within a society which might have radical effects on social cohesion. Precisely what these effects are is difficult to gauge, but it is apparent that the loss of moral community is a loss which has indicated to communitarian intuitions that something is amiss.

For the medical lawyer, a *de facto* pluralism rides on the coat-tails of the autonomy argument and, to an extent, on those of a harm principle of the sort so cogently argued for by Joel Feinberg.<sup>23</sup> The alternative to a liberal position of the sort developed by Feinberg strikes many as unattractive: if a section of the community desires a particular right, then there is no harm done to others by according it. And if to decline to accord it would prevent the exercise of individual autonomy, then what possible reason can there be for denying the right? This sort of question often arises in the context of artificial reproduction. If, for example, a single woman or a lesbian couple want a child, then why should she, or they, not avail themselves of artificial insemination and, more particu-

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22. This issue is addressed in detail by H. TRISTRAM ENGELHARDT, *BIOETHICS AND SECULAR HUMANISM: THE SEARCH FOR A COMMON MORALITY* (1991). For a contrary view, also from a bioethics perspective, see ERICH H. LOEWY, *MORAL STRANGERS, MORAL ACQUAINTANCE, AND MORAL FRIENDS* (1997).

23. Joel Feinberg's elucidation of the harm principle is developed in his magisterial, four-volume work, *THE MORAL LIMITS OF THE CRIMINAL LAW* (1988).

larly, why should they not be able to have equal access to public health resources in order to achieve this aim? The question as to who is being harmed in this scenario is difficult to answer. The child is probably not being harmed in any recognizable way. The harm, if it exists at all, must be located elsewhere. It is interesting to note that the British response to the issue of artificial reproduction, which is embodied in the Human Fertilization and Embryology Act of 1990,<sup>24</sup> deals with this issue by stating that the decision by licensed practitioners of artificial insemination must take into account the child's need for a father.<sup>25</sup> The official response to the issue, then, is one of discouragement, but it is significant that there are few defenses of this position which are based on principle. Arguments adduced in favor of the restriction tend to be based on the right of the future child to two parents.<sup>26</sup> This, however, is a vulnerable argument in a society where an ever-increasing number of children do not have two parents in the home and where the need for two parents is vociferously questioned. Whatever the merits of such arguments—and a number of strong, empirically backed cases for two parents have emerged in the United States<sup>27</sup>—the matter is surely not one simply of sociological evidence of either happy single-parent children on the one hand or, on the other, of higher incidences of poverty and delinquency among the children of single parents. The argument could equally well be seen as being one about one of the central institutions of society, the family, and about direct and indirect legal recognition for and support of the concept of the family. Yet, because of the centrality of the autonomy argument and the primacy of the liberal individualist position, this argument rarely has much impact. Significantly, well-argued opposition to a crude autonomy-based approach to reproductive issues has come from certain feminist critics who see the possibilities of exploitation in the contractarian vision of reproduction.<sup>28</sup>

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24. 1990, c.37, CURRENT LAW STATUTES ANNOTATED, 1990, Vol.3.

25. *Id.* at Section 13(5).

26. Report of the Committee of Enquiry into Human Fertilization and Embryology (H.M.S.O., London, Cmnd. 9314, 1984), para.2.11.

27. There is an interesting survey of the evidence in W.A. Glaston, *Causes of Declining Well-Being Among U.S. Children in SEX, PREFERENCE, AND FAMILY: ESSAYS ON LAW AND NATURE* 290 (David M. Estlund and Martha C. Nussbaum eds., 1997).

28. A feminist response to surrogacy is provided by L. B. Andrews, *Surrogate Motherhood: the Challenge for Feminists in THE ETHICS OF REPRODUCTIVE TECHNOLOGY* 205 (Kenneth D. Alpern ed. 1992). There is full airing of feminist concerns in *THE BABY MACHINE: REPRODUCTIVE TECHNOLOGY AND THE COMMERCIALISATION OF MOTHERHOOD* (Jocelyne A. Scutt ed. 1990).

## V. AN ALTERNATIVE APPROACH

The argument being advanced is that while recognition must be given to individual autonomy as an important value, autonomy must be subject to certain limiting considerations. What these considerations are might perhaps best be discovered by looking at another example of an area of medical law, that of euthanasia (and I include within euthanasia the question of non-treatment decisions).

