# Law, Bioethics and Biomedicine — Towards a Healthier Interaction

In matters of medical decision-making and policy-making, and despite a growing respect for interdisciplinary cooperation, there remains a strong current of misunderstanding, suspicion and antagonism in the claims and accusations made by practitioners and academics in law, bioethics and medicine.

Up to a point professional rivalry and even adversarial manoevering are clearly inevitable, and probably healthy. They can contribute to a better professional self-definition, the sharpening of each profession's special skills and tools, and even to the better protection of the rights of the perplexed patient being courted by these three competing suitors. Professions and disciplines, like virtues, need a degree of testing in an adversarial context if they are to have stamina and influence. For as Milton wrote of virtue,

> I cannot praise a fugitive and cloistered virtue, unexercised and unbreathed, that never sallies out and sees her adversary, but slinks out of the race where that immortal garland is to be run for, not without dust and heat.[1]

But beyond a certain point it is arguable that inter-professional struggles for ascendancy betray a dangerous degree of ignorance about the limited, but necessary, contribution of each dimension — legal, ethical and medical — in the arena of decision-making, policy-formulation and values-sorting. It is dangerous because in so far as such antagonism is based on ignorance it further delays productive interaction between them and retards the evolution of just and humane health-related principles, policies, laws, structures and processes. The ultimate losers continue to be individual patients and society generally.

This paper will first consider briefly some signs of this professional antagonism, and then, in greater detail, some new issues which urgently invite each of our three disciplines to interact more peacefully and productively.

## I. Some antagonisms and exaggerations

Consider, for example, this view of lawyers by a Canadian physician:

> Utter the dread word "lawyer" to the average Canadian physician and the organized response will leave little doubt of his mental image ... a

[1] *Areopagitica* (1644).

> picture of a rapacious and blood stained vulture, ready to swoop without warning on the hapless and defenceless body of an innocent physician... . There must be very few doctors who, after an unsought confrontation with the Canadian legal system, feel that they have been fairly done by.[2]

This picture is plainly more colourful than accurate. As the recent Annual Reports of the Canadian Medical Protective Association indicate, relatively few Canadian doctors are "swooped upon" by the law, as compared to doctors in some other countries and compared to some other professions in Canada, and very few are successfully sued. In view of these outcomes and the access of most physicians to more experienced legal services than the average patient can afford, it is not always clear whether it is the patient plaintiff or the defendant physician who is "hapless and defenceless". In any case, patients, not lawyers, sue physicians. In the final analysis, the lawyer only works for the aggrieved patient.

If the physician's self-perception as an increasingly emasculated quarterback is somewhat simplistic, then so too is the self-perception of some legal writers and bioethicists. Consider the typical views of a legal writer:

> [L]awyers, who in centuries past have abdicated the role of 'attorneys of the poor' to the medical profession and others, have an affirmative duty to insert themselves into the medical care delivery system *to insure that human rights are not the victims of medical progress.* When individuals are sick, dying, or both, they are perhaps least able to protect their own rights.[3]
>
> [T]he attorney ean ask questions that will help to define what actions need to be taken to insure that the decisions involved *will be in the best interests of his client or clients* ... the strategy is for the lawyer ... to enter the decision-making process *before a 'wrong' has been done* ... .[4]
>
> Are human rights and medical remedies compatible? In a society that values both human rights and medical progress, it should be *disturbing to civil rights lawyers that the most eloquent voices raising this question come not from the bar but from the scientific community itself* ... . Civil rights lawyers have a *duty to define the implications* of scientific developments for the individual and society.[5]

It is, of course, correct to claim that law, courts and lawyers have crucial roles to play in medical decision-making. But one is made uneasy by a contention that without the increased presence of lawyers, the rights of patients will go undefended. It is surely

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[2] Emson, *The Worm Should Turn* Canadian Doctor (May, 1980), 26.

[3] Annas, *Medical Remedies and Human Rights: Why Civil Rights Lawyers Must Become Involved in Medical Decision-Making* (1972) 2 Human Rights 151, 152 (emphasis added).

[4] *Ibid.*, 157 (emphasis added).

[5] *Ibid.*, 165 (emphasis added).

unfair and inaccurate to imply that physicians, families and others tend *as a general rule* to put at risk the rights and interests of their patients or that they have less will than lawyers to know and protect patients' rights and interests.

