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# The bioethics and law paradox: An argument to maintain separateness with a hint of togetherness

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*This article analyses how bioethics and law interact and work together. The first half of the article provides definitions of both ethics and bioethics. The article then considers a number of different bioethical standpoints to demonstrate the variance of views in relation to bioethics. In addition, the first half of the article focuses on the different regulatory possibilities in regard to bioethical contexts. This demonstrates that law is of central importance to bioethics. This part also shows that even though law and ethics are often used simultaneously to achieve bioethical goals, law and ethics cannot be used interchangeably. Thus, even though it is somewhat inevitable that law will be used in the pursuit of the goals of bioethics, bioethics and bioethical principle should not be merely a vehicle for law-makers to utilise. The second half of the article focuses on the issues of autonomy and consent to demonstrate how law and ethics have developed in one of the foundation areas of bioethics.*

## INTRODUCTION

In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.<sup>1</sup>

The purpose of this article is to demonstrate the interplay between law and bioethics. With the development of new technologies, bioethics has become an increasingly important tool in ascertaining what *should be done* in certain situations. The importance of bioethics is reflected in the developing role of the bioethicist, the actions of ethics committees in hospital settings and the establishment of a number of bioethical courses and specialties in the tertiary setting. In conjunction with the increasing importance of this area of thinking, the legal system has also been thrust into situations where either legislatures or the judiciary are forced to make decisions in regard to what *ought to be done* in a given situation. Members of the legal profession have consulted bioethical literature and bioethicists to determine what *should be done* in a particular situation. Bioethics, eg, has been expansively used by the legal profession to guide them on directions for new technologies. The article explores the role that law should have in modern bioethics. It is argued that even though law is centrally important to bioethics, the two systems should not work interchangeably. The legal system is of value to bioethics, though, as it helps to enhance and promote the goals of bioethics in many circumstances. To demonstrate how law and ethics combine, this article analyses how the ethical principles of autonomy and consent have been integrated into legal principle.

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<sup>1</sup> Mill JS, *On Liberty* (McCallum RB (ed), Blackwell, Oxford, 1946).

## WHAT IS THE ROLE OF LAW IN MODERN BIOETHICS?

### Defining bioethics?

Before one attempts to define “bioethics”, it is first necessary to define “ethics”. The word “ethics” comes from the Greek *ethikos*, meaning “an ethos, habit, pattern of behaviour or prevailing attitude”.<sup>2</sup> Ethics is defined by Beauchamp and Childress as “a generic term for various ways of understanding and examining the moral life”.<sup>3</sup> Kerridge et al have further described ethics as “the study of what *should* be done”.<sup>4</sup> Kuhse adds that any ethical principle should be impartial and universal, so that a moral principle should apply equally to everyone in a given situation.<sup>5</sup>

Bioethics relates to ethical issues in health care and the biological sciences.<sup>6</sup> Bioethics is expansive and interdisciplinary in nature and encompasses medical ethics, nursing ethics, psychological ethics as well as clinical ethics.<sup>7</sup> Lewins has stated that bioethics covers a number of areas such as priority of medical funding and research, AIDS care issues, implementing policies for organ donation and end-of-life decisions.<sup>8</sup> The best way to demonstrate what bioethics is, is to look at a number of approaches that have been advanced in relation to this area. These include principle-based ethics, moral friends and moral strangers and feminist approaches.

### Range of approaches

#### *Principle-based ethics*

Perhaps one of the main ethical approaches used in bioethics is principle-based ethics. This approach prescribes a number of principles or rules that should be followed to guide moral actions. Autonomy, beneficence, non-maleficence and justice have been enunciated by Beauchamp and Childress as the primary ethical guiding principles.<sup>9</sup> Autonomy concerns the self-determination of individuals, so that they should be free to make their own health care decisions. Beneficence prescribes a positive obligation to “act for the benefit of others”.<sup>10</sup> Non-maleficence prescribes an inflexible obligation not to do harm.<sup>11</sup> Justice, on the other hand, is more difficult to define and quantify. Some of the different theories of justice that have been advanced include justice as revenge,<sup>12</sup> justice as mercy,<sup>13</sup> justice as harmony in the soul and harmony in the state,<sup>14</sup> justice as equality, justice as equal distribution of benefits and burdens,<sup>15</sup> justice as what is deserved and justice as love.<sup>16</sup>

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<sup>2</sup> Kerridge I, Lowe M and McPhee J, *Ethics and Law for the Health Professions* (2nd ed, Federation Press, Sydney, 2005) p 1.

<sup>3</sup> Beauchamp T and Childress J, *Principles of Biomedical Ethics* (Oxford University Press, New York, 2001) p 1.

<sup>4</sup> Kerridge et al, n 2, p 1.

<sup>5</sup> Kuhse H, *Caring: Nurses, Women and Ethics* (Blackwell Publishers, Oxford, 1997) pp 80-81.

<sup>6</sup> Kerridge et al, n 2, p 1.

<sup>7</sup> Kerridge et al, n 2, p 1.

<sup>8</sup> Lewins F, “The Development of Bioethics and the Issue of Euthanasia: Regulating, De-regulating or Re-regulating?” (1998) 34(2) *Journal of Sociology* 123 at 124.

<sup>9</sup> Beauchamp and Childress, n 3.

<sup>10</sup> NHMRC, *National Statement on Ethical Conduct in Research Involving Humans 1999*, p 4; Johnstone M-J, *Bioethics: A Nursing Perspective* (3rd ed, Harcourt, Sydney, 1999) p 90.

<sup>11</sup> Johnstone, n 10, p 89.

<sup>12</sup> Retributive justice.

<sup>13</sup> Christian ethics.

<sup>14</sup> Pythagorean ethics, 600 BC-1 AD.

<sup>15</sup> Distributive justice.

<sup>16</sup> See Rawls J, *A Theory of Justice* (Belknap Press of Harvard University Press, Cambridge, 1971). See Johnstone, n 10, p 92.