The autonomy argument appears in several distinct contexts within the euthanasia debate. In respect to non-treatment decisions relating to infants and young children incapable of expressing any view, the autonomy of parents in making the decision is sometimes given great weight, as it is, for example, by Peter Singer and Helga Kuhse in *Should the Baby Live?*<sup>29</sup> and by Michael Tooley in his much-discussed work, *Abortion and Infanticide*.<sup>30</sup> According to this view, the determination of the fate of the child is, within limits, a parental matter. Certainly these authors would ascribe to the parental role in the decision more weight than would be given it in the majority of those legal systems, which focus on the interests of the child as the paramount consideration. Stressing parental autonomy promotes that particular autonomy above the interest which society has in the treatment of infants, a general social interest of profound importance. By thus promoting parental autonomy, the value of the child's life in itself is implicitly demoted. This is not to suggest that the value of life must be respected in all cases—there are circumstances in which death may be seen as preferable to a life of suffering. Parents may decide that a child should not live, but this decision should not be made on the basis of their right to decide this, but on the basis of their understanding of the best interests of the child, a valuable understanding to which very considerable weight should be given. This approach was adopted in the decision of the English Court of Appeal in *In re T*,<sup>31</sup> in which the court was invited to authorize medical treatment for an infant who required a liver transplant. This operation was medically recommended, but was vetoed by the parents who did not wish to have further surgery inflicted on the child.<sup>32</sup> The court gave considerable weight to the parental view and declined to au-

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29. HELGA KUHSE ET AL., *SHOULD THE BABY LIVE?: THE PROBLEM OF HANDICAPPED INFANTS* (1985).

30. MICHAEL TOOLEY, *ABORTION AND INFANTICIDE* (1983).

31. *In re T*, 1 W.L.R. 242 (1997).

32. *Id.* at 245.

thorize the procedure—a decision which has not been without its critics.<sup>33</sup>

Autonomy plays a major role in the debate on the position of the comatose, or otherwise incapacitated patients, who are incapable of expressing an opinion as to the continuation of treatment—including the provision of nutrition and hydration. Concern for the previously-expressed or assumed wishes of such a person has played an important part in United States decisions such as *In re Conroy*<sup>34</sup> and *Cruzan v. Director Missouri Department of Health*.<sup>35</sup> The patient's express wishes, also underlie the legal acceptance of advance directives and the theory of substituted judgment. Again autonomy becomes the dominant consideration even if it conflicts with other values, such as the value of respect for family wishes or the value of respect for the clinical and moral judgment of the medical practitioner. A physician may believe that allowing life to end is not what the incompetent patient wants. This intuition must yield to the patient's expression of opinion, even if that opinion was made some time before.

Respect for autonomy also leads to an endorsement of suicide. On occasion, suicide may be a morally acceptable act, but on other occasions it may not be. In the case of a person who has family responsibilities, an act of suicide may cause substantial harm to others and may therefore offend the harm principle. Similarly, a patient who refuses medical treatment for a life-threatening condition may risk causing considerable distress to family members should his death result. Surely an argument can be presented here for considering this distress as a possible justification for non-consensual treatment, even if this involves an infringement of the autonomy of the individual. Such non-consensual treatment is achieved, of course, by concluding that the patient is temporarily deprived of capacity and is acting irrationally, as was the case in the English decision of *In re T*.<sup>36</sup> Such an approach, however, may merely provide a convenient way of avoiding the central moral dilemma of balancing individual autonomy against other interests. At present, the undue weight given to individual autonomy will almost inevitably tip the scales in its own direction, with results so counter-intuitive that courts will stretch notions of incapacity to achieve the results they want. Such is the dilemma the court

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33. Marie Fox & Jean McHale, *In Whose Best Interests?*, 60 MODERN L.REV. 700 (1997).

34. *In re Conroy*, 464 A.2d 303 (N.J. 1983), *rev'd* 486 A.2d 1209 (N.J. 1985).

35. *Cruzan v. Director Missouri Dep't of Health*, 497 U.S. 261 (1990).

36. *In re T* [1992] 4 All E.R. 649, at 656.

faced in the difficult case of *In re R*,<sup>37</sup> which involved the refusal of medical treatment by a fifteen-year-old. English law acknowledged that such a minor can consent to treatment without parental involvement but had said nothing about a corresponding right to reject treatment.<sup>38</sup> It was only by a curious argument involving metaphors of joint “unlocking” that the court arrived at the decision it wanted, which was to deny competence to refuse treatment in such a case.<sup>39</sup> If other values were to be given greater weight, then the result might be more intellectually transparent and morally coherent. A prominent value in such a case is surely to avoid suffering and distress on the part of the parents. Why should this not be acknowledged as a value of great importance in such cases? After all, the parents have invested a major part of their lives in the child, and, arguably, they have an interest in being protected from the destruction of this emotional investment, until at least the child has achieved greater emotional and intellectual maturity than normal in children under the age of eighteen (the age of legal majority in Britain).

According to a position of moral primacy to autonomy makes refuting a right to voluntary euthanasia difficult. A decision to seek the ending of life is an act of self-authorship *par excellence*. If autonomy allows people to create the conditions of their lives, then it should allow people to dictate the conditions of its ending. Viewed thus, as an entirely self-regarding act, agreement to voluntary euthanasia is a private act of no concern to others and, in simple Millian terms, of no business of the criminal law. An adherent of this position might, of course, be expected to insist on procedures calculated to ensure that the decision is genuinely autonomous, but, would refute any state interest in intervention given such safeguards.