Second, it is not at all clear why lawyers should be "disturbed" that scientists and physicians, rather than lawyers, are raising questions about rights and values. One tends to find such examples more encouraging than disturbing. Surely what matters most is that such concerns are raised, not which particular discipline raises them. One could only be disturbed at signs of physician awareness of the implications of the various uses of medical technology if one believed that physicians should stick to "values-free" science and leave concern for values and rights to others, especially lawyers.

One of the prevailing temptations in bioethics is to imagine that as a discipline it is sufficiently mature and coherent to provide medicine, law and society with final and compelling arguments to establish the moral parameters and directions for every biomedical issue. Such is the open or hidden assumption in much biomedical writing — not surprisingly for a discipline existing only some ten years, and including within its scope subjects as complex and varied as death and dying, genetic screening, organ transplantation, behaviour modification and allocation of scarce resources, the facts suggest otherwise. A more accurate reading of the biomedical scene is probably the following:

> The rapid growth of biomedical ethics is reflected in the theoretical disarray that exists in the field. A vast range of subjects is included under the heading of biomedical ethics, but these subjects often are discussed in isolation. No overall conceptual scheme exists to unite these topics or to ground a coherent theoretical approach to them. In short, from a theoretical perspective biomedical ethics is a hodge-podge.[6]

A number of seldom-acknowledged factors have been suggested as contributing to this lack of coherence.[7] One is the variety of normative approaches and views advanced on any issue. Among the competing and very different moral theories and approaches are: the theological approach, situation ethics, consequentialism, rule utilitarianism, rule deontology and others. Each approach has its influential and articulate spokesmen and promoters who come to very different conclusions on the basis of different premises. There is even a real danger that the very emergence of bioethics as a new and distinct discipline, subdivided from moral philosophy and moral theology, could further promote and encourage the already over-

[6] Hoffmaster, *Biomedical Ethics in Canada* (unpublished ms., 1979), 1.
[7] *Ibid.*, 3-24.

specialized and splintered approaches to health care and health policy.[8]

Another exaggerated claim which sometimes emerges in bioethical writing is that because a particular *act* is held to be morally right or wrong, one need not weigh other and new factors to conclude that therefore there should be a *policy* or *law* permitting or prohibiting that act. Moral considerations are, of course, very relevant in the formation of policy but so are concerns such as the degree of public acceptance of any particular moral stance, the cost and likelihood of enforcement, and the potential for further abuse resulting from a new policy or law.

## II. Some real problems and challenges

So far we have only indicated some examples of minor irritants, disciplinary pretensions and unilateral claims. To a large degree they are only distractions from the larger purposes and problems which invite an escape from parochialism and the realistic interaction of all three perspectives. Let us turn now to what are arguably three of those fundamental issues.

### A. *Law v. legalism*

A first and fundamental issue relevant to our biomedical context is that of law *versus* legalism. Some attention to biomedical decision-making and policy-making from this perspective is instructive. It serves as a reminder that health policy and law are small parts of a larger scene and not at all immune from the latter-day trend to obscure the values-expressing role of law and policy behind a thickening screen of regulatory and conventional rules.

Several factors have been suggested as combining in our times to weaken the moral claims of law and, consequently, our respect for it.[9] It is arguable that by extension the same factors and results apply to policy-making generally, whether in the form of law, quasi-law or guidelines. The first of these causes is the large amount of law which regulates behaviour only because some order is needed, not because the behaviour in question is seen by the regulators or the regulated as right or wrong. As one legal commentator put it,

> [m]odern societies are so complex and so divorced from organic order that they need a high degree of amoral, inorganic order — order which is

[8] See, *e.g.*, Steinfels, *Against Bioethicists* (1976) 6 The Hastings Center Report (No. 2) 18.

[9] The three factors which follow were suggested by Wexler, *The Intersection of Law and Morals* (1976) 54 Can. Bar Rev. 351, 356-9.

> neither tied to recurrent, inevitable natural phenomena, nor cloaked in religious or moral imperatives .... People tend to be blasé about rules without moral content ... we do not invest them with much, if any, moral authority and most people are not ashamed to disobey them occasionally.[10]

It hardly needs saying that there is a vast and growing amount of health-related law and policy which fits this category. It may or may not be avoidable, but it is at least regrettable.