This approach does not provide a definitive solution for all ethical problems.<sup>17</sup> Rather it provides a platform or set of principles that people can use to determine what would constitute ethical conduct in a given scenario.<sup>18</sup>

### ***Moral friends and moral strangers***

The philosophy of moral friends and moral strangers suggests that groups and communities in society can be classified as “moral friends whereas the wider society and community has been defined as ‘moral strangers’.”<sup>19</sup> It is unclear how this principle applies to health care professionals as it is questionable whether this group should or would be constituted as moral friends or moral strangers.<sup>20</sup> Kerridge et al argue that even though health care professionals are not “complete moral strangers”, they are not “moral friends” either.<sup>21</sup> Clearly health care workers do not share religious, cultural and moral backgrounds.<sup>22</sup> They do obviously share educational experiences though, at least to a certain extent. Kerridge et al state that possibly the best way to describe the relationship between health professionals is that they are moral acquaintances.<sup>23</sup> Thus, under this approach, there are always going to be difficulties in getting a unanimous bioethical approach to health care decisions.

### ***Feminist approaches***

Even though there is a close working relationship between feminist bioethicists, there are a number of different perspectives within this school of thought. For example, Wolf states that there are liberal, Marxist, radical, psychoanalytic and even antifeminist bioethical feminists.<sup>24</sup> As a general proposition, however, Sherwin states:

Feminist ethics proposes that when we engage in moral deliberation, it is not sufficient just to calculate utilities or to follow a set of moral principles. We must ask whose happiness is increased, or how the principles in question affect those who are now oppressed in the circumstances at hand.<sup>25</sup>

Thus, before one re-analyses a particular issue, it is necessary to investigate the effects of the practice “on existing powers of oppression”. Thus, rather than taking the view that a principle should be followed regardless of the repercussions, the happiness and effects on the relevant people need to be taken into consideration. Wolf also suggests that feminist bioethics would do “more than use gender as an analytical category; it would oppose harm to women”.<sup>26</sup> How this would work can be demonstrated in an example that Wolf has articulated in relation to physician sex with patients.<sup>27</sup> Whereas traditional bioethics views this as a wrongdoing in itself, feminist bioethics would consider that this event tells us “something fundamental about the problems that pervade patient-physician relations”.<sup>28</sup> Accordingly, the feminist perspective appears to view breaches of ethical principle as examples of fundamental problems pervading the relationship rather than as a single occurrence, as most bioethical literature would indicate. Wolf also suggests that feminist bioethics focuses on medical and scientific practices

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<sup>17</sup> Kerridge et al, n 2, p 55.

<sup>18</sup> Kerridge et al, n 2, p 55.

<sup>19</sup> Kerridge et al, n 2, p 43.

<sup>20</sup> Kerridge et al, n 2, p 44.

<sup>21</sup> Kerridge et al, n 2, p 44.

<sup>22</sup> Kerridge et al, n 2, p 44.

<sup>23</sup> Kerridge et al, n 2, p 44.

<sup>24</sup> Wolf S (ed), *Feminism and Bioethics: Beyond Reproduction* (Oxford University Press, New York, 1996) p 72.

<sup>25</sup> See Wolf, n 24, p 52.

<sup>26</sup> Wolf, n 24, p 21.

<sup>27</sup> Wolf, n 24, p 22.

<sup>28</sup> Wolf, n 24, p 22.

that have harmed women such as forced Caesareans, IUDs and breast implants.<sup>29</sup> In addition, feminist bioethics would also consider women's role as caregivers and professionals rather than merely as research subjects or patients.<sup>30</sup>

Wolf has suggested that the area of feminism and bioethics has for too long been either ignored in the bioethical context or simply been construed as bioethics applied to women.<sup>31</sup> The failure of many to acknowledge feminist bioethics is somewhat surprising as women often organise their family's visits to health care professionals.<sup>32</sup> Furthermore, women are often the primary caregivers in a family.<sup>33</sup> Paternalism and the fact that bioethics has often focused on the predominantly male physician rather than the patient and care giver and nurses and nurses' aides (who are often women) is one suggestion as to why this area of bioethics has long been ignored.<sup>34</sup> Wolf argues that this blindness towards feminist bioethics is reflected in the fact that bioethics has largely ignored ethical and legal rules that affect women foremost, such as abortion and reproduction issues and the "gender inequalities they may enforce or create".<sup>35</sup>

This article now examines how a number of bioethical approaches and situations have been encapsulated in law and regulations.

### Different regulatory possibilities

There are several regulatory possibilities that can be utilised to embrace bioethical principles. Examples of these include statutory models, as well as guidelines issued by the executive and professional codes. This section provides an overview of the different regulatory approaches that have been utilised in respect to bioethical principles. There have been attempts to regulate bioethical principles under both domestic and international law. For example, under international law the World Medical Association implemented a policy relating to bioethics that set out the duties of a physician<sup>36</sup> as well as conduct that would be deemed to be unethical.<sup>37</sup> The World Medical Association's *Declaration of Helsinki* has also implemented a number of ethical principles in relation to medical research involving human subjects.<sup>38</sup>

The main instrument that is looked at in Australia to ascertain how medical practitioners should act in given circumstances is the Australian Medical Association's *Code of Ethics*. The *Code of Ethics* acknowledges that changes in society, science and the law constantly raise new ethical issues that may challenge existing ethical perspectives.<sup>39</sup> It is evident that a number of the ethical guidelines that permeate the *Code of Ethics* are also important codes of behaviour to prevent legal liability. For example, the obligation of keeping contemporaneous medical records is also important in relation to legal liability.<sup>40</sup> Legal implications are also cited in s 1.1(l) that relates to confidentiality.<sup>41</sup> Autonomy issues are also highlighted in the dying patient section in the *Code of Ethics*. It is suggested that a

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<sup>29</sup> Wolf, n 24.

<sup>30</sup> Wolf, n 24, p 24.

<sup>31</sup> Wolf, n 24, p 5.

<sup>32</sup> Wolf, n 24, p 11.