Only the emotionally and philosophically rigid would be incapable of appreciating the real concern and, indeed, sympathy which underlies the arguments for voluntary euthanasia. These matters are far from simple and are not helped by doctrinaire debate. Yet such a debate, ironically, is precisely what a simple autonomy-inspired approach creates. In seeing a human need—relief from suffering—the instant response of the exponent of autonomy is that the need must be answered in such a way as to maximize autonomy, for autonomy, in this view, is the greatest good. This leads to the simple response: it’s your life, you may end it as you wish.

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37. *In re R*, [1991] 4 All E.R. 177.

38. *Id.* at 187.

39. *Id.*

The central flaw in this response is that nobody's life is his or her own. We live our lives in the moral company of others. At the crudest of levels, we may be separate beings, with a separate subjective experience of the world, but the actual pattern of our lives intersect at every point with the lives of others.<sup>40</sup> Every significant decision we make entails the potential co-operation or involvement of others. Decisions as to careers, decisions as to personal relationships, and decisions as to medical treatment all involve other people. If one seeks treatment for a medical condition, one seeks it from another, who is also a moral actor. Treatment is the result of the scientific and physical effort of others, to whom I become obligated by accepting it. The treatment is carried out within the context of a system of medicine and involves decisions made by the community in general as to the allocation of resources. None of this occurs in isolation, and must be seen in a moral and political context.

The philosophy of separateness advanced by exponents of liberal individualism encourages a vision of individuals existing in isolation from one another, pursuing their rational self-interest. In extreme versions, these pursuits are reduced to the economic, for the economic advantage of the individual actor is held to be paramount. People can, of course, be encouraged to act in this way, but the results are the denial of community. Such a model creates moral strangers, and a community of moral strangers is no community at all.

The contrasting view places autonomy in its place as one of a number of values. If autonomy is relegated in this way, the way is open to acknowledge the social dimension of so many of our actions, and to understand that moral decisions impinge on others to a greater extent than imagined. The question of voluntary euthanasia then becomes subject to a whole raft of values which must be considered. Should we, for example, expect physicians to undertake the task of ending life? How is our general social understanding of the value of human life changed by the admission of euthanasia? If life is permitted to be taken in this way—even for a good motive—then will we value it less in general? In particular, does the acceptance of euthanasia in some subtle way compromise the protection which the criminal law gives to human life? What is the symbolic significance of a practice which recognizes that some lives are not worth living?

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40. Jean Bethke Elshtain, *The Communitarian Individual in NEW COMMUNITARIAN THINKING: PERSONS, VIRTUES, INSTITUTIONS, AND COMMUNITIES*, 99 (Amitai Etzioni ed., University Press of Virginia, 1995).



Each of these questions requires scrupulous consideration. Perhaps upon careful reflection, a decision to retain existing restrictions on euthanasia is correct. Such debate has occurred; the literature on the issue is voluminous. However, it is important that one does not forget that the debate must be all-encompassing, that there are many values at stake, and that autonomy is only one of them. Rights language is powerful and tends to intimidate. Once people start claiming a right to die, it easily may become vested in the armor in which the great, recognized rights (the right to free speech, for example) are cloaked. The onus of refutation then shifts to those who would deny the right. That distorts the debate and leads to its becoming morally much shallower. The question, "Whose life is it anyway?," is of immense rhetorical force. The glib answer, particularly from those for whom liberal individualism and moral pluralism (or subjectivism) have been the sole diet, is, "it is mine." In fact, that answer is only half the truth. A more morally sensitive answer recognizes that while it is mine in one sense, in another sense it belongs to others.

## VI. CONCLUSION

The argument presented above may strike some as being a recipe for disempowerment and for the return, possibly to professional control, of rights hard won through the courts and political debate. In fact, it is not this at all. Many of those who question the primacy of liberal individualism and autonomy do so from a position of wanting more, rather than less, self-fulfillment for people. In *Beyond Separateness*,<sup>41</sup> for example, Richard Schmitt proposes the substitution of what he calls "being-in-relation" for autonomy precisely, because he sees an insistence on autonomy as creating unequal power relationships between people and allowing for domination.<sup>42</sup> Autonomous decision-making, at least in its crude form, does not stress sharing of responsibility or a taking into account of the views and feelings of others. Similarly, Robert George's critique of autonomy is intended to explore the possibilities of a pluralism which enhances and protects different versions of the good.<sup>43</sup>

The real problem for medical law is that, by focusing so strongly on autonomy and its enhancement, one risks ignoring the moral shading

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41. RICHARD SCHMITT, *BEYOND SEPARATENESS: THE SOCIAL NATURE OF HUMAN BEINGS—THEIR AUTONOMY, KNOWLEDGE, AND POWER* (1995).

42. See generally *id.*

43. GEORGE, *supra* note 20.

which other values bring. One also risks falling into a moral pluralism which easily transforms itself into moral relativism and is corrosively destructive of moral community. There is a view that we cannot have community without shared moral values. Medical law can play a vital part in the elucidation of these values. If it is so framed as to imply that anything is permissible as long as it serves the interest of autonomy, then medical law contributes to the dissolution of moral community and we are all diminished, even in the vastness of our autonomous selves.