A second cause is that the involvement of the law in many seriously harmful areas tends to be selective and biased. Environmental pollution, false advertising and resource prodigality to a large degree escape legal regulation and sanction. It is increasingly argued that there are a number of acts and techniques in the biomedical field which fit in this category, and should at least be more effectively regulated to prevent abuses; examples include genetic screening, DNA research, non-consensual sterilization and others.

A third cause of the narrowing of the interaction of law and morals, and consequently of a weakened moral claim of law, is that some acts still prohibited by law because they were once considered immoral are no longer so considered by a large section of the population. It is argued, for example, that the continued illegality of marijuana smoking promotes callousness and lying and further erodes the moral claim of law generally.

In the biomedical field as well there may be some laws and policies in this category, and if so they should be seriously reconsidered lest their continued illegality merely encourages the sweeping of the acts and the problems under the rug. This was once the case with abortion and with consensual non-therapeutic sterilization.[11] Many now argue that voluntary active euthanasia in some limited instances is not wrong and should no longer be considered illegal for fear that otherwise such acts may be concealed and done covertly, making them inaccessible to moral and legal limitations and standards.

A conclusion to be drawn from all the above is that law and morals in the biomedical field need each other as much as ever, and barriers between them in the form of prejudice or ignorance should be replaced by vigorous interaction. Delusions of self-sufficiency notwithstanding, without the influence of the other, each perspective is weakened. For its part, law needs the influence of the value sciences, and should attempt to articulate the values it is

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[10] *Ibid.*, 356.

[11] On the legality of consensual non-therapeutic sterilization for contraceptive purposes, see *Cataford* v. *Moreau* [1978] C.S. 933.

underlining or protecting if it is to earn respect and not degenerate into legalism. But the value sciences, including bioethics, need the influence of law in order to give values, ethics and religion a social dimension lest they degenerate into vague idealism or privitistic religiosity.[12] Harold Berman of Harvard Law School expressed this point and challenge clearly. Using the word "religion" in its broadest sense, that is society's intuition of and commitment to the meaning and purpose of life, he wrote the following:

> Law is not only a body of rules; it is people legislating, adjudicating, administering, negotiating — it is a living process of allocating rights and duties and thereby resolving conflicts and creating channels of cooperation. Religion is not only a set of doctrines and exercises; it is people manifesting a collective concern for the ultimate meaning and purpose of life.[13]

Among bioethicists and physicians a healthy suspicion of legalism can sometimes be stretched too far, and an approach proposed as superior to legalism is sometimes capable of coping only with individual cases and not the social and institutional factors which provoke the recourse to "legalistic" defences by patients. An example is the critique by Professor John Ladd of what he calls a legalistic ethic of rights.[14] He objects to the appeal to moral rights which share the logical properties of legal rights, that is their peremptory nature, the impersonal and adversary relationship they presume, and the right-ower's duty to do what the right-holder demands, regardless of other considerations. For Ladd, appeal to these "legalistic rights" threatens the physician-patient relationship, which ideally should be neither peremptory nor adversarial. Instead he proposes an "ethics of responsibility", based upon the patient-

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[12] The concentration in this paper on only bioethics (including elements of moral philosophy and moral theology) as the "source" of moral reflection and values-sorting, is not meant to suggest that there are not other non-academic, non-professional sources as well. Of course there are. In a paper with wider parameters serious attention would also have to be paid for instance to what Peter Berger and Richard Newhaus call *mediating structures* — family, Church, neighbourhood and voluntary associations. They all have essential roles to play in providing meaning and values both to private life and to the "mega structures" of public life: see Berger & Newhaus, *To Empower People* (1977). In a sense that study continues and makes more specific Lord Devlin's point that while there is a role in law reform for professional moral argument by moral philosophers, in the final analysis, when opinions differ as they must, legislation with a moral content should be determined by the wishes of "ordinary" people.

[13] Berman, *The Interaction of Law and Religion* (1974), 24.