<sup>33</sup> Wolf, n 24, p 11.

<sup>34</sup> Wolf, n 24, p 11.

<sup>35</sup> Wolf, n 24, p 12.

<sup>36</sup> This includes that a physician shall always maintain the highest standards of professional conduct, not permit motives of profit to influence the free and independent exercise of professional judgment on behalf of patients, be dedicated to providing competent medical service in full technical and moral independence, with compassion and respect for human dignity and deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

<sup>37</sup> World Medical Association, *Policy, World Medical Association International Code of Medical Ethics*, <http://www.wma.net/e/policy/c8.htm> viewed 25 July 2005.

<sup>38</sup> World Medical Association, *Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects*.

<sup>39</sup> Australian Medical Association, *Code of Ethics* (revised 2004).

<sup>40</sup> Australian Medical Association, *Code of Ethics* (revised 2004), s 1.1(f).

medical practitioner “respect the patient’s autonomy regarding the management of their medical condition including the refusal of treatment”.<sup>42</sup> Other ethical guidelines for medical personnel, including nurses, have also been implemented to help clarify ethical ideals in different contexts.<sup>43</sup>

Now that we have examined the general codes of ethics that permeate both international and domestic law, this article discusses some of the different regulatory possibilities that have been embraced. It examines methods of self-regulation, re-regulation and non-legal regulation systems. The significance of ethical regulation in this context is that it indicates how the legal and ethical systems collide.

### **Self-regulation**

Self-regulation relates to the situation where a professional body sets standards and, when appropriate, also disciplines its members.<sup>44</sup> Self-regulation is arguably driven by the desire of medical and other professionals to maintain professional independence and to be protected from state interference.<sup>45</sup> More contentiously, Boulding has suggested that self-regulation may be used “as a device to avoid new and or existing legislation”.<sup>46</sup>

Boulding has suggested that a self-regulatory system cannot be used as an effective substitute for law.<sup>47</sup> He argues that this is the case for a number of reasons. First, self-regulation only works for those who agree to be involved and adhere to the self-regulation.<sup>48</sup> Thus, self-regulation does not serve as a replacement for law as potentially only a small percentage of the people from the industry would choose to adhere to the self-regulation.<sup>49</sup> Second, as the self-regulatory system only covers a limited audience, it would not provide an effective system of avoiding new laws.<sup>50</sup> Third, many industries that are self-regulating also have the support of law.<sup>51</sup>

Boulding suggests that there are a number of benefits of self-regulation as it may provide a “basis for improving trust, educate policymakers, and remove some of the burden of policing an industry sector from the government”.<sup>52</sup> Caton has also suggested that there are a number of advantages to self-regulation.<sup>53</sup> He argues that people who work within a particular profession are probably in the best position to judge the competence of other people in their profession.<sup>54</sup> In contrast to this, legislative regulation “imposes norms from outside the profession and subordinates the amorphous

<sup>41</sup> “Maintain your patient’s confidentiality. Exceptions to this must be taken very seriously. They may include where there is a serious risk to the patient or another person, where required by law, where part of approved research, or where there are overwhelming societal interests”: Australian Medical Association, *Code of Ethics* (revised 2004), s 1.1(l).

<sup>42</sup> Australian Medical Association, *Code of Ethics* (revised 2004), s 1.4(b).

<sup>43</sup> Australian Nursing Council, *Royal College of Nursing, Australia, Australian Nursing Federation, Code of Ethics for Nurses in Australia* (revised 2002). The six value statements that are implemented are that nurses respect individuals’ needs, values, culture and vulnerability in the provision of nursing care; nurses accept the rights of individuals to make informed choices in relation to their care; nurses promote and uphold the provision of quality nursing care for all people; nurses hold in confidence any information obtained in a professional capacity, use professional judgment where there is a need to share information for the therapeutic benefit and safety of a person and ensure that privacy is safeguarded; nurses fulfil the accountability and responsibility inherent in their roles; and nurses value environmental ethics and a social, economic and ecologically sustainable environment that promotes health and well being.

<sup>44</sup> Caton H, *Trends in Biomedical Regulation* (Butterworths, Sydney, 1990) p 65.

<sup>45</sup> Lewins, n 8 at 128.

<sup>46</sup> Boulding M, “Self Regulation: Who Needs It?” (2000) 19(6) *Health Affairs* 132 at 133.

<sup>47</sup> Boulding, n 46 at 134.

<sup>48</sup> Boulding, n 46 at 134.

<sup>49</sup> Boulding, n 46 at 134.

<sup>50</sup> Boulding, n 46 at 135.

<sup>51</sup> Boulding, n 46 at 135.

<sup>52</sup> Boulding, n 46 at 137.

<sup>53</sup> Caton, n 44, p 65.

<sup>54</sup> Caton, n 44, p 65.

though real processes of exchange to a formally constituted body armed with legal powers to inspect and discipline".<sup>55</sup> Thus Caton states that, on the whole, professional bodies restrict outside legislative change so they can maintain their independence.<sup>56</sup>

This article now discusses re-regulation as an alternative to self-regulation.

### **Re-regulation**

Re-regulation in this context relates to the increase in governmental and bureaucratic control over clinical practice. The arguable effect of this is that there is transference of control from the "private to the public realm, or from health professionals to the state".<sup>57</sup> Arguably, ethics committees have attempted to re-regulate medical research and practice. According to Lewins, this has often been met with negative feeling from the medical profession.<sup>58</sup> Jamrozik wrote in the *Medical Journal of Australia* that the system of institutional ethics committees was a case of "the tail wagging the dog".<sup>59</sup> He described the system as

[c]umbersome, overloaded with paperwork, and tiresome for both committee members and investigators. Its inception has burdened investigators, in particular, with an ever-expanding list of demands, each apparently reasonable in its own right, but collectively amounting to a significant diversion from the research itself.<sup>60</sup>

In regard to the increasing re-regulation of the medical system brought about by ethics committees, Ellard has also voiced strong opposition on the basis that it decreases clinical autonomy.<sup>61</sup> Ellard has stated that "our clinical autonomy is being eroded and we are being subject to constraints and imperatives which determine more and more the way in which we relate to our patients".<sup>62</sup>

Lewins has also argued that there is increasing governmental and bureaucratic control in relation to euthanasia.<sup>63</sup> He states that in relation to bioethics and euthanasia there is an increase towards government control and re-regulation and a decrease in medical control.<sup>64</sup> He argues that this can be evidenced from attempts to legalise euthanasia.<sup>65</sup> How effective any type of legal re-regulation will be in relation to euthanasia is questionable, however. Many medical practitioners have acted defiantly towards criminal sanctions relating to euthanasia. For example, active voluntary euthanasia has been described as being a fact of life and possibly performed by one in every three or four doctors.<sup>66</sup>

The other possible scenario in relation to regulation is a system where there is no regulation at all.

### **No regulation**

An interesting area where bioethical regulation has been discussed and partially implemented is in surrogate motherhood cases. Surrogacy has been classified in two primary ways: commercial surrogacy and altruistic surrogacy. The legislatures have treated these categories of surrogacy in distinct ways.<sup>67</sup> The interesting thing to note, however, is that even though there is legislative intervention in relation to commercial surrogacy, the legislatures have been silent in regard to altruistic

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<sup>55</sup> Caton, n 44, p 66.

<sup>56</sup> Caton, n 44, p 66.

<sup>57</sup> Lewins, n 8 at 132.

<sup>58</sup> Lewins, n 8 at 127.

<sup>59</sup> Jamrozik K, "Ethics Committees: Is the Tail Wagging the Dog?" (1992) 157 MJA 636.

<sup>60</sup> Jamrozik, n 59 at 636.

<sup>61</sup> Ellard J, "Medical Ethics Fact or Fiction?" (1993) 158 MJA 460 at 464.

<sup>62</sup> Ellard, n 61 at 464.

<sup>63</sup> Lewins, n 8 at 123.

<sup>64</sup> Lewins, n 8 at 123.

<sup>65</sup> Lewins, n 8 at 124.

<sup>66</sup> Lewins, n 8 at 128.

<sup>67</sup> Stuhmcke A, "For Love or Money: The Legal Regulation of Surrogate Motherhood" (1995) 2(3) *Murdoch University Electronic Journal of Law*, <http://www.murdoch.edu.au/elaw/issues/v2n3/stuhmcke23.html> viewed 14 November 2005, p 1.

surrogacy.<sup>68</sup> Stuhmcke has argued that this implies a “tacit acceptance and acknowledgment of its practice”.<sup>69</sup> The legislative discrepancies thus appear to imply that love and intimacy and cash and commerce are not an appropriate mix whereas actions generated from generosity and feelings are.<sup>70</sup> The regulation of surrogate motherhood may be in need of further regulation so as to counteract the traditional stereotypes that are inherent within the legislation.

Employment genetic testing is another area where there is no specific legislative regulation.<sup>71</sup> This is evidenced from the fact that there are not any legal preconditions for the introduction of a workplace genetic screening program.<sup>72</sup> Further, there are no specific regulatory frameworks that suggest how the information should be used and obtained.<sup>73</sup> The only restraints on employers are the requirements that genetic testing is voluntary and, when using the information, employers must not discriminate against their employees.<sup>74</sup> Arguably, this lack of legal regulation is not appropriate either. Otlowski has set out a number of different options for regulating this area.<sup>75</sup> For example, a legislative model could be employed. In the alternative, a non-legislative or self-regulatory model could be utilised.<sup>76</sup> It is evident that in such an area some sort of regulatory model should be employed so as to protect workers’ rights and safety, individual privacy and non-discrimination. On the whole, it would appear that different regulatory systems are appropriate for different bioethical areas. The next question addressed in this article is to what extent, if at all, law should be used in the pursuit of modern bioethical principles and goals.

### **Should law be used in the pursuit of modern bioethics?**

In its *Draft Report on the Potential to Extend a Universal Instrument of Bioethics*, the International Bioethics Committee stated:

Moral and legal rules correspond to two distinct but interconnected orientations. Moral rules which are set in cultural, philosophical and religious background of the various human communities can develop by enrichment and consensus and thus contribute to common universal values. Legal rules cannot pretend to encompass all fields and cases of bioethics nor to judge or interfere in every moment of the lives and individual choices of persons. At any level, laws accompanied by effective control should be adopted in order to facilitate personal choices, and only a few substantial issues should be regulated through international rules. In other words, the aim should be to maximise moral evolution and to minimise the need for legislation.<sup>77</sup>

This passage emphasises the need to encourage moral evolution and in turn minimise legislation and legal regulation. This statement does have substantial value in the Australian context as arguably our society has become overly regulated. In considering the question of whether or not law should be used in the goals of bioethics, it is first necessary to examine what the goals of bioethics are. This is somewhat difficult to quantify due to the differing perspectives of bioethicists and the other disciplines that are involved with bioethics. However, as a general proposition, one of the key goals of bioethics

<sup>68</sup> Stuhmcke, n 67, p 14.

<sup>69</sup> Stuhmcke, n 67, p 14.

<sup>70</sup> Stuhmcke, n 67, p 14.

<sup>71</sup> Otlowski M, “Employer’ Use of Genetic Test Information: Is There a Need for Regulation?” (2002) 15 *Australian Journal of Labour Law* Lexis 1, <http://www.lexis.com.ezproxy.une.edu.au/research.html/> viewed 14 November 2005, p 8.

<sup>72</sup> Otlowski, n 71.

<sup>73</sup> Otlowski, n 71.

<sup>74</sup> Otlowski, n 71.

<sup>75</sup> Otlowski, n 71, p 39.

<sup>76</sup> Otlowski, n 71, p 39.