[14] Ladd, "Legalism and Medical Ethics" in Davis, Hoffmaster & Shorten, *Contemporary Issues in Biomedical Ethics* (1978), 1, 4.

physician relationship as a personal relationship, and which seeks to respond to the patient's *needs* rather than interests. A physician and patient using this ethic presumably are able to weigh and balance, in the context of consultation and dialogue, many more and more personal factors than simply the existence or non-existence of a right.

There is much to be applauded in Ladd's criticisms of the limitations of an ethics of rights and his emphasis on the patient-physician relationship. But, as has been observed,[15] it is not obvious that a theory of moral rights must be legalistic, or that the patient-physician relationship really is a personal relationship like that of parent-child or husband-wife. The physician's role inescapably has a large dimension of the social and the professional. Ladd himself admits that patient appeals to rights are particularly valuable as a protection from impersonal decision-making in institutions. Given the social, professional and institutional dimensions of a physician's role, appeal to rights, even within the patient-physician relationship, will inevitably be sometimes valuable and necessary.

The suggested alternative remedy, an ethics of responsibility, by focusing only on individual cases, is directed more at a symptom than the real cause of the malaise. As another moral philosopher has observed,

> [t]he focus of medical ethics should be the institutional arrangements that make an ethics of rights an indispensable weapon in a patient's moral armamentarium. One needs to rise above the individualistic, case-oriented approach to medical ethics, an approach which Professor Ladd's ethics of responsibility exemplifies, and address the more global questions of institutional design ... . The crucial question then is: how can one change the impersonal decision-making processes of institutions so that morally sensitive decisions emerge?[16]

If we agree that bioethical thinking sometimes tends to abstract too much from questions of structure, process and institution, by concentrating mainly on the individualistic dimension, then we have further confirmation of a value-science's need to interact with law — not just law as positive rules or legalism but as generally concerned with societal structure and cohesion.

But the problem and challenge goes well beyond hospitals. Another area in which one finds examples of the impersonality and insentivity of institutional decision-making is the "risk regulation" of hazardous products and substances. There is a growing amount of such regulation, but also an increasing public impatience

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[15] See Hoffmaster, "Comments on 'Legalism and Medical Ethics'" in *Contemporary Issues in Biomedical Ethics*, *supra*, note 14, 37, 41.

[16] *Ibid.*, 42.

with the cloak of scientific objectivity and expertise which covers both the value-choices and the large areas of scientific ignorance which have gone into determining levels of "acceptable" risk. Here too is a place for law and courts to contribute to the evolution of more sensitive and open decision-making processes. As David Bazelon recently wrote,

> In the scientist's realm — the sphere of fact — courts can ask that the data be described, hypotheses articulated, and above all, in those areas where we lack knowledge, that ignorance be confessed. In the political realm — the sphere of values — courts can ask that decision-makers explain why they believe that a risk is too great to run, or why a particular trade-off is acceptable. Perhaps most important, at the interface of fact and value, courts can help ensure that the value component of decisions is explicitly acknowledged, not hidden in quasi-scientific jargon.[17]

B. *Resolving new rights and values conflicts*

A second problem area, equally so for law , bioethics and biomedicine, is the absence to date of any generally acceptable theory test to justify choices between competing values and rights in difficult cases. Increasingly, the sort of medical cases and issues brought to or raised by health professionals, bioethicists, courts and legislators are those which combine diagnostic and prognostic uncertainties with new, or at least newly complex, rights and values-conflicts. The most difficult of such cases involve incompetent persons unable to make their own choices between two or more of their own rights, values or interests, one of which has traditional legal support and superiority, whereas the others are attractive (or at least insistent) new arrivals on the scene but with questionable legal pedigrees.

Given that contemporary bioethics (or moral philosophy) does not yet really have a convincing way of testing conflicting moral views,[18] or a generally acceptable theory of value, it cannot presently be of much help to law in these truly new and challenging cases. As for courts, they cannot as easily as bioethics escape concrete decisions, but in some judgments one finds little by way of compelling theoretical justification for the preferred right, value or interest on which the decision is based. Two examples might illustrate these points.

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[17] Bazelon, *Risk and Responsibility* (1979) 205 Science 277, 279.

[18] Many such methodologies have been proposed, such as Rawls's method of "reflective equilibrium" (*Theory of Justice* (1971), 46-53), but it cannot be said of this or any other proposed methodology that it has gained general acceptance.