<sup>77</sup> International Bioethics Committee, *Draft Report on the Potential to Extend a Universal Instrument of Bioethics* (2002) at [40]. See Plomer A, *The Law and Ethics of Medical Research: International Bioethics and Human Rights* (Cavendish Publishing, London, 2005) p 15.

is to suggest what *should* be done in any given situation.<sup>78</sup> One of the other key goals of modern bioethics is that any moral principle should be universal in nature and apply to all people and situations equally.<sup>79</sup>

The Draft Report on the Universal Instrument of Bioethics also states that there should be separation between legal and moral rules and principles. That being said, due to the interdisciplinary nature of bioethics this may be difficult to achieve in its entirety. Certainly, law and other disciplines do need to be used as a tool in the pursuit of modern bioethics. Arguably, bioethical ideas will be more effectively integrated into our society if they are encompassed within the legal system. Implementing ethical principles into Australian law may also mean that ethical principles will more readily be adhered to in a given situation. This is the case because the ethical duties are not legally enforceable whereas legal duties are.<sup>80</sup> For example, a doctor who breaches the criminal law may be prosecuted and a medical practitioner who fails to take adequate care may be sued in negligence and required to pay damages.<sup>81</sup> The Medical Practitioners Board may also find a doctor guilty of professional misconduct and thus discipline the doctor.<sup>82</sup> Bioethical principles by themselves are not enforceable. They do, however, provide an indication as to the standard of conduct that is reasonably expected of medical practitioners.<sup>83</sup> Implementation of the law is not needed to achieve this aim.

In the context of feminist bioethics, Wolf provides some interesting insights on how law and bioethics work together.<sup>84</sup> One example where this is poignant is the enthusiasm with which bioethics has embraced liberal individualism.<sup>85</sup> Wolf argues that this change in direction has been greeted with mere ambivalence by most bioethicists.<sup>86</sup> She suggests that “feminist work is only one of several intellectual currents widely valued and debated in the humanities and law, yet largely overlooked by bioethics”.<sup>87</sup> Wolf has also suggested that critical race theory, critical theory generally and other forms of race-attention analysis have also been largely ignored by bioethicists.<sup>88</sup> This argument may therefore suggest that many principles and fields of work that are accepted by older fields of practice are not yet fully accepted in the field of bioethics.<sup>89</sup>

There are difficult situations where the legal system and bioethical principles do not mesh well together. For example, in relation to euthanasia, from a bioethical perspective euthanasia is acceptable in a case where the patient’s death would bring about the patient’s rational wishes.<sup>90</sup> From a legal perspective, however, euthanasia is constituted as murder and the patient’s wishes would not constitute a legal defence.<sup>91</sup>

Johnstone also makes an interesting point in relation to ensuring that law and ethics are kept as separate entities.<sup>92</sup> She states that making the distinction between the two areas helps to guard against

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<sup>78</sup> Kerridge et al, n 2, p 1.

<sup>79</sup> Kuhse, n 5, pp 80-81.

<sup>80</sup> Skene L, *Law and Medical Practice, Rights, Duties, Claims and Defences* (2nd ed, LexisNexis Butterworths, Sydney, 2004) p 30.

<sup>81</sup> Skene, n 80.

<sup>82</sup> Skene, n 80, p 31. See generally Freckelton I, “The Margins of Professional Regulation: Disjunctions, Dilemmas and Deterrence” (2006) 23(2) *Law in Context* 148.

<sup>83</sup> Skene, n 80.

<sup>84</sup> Wolf, n 24, p 16.

<sup>85</sup> Wolf, n 24, p 16.

<sup>86</sup> Wolf, n 24, p 16.

<sup>87</sup> Wolf, n 24, p 20.

<sup>88</sup> Wolf, n 24, p 20.

<sup>89</sup> Wolf, n 24, p 20.

<sup>90</sup> Johnstone, n 10, p 48.

<sup>91</sup> Johnstone, n 10, p 48.

<sup>92</sup> Johnstone, n 10, p 48.



moral errors and to “enforce moral and intellectual honesty about the undesirability of morally iniquitous law”.<sup>93</sup> Furthermore, it is arguably desirable to maintain an independent value system so that the moral acceptability of a valid legal rule may be questioned.<sup>94</sup>

The above discussion analyses whether or not the legal system should be used in the pursuit of the goals of bioethics. The author has argued that to some extent it is valuable to use the legal system as a tool to promote bioethical principles. This is especially the case in relation to the enforceable nature of the legal system. On the other hand, however, the goals of bioethics do need to be kept somewhat separate from the legal system. This is fundamentally important as it is socially and morally desirable for a separate system to be working in parallel with the legal system so that there is a principle base that the legal system can work from and be measured against.

### **The relationship between ethics and law**

The above discussion has indicated that even though bioethics and law do need to work in conjunction with each other, the social and moral desirability of maintaining their independence is also important. This section of the article looks at the ways that law and bioethics work together. Kerridge et al have suggested that when health care professionals are faced with difficult ethical issues they often, incorrectly, look to the law for the appropriate answers.<sup>95</sup> They have suggested that, even though law and ethics do often concern similar issues, they are “quite distinct” areas.<sup>96</sup>

Law and ethics, however, do have several similarities. Both are human creations that have historical significance and they both mirror religious, scientific, human experience and customary influences.<sup>97</sup> Other common elements of both disciplines include using reasoning, justifying one’s position by authority or argument and critical analysis.<sup>98</sup>

The second part of this article compares and contrasts the role of ethics and law in relation to autonomy and consent.<sup>99</sup> Autonomy and consent are fundamentally ethical principles, but legal principles play a large part in their application. Moreover, in this area legal argument and analysis have likewise had an effect on ethical thinking.<sup>100</sup>

### **AUTONOMY AND CONSENT FROM A LEGAL AND BIOETHICAL PERSPECTIVE**

This article now analyses the legal and ethical principles in relation to autonomy and consent. In particular, it concentrates on the ethical ideals in relation to consent, informed consent and autonomy. It also focuses on the case law that has evolved in this area in Australia and overseas. It is argued that bioethical ideals and the legal system have each influenced the other.

#### **Consent**

Historically, the importance of consent was derived from the change from feudalism to individualism.<sup>101</sup> This meant that there was a renewed focus on respect for the dignity of human beings, consent and the right of individuals to determine their own lives as they wished.<sup>102</sup>

#### ***Ethical issues relating to consent***

The main ethical ideal that is focused on in regard to consent is autonomy. In Australia this ethical consideration is highlighted by the fact that to gain effective consent it is necessary to have *informed*

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<sup>93</sup> Johnstone, n 10, p 49.

<sup>94</sup> Johnstone, n 10, p 49.

<sup>95</sup> Kerridge et al, n 2, p 5.

<sup>96</sup> Kerridge et al, n 2, p 5.

<sup>97</sup> Kerridge et al, n 2, p 5.

<sup>98</sup> Kerridge et al, n 2, p 5.

<sup>99</sup> Kerridge et al, n 2, p 5.

<sup>100</sup> Kerridge et al, n 2, p 5.

<sup>101</sup> Arras J and Steinbock B, *Ethical Issues in Modern Medicine* (4th ed, McGraw Hill, London, 1995) p 88.

<sup>102</sup> Arras and Steinbock, n 101.

consent. Informed consent is the primary way that autonomy is preserved in the health care system.<sup>103</sup> In order to allow patients to make free and autonomous decisions, it is necessary for a medical practitioner to warn a patient of all possible risks involved with a procedure.<sup>104</sup> As we will see from the discussion below, these considerations are ingrained in the common law in Australia.

The necessity of having informed consent in the health care context has demonstrated the change of stance in relation to the power relationship between doctors and patients. Traditionally the principle of paternalism was practised by health care professionals, which effectively meant that it was up to the medical practitioner to decide what was in the best interests of the patient rather than the patient deciding this. This article now considers the two conflicting ethical principles that permeate this area, paternalism and autonomy.

At this juncture it is prudent to note that the “best interests of the patient” philosophy permeates both autonomy and paternalistic principles. For example, there can be a strongly held contention that it is in the best interests of the patient to be free to make their own individual choices.<sup>105</sup> In the alternative, however, it has been suggested that the health practitioner is actually the best person to assess what is in the best interests of their patients.<sup>106</sup> Perhaps the most effective way to reconcile this issue is through the notion of shared decision-making. Arguably, the main ethical and legal principle that should be employed in relation to consent is that it is a two-way process that requires communication and collusion between both doctor and patient.<sup>107</sup> This model therefore focuses on the interests and autonomy of the patient but does not oversimplify the professional role.<sup>108</sup> This model also recognises that health care professionals have their own values and beliefs in relation to health, disease and their role in the health care process.<sup>109</sup> Thus the decision-making process is inevitably shared as each party brings their own value systems and beliefs to the relationship.<sup>110</sup> This article now considers the principles of paternalism and autonomy.

### **Paternalism**

Traditionally, the notion that has constituted a basis for medical practice and informed consent issues is that of paternalism and beneficence.<sup>111</sup> The *Oxford English Dictionary* defines “paternalism” as “the principle and practice of paternal administration; government as by a father; the claim or attempt to supply the needs or to regulate the life of a nation or community in the same way as a father does those of children”.<sup>112</sup> Thus, paternalism in a health care sense embraces the notion that sometimes the doctor or medical practitioner is the best and most objective person to be making decisions relating to what is in the best interests of their patient. Bailey has stated that paternalism can be interpreted as a forcible interference with a person’s liberty of action, which is justified on the grounds that it will prevent harm to the individual’s interests.<sup>113</sup>

Engelhardt has argued that in some cases a patient may seek a paternalistic approach from their medical practitioner: “Patients often regress under the stress of disease and want to be treated as children by health professionals”,<sup>114</sup> reverting to a paternalistic relationship as they are outside their

<sup>103</sup> Kerridge et al, n 2, p 216.

<sup>104</sup> Kerridge et al, n 2, p 217.

<sup>105</sup> Engelhardt T, *The Foundation of Bioethics* (2nd ed, Oxford University Press, Oxford, 1996) p 300.

<sup>106</sup> Engelhardt, n 105.

<sup>107</sup> Kerridge et al, n 2, p 220.

<sup>108</sup> Kerridge et al, n 2, p 220.

<sup>109</sup> Kerridge et al, n 2, p 220.

<sup>110</sup> Kerridge et al, n 2, p 220.

<sup>111</sup> Bailey S, “Ethically Defensible Decision-making in Health Care: Challenges to Traditional Practice” (2002) 25(2) *Australian Health Review* 27.

<sup>112</sup> Engelhardt, n 105, p 321.

<sup>113</sup> Bailey, n 111 at 28.

<sup>114</sup> Engelhardt, n 105, p 321.

familiar environment. Englehardt draws the analogy between this situation and a situation where one is travelling in a foreign country. Both in foreign countries and in the health care setting, people often struggle with the both the language and method of communication. Englehardt states that the doctor-patient relationship can be compared to the tour guide-tourist relationship as trust is evident in both relationships with regard to what is the best course of action.<sup>115</sup> This is a valid consideration in some cases; however, one may argue that the onus should be on the medical practitioner to make the patient feel at ease when communicating with the doctor so that the patient can then effectively make her or his own autonomous decisions.

In a liberal society such as Australia, notions and practices of paternalism should be restricted to distinct cases where there are compelling justifications for doing so.<sup>116</sup> According to John Stuart Mill, “He cannot rightly be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others to do so would be wise, or even right.”<sup>117</sup>

The contrasting principle to paternalism is autonomy. This ethical consideration is now the primary consideration that is taken into account in relation to patient care and consent.