The first example has to do with what American courts have come to call "actions for wrongful life". One instance of such an American action and case is *Gleitman* v. *Cosgrove*.[19] The mother had German measles during pregnancy, and a child was born with birth defects. The parents sued the doctors on behalf of the infant, claiming that the doctors should have informed the parents of this possibility and that had they known of it the mother would have had an abortion. The claim was for damages on behalf of the infant, on the grounds that he would have been better-off not being born. But it was held that:

> The normal measure of damages in tort actions is compensatory. Damages are measured by comparing the condition plaintiff would have been in, had the defendants not been negligent, with plaintiff's impaired condition as a result of the negligence ... This Court cannot weigh the value of life with impairments against the non-existence of life itself. By asserting that he should not have been born, the infant plaintiff makes it logically impossible for a court to measure his alleged damages because of the impossibility of making the comparison required by compensatory remedies.[20]

A recent Quebec case involved a negligently performed sterilization, as a result of which an unwanted (though healthy) child was born: a claim for $20,000 was advanced on the basis that the infant plaintiff was brought into the world against the parents' wishes, but here too the Court held:

> Il est bien impossible de comparer la situation de l'enfant après sa naissance avec la situation dans laquelle il se serait trouvé s'il n'était pas né. Le seul énoncé du problème montre déjà l'illogisme qui l'habite.[21]

For present purposes the point is that contemporary bioethics or moral philosophy has little help to offer law either by confirming or challenging the "impossibility" of determining damages based on the comparison implicit in "wrongful life" suits. There is no widely acceptable and coherent *moral* theory to deal with such questions as whether and in what circumstances life itself may be an injury, whether there may be a duty not to give existence to another, and whether abortion in these circumstances of known pre-natal injury is permissible.[22] Bioethicists and others sometimes assume that it is occasionally preferable for a child not to have been born, but they

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[19] *Gleitman* v. *Cosgrove* 227 A. 2d 689 (N.J. 1967).

[20] *Ibid.*, 692.

[21] *Cataford* v. *Moreau, supra,* note 11, 940.

[22] Given the weakness of moral theory, the debate tends to focus on "catch-all" concepts such as "quality of life", but one of the difficulties with such concepts is that they allow no uniformity of meaning: for more on the subject of "quality of life", see Keyserlingk, *Sanctity of Life or Quality of Life* (1979).

seldom offer sufficient argument to support that contention or norms with which to gauge that decision in individual cases.[23]

It should therefore not be surprising that courts have so far more or less summarily ruled that comparison in question out of order only on the basis of the traditional measure of compensatory damages, without delving into the possibility of alternative measures based on a fresh study of legal and moral sources. But whatever the eventual policy outcome of more ethical and legal thinking on this issue, it is clearly overdue. Given the increasing ability to determine pre-natal injuries or defects, the pressure for more fundamental and compelling moral arguments and legal stances on the issue of "wrongful life" will undoubtedly increase.

A second and related example of a hard case involving choices between a person's conflicting rights, values and interests, is that of the sterilization of incompetent mentally handicapped persons for contraceptive purposes. Until a recent Canadian appellate decision, the relatively few legal judgments on this issue have assumed that, except for therapeutic reasons, the right of such persons to procreate was absolute and inviolable and could not be made to give way to any other right or interest of that handicapped person. Therefore courts did not see it within their power to authorize such sterilizations when requested.

The Prince Edward Island Supreme Court decision, *Re "Eve"*,[24] typified that legal stance. "Eve" was 24 years old, mildly to moderately retarded, and suffered from extreme expressive aphasia. The medical and parental evidence established to the satisfaction of the Court that: there had been no perceptive improvement for the past ten years; Eve was capable of being attracted and attractive to the opposite sex, but incapable of functioning as a mother and caring for a child; there would be a strong probability that any child she bore would have to be placed for adoption. Eve's mother felt that

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[23] Tristram Engelhardt is an example of one who holds that there are both instances of wrongful life and wrongful continuance of existence, with corresponding rights and duties. But he argues that the concept of tort for wrongful life is transferrable to an injury for continued existence, without either acknowledging that damages for "torts for wrongful life" have never yet been awarded in fact, or providing any moral argument as to how to found and apply such a tort and its inherent comparison between non-existence and actual life: see Engelhardt, *Euthanasia and Children: The Injury of Continued Existence* (1973) 83 The Journal of Pediatrics 170, and "Ethical Issues in Aiding the Death of Young Children" in Kohl, *Beneficent Euthanasia* (1975) 180, 185-92.