### **Autonomy**

The primary ethical consideration that justifies the notion of informed consent is autonomy. Autonomy relates to the idea that “if I am to act in an ethical or moral way I must choose for myself what I am going to do”.<sup>118</sup> The word “autonomy” is derived from the Greek terms *autos* (self) and *nomos* (law or rule). Thus, essentially, autonomy means self-rule or self-determination. The basic premise behind autonomy is that, if one is to act in an ethical or moral way, one must make one’s own decisions.<sup>119</sup> The essence of personal autonomy is the freedom to choose one’s own actions that one believes are morally sound.<sup>120</sup> Thus, an autonomous being is one who is able to choose or devise a plan for one’s life.<sup>121</sup>

The notion of autonomy and ethical thought has been evident since Aristotle’s discussion of “voluntary action” in the *Nicomachean Ethics*.<sup>122</sup> The concept of personal autonomy is also linked with Kantian philosophical ideas. It has been argued that Kant’s moral philosophy entirely revolves around the idea that the moral agent is her or his own law-giver.<sup>123</sup> Kantian ethical philosophy advocates that the capacity of self-determination is valuable in itself. Even though a personal choice that is made may objectively be found to be immoral or bad, the fact that one is able to make one’s own autonomous choice is still inherently good, as it has come about as the result of a free and autonomous decision and act.<sup>124</sup> Bailey has further argued that the intrinsic value of autonomy is related to self-esteem and to living an authentic life.<sup>125</sup> She states that self-esteem will be enhanced when individuals are able to shape their own lives in ways that are considered personally valuable.<sup>126</sup> Thus it would appear from an ethical viewpoint that autonomy is the foremost concept in relation to medical care and informed consent.

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<sup>115</sup> Englehardt, n 105, p 321.

<sup>116</sup> Charlesworth M, *Bioethics in a Liberal Society* (Cambridge University Press, New York, 1993) p 17.

<sup>117</sup> Mill, n 1, pp 8-9.

<sup>118</sup> Charlesworth, n 116, p 10.

<sup>119</sup> Charlesworth, n 116, p 10. “No life goes better by being led from the outside according to values the person doesn’t endorse. My life only goes better if I’m leading it from the inside, according to my beliefs about value.”

<sup>120</sup> Charlesworth, n 116, p 13.

<sup>121</sup> Young R, “Informed Consent and Patient Autonomy” in Kuhse H and Singer P (eds), *A Companion to Bioethics* (Blackwell Publishers, Oxford, 1998). Evidently one’s life plan is subject to change throughout one’s lifespan.

<sup>122</sup> Charlesworth, n 116, p 11.

<sup>123</sup> Charlesworth, n 116, p 12.

<sup>124</sup> Charlesworth, n 116, p 13.

<sup>125</sup> Bailey, n 111.

<sup>126</sup> Bailey, n 111.

Autonomy has also been strongly advocated in contemporary times, especially since the inception of our liberal philosophical principles.<sup>127</sup> Thus, subject to such actions as defamation and discrimination, government intervention in relation to freedom of speech and thought should be kept to a minimum so that people can generally be fully autonomous beings.<sup>128</sup> This is a strong argument especially when one considers that in Australia we do not have a written Bill of Rights. Interestingly though, Sherwin argues that many feminists perceive that the concept of autonomy can actually have an adverse affect on the oppressed and exploited, and merely empowers and privileges the more powerful elements in society.<sup>129</sup> Thus, Sherwin argues that autonomy “provides the most convincing rationale for resisting the intrusion of claims of equality on the privileges of advantaged individuals”.<sup>130</sup>

From a medical perspective, the notion of autonomy in the informed consent context is most acutely tested when a patient autonomously decides on a course of action which runs counter to what a medical practitioner would conceive as being in the patient’s medical interests.<sup>131</sup> Generally speaking, the notion of autonomy allows patients to make health care decisions without having regard to the values of the medical practitioner, the health care industry or the rest of society.<sup>132</sup> It is also clear that, in recent times, there has been a shift in medical practice from notions of paternalism to an emphasis on autonomy.<sup>133</sup> The emphasis on autonomy is also increasingly evident within the legal system.

### Legal issues in relation to consent

From a legal point of view, health practitioners need to gain consent from their patients before they undertake any medical procedure. Gaining consent is important as it helps to safeguard the medical practitioner against both civil and criminal repercussions. Consent therefore transforms unlawful behaviour into acceptable and therefore lawful behaviour.<sup>134</sup> The main cause of action is relation to failing to gain adequate consent is that of assault and battery. Under the criminal law, assault is defined as,

a person who strikes, touches, or moves, or otherwise applies force of any kind to, the person of another, either directly or indirectly, without his [sic] consent if the consent is obtained by fraud, or who by any bodily act or gesture attempts or threatens to apply force of any kind to the person or another without his [sic] consent, under such circumstances that the person making the attempt or threat has actually or apparently a present ability to effect his [sic] purpose, is said to assault that other person, and the act is called an assault.<sup>135</sup>

In civil actions, the tort of trespass to the person includes assault, battery and false imprisonment. Assault relates to a situation where a person is in fear that imminent harm is forthcoming. Battery relates to a situation where there is an unlawful touching (eg a punch or kick). False imprisonment is apparent when a person is not free to leave an area or room and there is no reasonable means of escape (eg being locked in a toilet). An example of a successful false imprisonment and battery civil action can be seen in *Hart v Herron* [1984] Aust Torts Reports 80-201.

For consent at law to be valid, a number of elements must be adhered to. First, it is necessary for consent to be free and voluntary. This means that health care providers need to ensure that they do not

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<sup>127</sup> Charlesworth, n 116, p 14.

<sup>128</sup> Charlesworth, n 116, p 14.

<sup>129</sup> See Wolf, n 24, p 53.

<sup>130</sup> Wolf, n 24, p 53.

<sup>131</sup> Wolf, n 24, p 53.

<sup>132</sup> Schwartz R, “Autonomy, Futility, and the Limits of Medicine” in Kuhse H and Singer P (eds), *Bioethics: An Anthology* (Blackwell Publishing, Oxford, 1999) p 519.

<sup>133</sup> Wallace M, *Health Care and the Law* (3rd ed, Lawbook Co., Sydney, 2001) p 63.

<sup>134</sup> *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 at 233.