[24] *Re Eve*, reported *sub nom. Re E* (1979) 10 R.F.L. (2d) 317 (P.E.I.S.C.).

being almost sixty years old she would not by herself be able to look after any child Eve might have, and that the emotional effects on Eve of a pregnancy and birth might be very detrimental. She therefore applied to the Court for authorization to consent to a tubal ligation on Eve. McQuaid J. held in part:

> The Eves of this world, regardless of how retarded, are, nevertheless, persons with rights which the courts must preserve and protect. One of these rights is the inviolability of their persons from involuntary trespass. This right *supersedes that referred to by Dr. Beck as the right to be protected from pregnancy.* While the preservation of this right might well, and even predictably, result in no little inconvenience and expense, and indeed, even hardship to others, the Court must, regardless of its own natural sympathy to those others, ensure that the law have the care of those who are not able to care for themselves, and ensure *preservation of the higher right* ... [emphasis added].

But of particular interest for the purposes of this paper is that no coherent argumentation or theory is offered as to exactly why, in non-therapeutic situations, the right to procreate must always "supersede" other rights such as being protected from pregnancy, and why the former is necessarily a "higher" right than the latter. To imply that the basis for this conclusion is that the law has a traditional and fundamental interest in protecting from "involuntary trespass" appears somewhat to beg the question. The issue after all is precisely whether sterilization, given the circumstances of this kind of case, really would be "involuntary trespass" in the ordinary meaning of that term.

McQuaid J. gives much attention to earlier cases dealing with this issue.[25] But even if the facts of those cases matched the facts of the *Eve* case (which on appeal the Court felt they did not), those earlier judgments also provide little by way of analysis or justification. For example, in the case of *Re D.*, Heilbron J. made the following observation, cited as relevant and normative in the *Eve* case:

> The type of operation proposed is one which involves the deprivation of a basic human right, namely the right of a woman to reproduce, and *therefore* it would, if performed on a woman for non-therapeutic reasons and without her consent, be a violation of such right.[26]

But on appeal of the *Eve* case the Prince Edward Island Supreme Court reversed the lower court's decision and held that the court is competent to authorize a non-therapeutic sterilization and con-

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[25] Especially two English cases: *Re X (a Minor)* [1975] Fam. 47, [1975] 1 All E.R. 697 (C.A.); *Re D (a Minor)* [1976] Fam. 185, [1976] 1 All E.R. 326.

[26] *Re D, supra,* note 25, 193 (Fam.), 332 (All E.R.) (emphasis added).

sented to it in the case of Eve.[27] It is beyond the scope of this paper to indicate all the considerations which went into that judgment,[28] or to debate all the merits of the decision itself. But on the issue of interest here, that of evaluating conflicting rights and providing reasoned argumentation for the choice made, the appeal judges went considerably further than the trial judge. For example, Campbell J. reasoned, in part, as follows:

> In the recognition of individual rights and in the process of according them judicial application to specific circumstances, it would be unwise and a travesty of justice to priorize in order of precedence a list of rights applicable for all given circumstances. For example, the right to procreate must be given preeminence in a fact situation as found in *Re D* [because she was found to be improving and capable of marriage] but the protection of the right to procreate would be a meaningless gesture for a female who had lost her mind ... . Each case demands, perforce, an objective but compassionate assessment of the relative facts and circumstances and the rights and remedies as appropriately apply. It cannot be taken as a rule of law that the inviolability of the person from involuntary trespass supersedes the right to be protected from pregnancy. Such a contention can only be sustained by the special circumstances which can be found to support it.[29]

In view of these special circumstances, Campbell J. concluded:

> I am of the opinion that without the protection of a permanent sterilization the protected environment will become a guarded environment and the loss to 'Eve' in terms of her social options and her relative freedom would cause substantial injury of sufficient degree to meet the test.[30]

We may not have here, and should not reasonably expect, a detailed and coherent methodology for choosing between conflicting rights, values and interests. But we do have the acknowledgement that the ranking of rights is not frozen in one mold and does need to refer to circumstances and consequences. We do at least have the acknowledgement that it is no longer sufficient in the face of complex new biomedical challenges and conflicts to maintain with little further distinction or consideration that the primary interest of

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[27] *Re Eve* (1980, 1981) 115 D.L.R. (3d) 283 (P.E.I.S.C., *in banco*), now in appeal before the Supreme Court of Canada.

[28] Considerable reference was made in the *Eve* appeal to some of the analyses, norms and criteria advanced by the Law Reform Commission of Canada in *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons* (Working Paper No. 24, 1979): see *supra*, note 27, 304-10 *per* MacDonald J., dissenting in part. The specific norms or limitations formulated by Campbell J., for example, were these: it must be shown that the real, the genuine, object is to protect the child; there must be no overriding interest the other way; there must be a likelihood of substantial injury to the child: see *supra*, note 27, 318-20.

[29] *Supra*, note 27, 317-8.

[30] *Ibid.*, 320.

law is in protecting autonomy, self-determination and physical integrity. That remains true, but to stop there is to remain at too high a level of abstraction, generality and absoluteness to respond adequately with compassion and sophistication to the complexity of the human situation and the full range of interests, rights and needs presenting themselves for approval, balancing and choice. Among these new claimants for the title of "right" are, for example, the "right to die" and the "right to be protected from pregnancy". As Campbell J. observed in the *Eve* case:

> In the past few decades, society's perspective of the mentally retarded has undergone dramatic changes and we have seen the mentally handicapped in recent years raised from disgrace to the sunlight of the classroom, the job market and the company of their peers. These new found privileges call for new found responses in the law.[31]

There are still other considerations which could be weighed in such cases. One is the issue of the "rights" of potential offspring of mentally handicapped persons, and the direct relevance of those rights to decisions about sterilization. Most legal and much bioethical thinking about sterilization (and the *Eve* case is an example) tends to weigh the effects of child-rearing and child-bearing only as they will affect the rights and interests of the handicapped potential parent being considered for sterilization, but not in so far as the quality of life and rights of potential offspring are also directly relevant to that decision. If the rights of potential children were one of the justifiable and central concerns, then one could perhaps recognize judicially a moral argument to the effect that when there is a strong likelihood that potential offspring will inherit a serious genetic defect, then the interest of that child in not being inflicted with that defect is a further reason for the sterilization of the mentally handicapped and incompetent potential parent.[32]

It should probably not be surprising that law does not acknowledge a quality of life interest of potential offspring in sterilization decisions for mentally handicapped persons likely to transmit serious genetic defects. One good reason is undoubtedly to be found

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[31] *Ibid.*, 319.

[32] Of course there would be other factors and safeguards to consider as well, those which should apply in *any* involuntary non-therapeutic sterilization, as proposed for instance by the Law Reform Commission of Canada in its working paper, referred to above (note 28). The first of these safeguards is the careful determination that the mentally handicapped person is in fact incompetent to consent. Among the minimum criteria are these: that the individual is probably fertile, of child-bearing age and sexually active, and that the sterilization will not cause physical or psychological damage greater than the beneficial effects to the individual.

in past legal abuses based on faulty genetic theory and discriminatory policies. Another is that the whole question of the rights of potential human life has long been one of the most difficult of legal questions as witnessed for some time in the issue of abortion and more recently that of the "wrongful life" suits referred to earlier. But given today's growing certainty about which serious genetic defects are and are not transmissible, one suspects that the rights of potential offspring as regards the sterilization of their mentally handicapped potential parents is one of those biomedical problems which will increasingly call for "new found responses in the law".

C. *Physicians and parents in the courtroom*

A third challenge for law and biomedicine has to do with clarifying the nature of the contribution of each of the three major parties involved when a "substituted consent" issue is brought to a court for decision — parents, physicians and the court itself. It is instructive to consider the note of mutual antagonism and/or exaggeration in the claims sometimes made by or for each of these parties. The three actors at times have different expectations not only about the outcome, but also about the process.

The special qualities claimed for courts are especially those of detachment and objectivity. One legal writer disapprovingly described such a claim as follows:

> The ideal health care decision-maker is 'objective', 'rational', 'detached' .... Accordingly, the argument runs, it is appropriate in these situations to have the decision made by an outsider who can more closely approximate the detached and rational ideal — a judge, that is, who guides his decisions by public norms in law.[33]

Another legal writer, approvingly, puts the matter this way:

> A correct resolution ... is more likely to come from a judicial decision after an adversary proceeding, in which all interested parties have fully participated, bringing in all their own perceptions, beliefs, and biases, than from the individual decisions of the patient's family, the attending physician, an ethics committee, or all these combined.[34]

It would be foolish to deny the positive aspects of detachment and objectivity, and the appropriateness of these qualities brought to bear on a conflict in the courtroom. What bothers one is the implied assumption in both passages that decision-making in extra-legal contexts, in the family and the medical profession for instance,

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[33] Burt, *The Limits of Law in Regulating Health Care Decisions* (1977) 7 The Hastings Center Report (No. 6) 29.

[34] Annas, *The Incompetent's Right to Die: The Case of Joseph Saikewicz* (1978) 8 The Hastings Center Report (No. 1) 21, 23.

is only second-best because it is subjectively biased and unlikely to be sufficiently objective to decide fairly and protect properly.

In effect, what is insufficiently appreciated by those observations are the positive and protective features of parental bonding and identification, features also to be found (though with differences) in healthy doctor-patient relationships in which the patient is treated as a person and not as an object. Surely parent-child bonding, identification and love can serve and have served the interests of children very well, whether decisions are made entirely in the family context, or whether, when the need arises, those characteristics are drawn upon in the form of parental testimony in court.

Excessive bonding may of course lead to various forms of paternalism, both from parents and from physicians. But parental bonding is also the best protection against child abuse.[35] Clearly parent-child or physician-patient bonding can sometimes be too subjective to resolve all biomedical problems and conflicts. But the detachment and objectivity of a court also has its limits and potential for abuse. They are positive values, but alone or exaggerated they can lead to insensitive decisions. Viewed from the perspective of a parent, this fear or danger conld be expressed this way:

> [W]hen a judge supervises parental decisions and thus accepts apparent responsibility for the decision whether a child should donate his kidney to a sibling or whether a comatose child's respirator should be disconnected, the judge can act with the comforting knowledge that he and this child are quite separate from one another — that the child is not his, that the consequences of this decision will not shape his family's life and his self-conception forever, that he is after all only applying 'the rules' with an impartial eye or even, as the popular image of Lady Justice suggests, with blindfolded eyes.[36]

This view, like those cited earlier, is probably somewhat exaggerated and one-sided. Clearly it should not be a question of "either" (courts and detachment) "or" (parents and bonding). Both kinds of qualities, though with different stresses, should be welcome in both contexts. Nor is it simply a question of more or less recourse to courts, which is often the somewhat simplistic way in which this problem is posed.

A brief and last look back at the case of Eve might help to illustrate how both parental bonding and judicial detachment combined, at least at the appeal level, to produce a decision which attempted to be both just and compassionate.

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[35] See Raymond, *Child Abuse: can bonding prevent it?* The [Toronto] Globe and Mail (Jan. 8, 1981), T-1.

[36] Burt, *supra*, note 33, 32.

At the trial level one could say that the keynote was detachment. What especially counted was the rule. We may recall the words of McQuaid J.:

> While the preservation of this right might well, and even predictably, result in no little inconvenience and expense, and indeed, even hardship to others, the Court must, regardless of its own natural sympathy ... ensure the preservation of the higher right.[37]

But at the appeal level detachment was combined with compassion and sensitivity. Though the parental and medical testimony weighed was the same, it appears to have been given more weight at the appeal level, both in terms of the mother's pleas that pregnancy and childbirth would be a heavy burden for the child she knew and loved, and the doctor's medical testimony, based on his long acquaintance with Eve, supporting his view that the right to be protected from pregnancy should prevail.

In the words of Campbell J.:

> Each case demands, perforce, an *objective but compassionate* assessment of the relative facts and circumstances and the rights and remedies as appropriately apply.[38]

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[37] *Supra,* note 27, 328-9.

[38] *Ibid.,* 317 (emphasis added).

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