<sup>135</sup> Kerridge et al, n 2, p 223.

pressure the patient into accepting a particular course of action.<sup>136</sup> Likewise, consent cannot be general in nature. Thus, it must be limited to the specific procedure for which the consent has been given.<sup>137</sup> In addition, the patient needs to have a general understanding of the nature of the act.<sup>138</sup> Lastly, just because consent is gained for one medical practitioner to perform a procedure, this does not mean that this will immediately cover another medical practitioner.<sup>139</sup> Consent is therefore one of the central tenets in relation to both civil and criminal actions in Australia and other common law countries.

### **Informed consent**

In relation to medical practice, the requirement for there to be informed consent is a relatively recent phenomenon.<sup>140</sup> Katz has argued that disclosure and consent are notions and obligations that are alien to medical thinking and practice.<sup>141</sup> Traditionally, disclosure in medicine has served the function of getting patients to agree with their doctor's advice rather than allowing them to make autonomous decisions.<sup>142</sup> For example, Hippocrates stated:

[L]ife is short, the Art long, Opportunity fleeting, Experiment treacherous, Judgement difficult. The physician must be ready, not only to do his duty himself, but also to secure the cooperation of the patient, of the attendants and of externals.<sup>143</sup>

In contemporary times, however, it is evident that medical practitioners not only have an obligation from an ethical perspective to inform their patients of all the risks of the procedure, but there is also an obligation in a legal sense. The rationale behind this principle is that if competent people have the right to self-determination, then they should also be able to claim protection against interference with their bodies.<sup>144</sup> In *Schloendorff v Society of New York Hospital* 211 NY 125 at 126; 105 NE 92 at 93 (1914) Cardozo J stated that "every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages".

In relation to informed consent, there are a number of legal elements that need to be satisfied; these include the nature of the proposed procedure, its risks, the alternatives to the procedure and the benefits of the procedure.<sup>145</sup> The clearest pronouncement of the legal obligations that are required in this area can be gleaned from the majority judgment in the High Court of Australia decision of *Rogers v Whitaker* (1992) 175 CLR 479 at 490 which determined that Mrs Whitaker's surgeon had a responsibility to warn her of the risk of sympathetic ophthalmia. From a legal perspective, it can be said that doctors in Australia owe duties to inform their patients of any risks that may be inherent within a procedure.<sup>146</sup> This test is subject to a number of qualifications, one of which is therapeutic privilege.

Therapeutic privilege allows medical practitioners to have discretion in providing patients with all relevant information if they feel that the information would prove to be damaging to their patients,<sup>147</sup>

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<sup>136</sup> Kerridge et al, n 2, p 226. See *Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782; [1993] Fam 95.

<sup>137</sup> Kerridge et al, n 2, p 227.

<sup>138</sup> Kerridge et al, n 2, p 227. See *R v Mobilio* [1991] 1 VR 339.

<sup>139</sup> Kerridge et al, n 2, pp 229-230.

<sup>140</sup> Veatch R, "Abandoning Informed Consent" in Kuhse and Singer, n 132, p 524.

<sup>141</sup> Beauchamp T and Walters LR, *Contemporary Issues in Bioethics* (5th ed, Wadsworth Publishers, Belmont, 1999) p 135.

<sup>142</sup> Beauchamp and Walters, n 141.

<sup>143</sup> Beauchamp and Walters, n 141.

<sup>144</sup> Young, n 121, p 445.

<sup>145</sup> Young, n 121, p 447.

<sup>146</sup> Note that this is subject to three provisions, including when the procedure is being undertaken in an emergency situation. In some emergency situations patients will lack the capacity to consent to a procedure or there may not be the requisite time in which to discuss the risks. Therapeutic privilege can also be used as a defence by a legal practitioner.

<sup>147</sup> *Rogers v Whitaker* (1992) 175 CLR 479 at 486.

or where a patient is unusually nervous, disturbed or volatile.<sup>148</sup> Ethically speaking, however, this is a very contentious exception. Engelhardt has stated that disclosure that could seriously harm a patient may constitute bad medical practice.<sup>149</sup> Young, however, has argued that therapeutic privilege should only be used in very limited circumstances.<sup>150</sup> Young further argues that a patient who is frightened of, or in denial of, her illness may need to be encouraged by her health care practitioner to reflect openly and fully about her illness rather than waiving her right to participate in the decision-making process.<sup>151</sup> Engelhardt has also stated that this principle can create problems if one highly values freedom.<sup>152</sup> Utilising therapeutic privilege has also been criticised on the basis that it is the legal answer or alternative to paternalism. Therapeutic privilege provides a good example of where legal and bio-ethical principles can come into conflict.

### The overlap of consent to legal and ethical practices

As the above discussion demonstrates, consent is relevant to both legal regulation and ethical theory. Kerridge et al suggest that the ethical issues surrounding consent have been influenced by the development of the relevant law.<sup>153</sup> In turn, the law has also been greatly influenced by ethical discussion in this area.<sup>154</sup> This article now examines the common law relating to consent and autonomy to demonstrate how the ethical and legal principles are implemented in practice. To do this, the article examines cases relating to consent and forced Caesareans, refusal of life-prolonging medical treatment and cases involving Jehovah's Witnesses.

### Forced Caesarean cases

The key legal and ethical tensions that permeate forced Caesarean cases are the interests of the unborn child as opposed to the autonomy of the pregnant woman to make decisions about what happens to her body. The early case law in this area, in both the United States and the United Kingdom, generally found that the interests of the fetus were predominant. In the early 1990s this situation was reversed, so that the self-determination and autonomy of the pregnant woman become paramount.<sup>155</sup> Even though there is no case law in Australia that is directly relevant to this scenario, the related case law and the academic commentaries suggest that Australia would follow the contemporary position of the United States and the United Kingdom, which is that ethical notions are highly important to the legal ramifications of consent.

#### United Kingdom

In the late 1990s the judicial approach to this issue started to change, so that the mother's autonomy was found to override the interests of the unborn child. In *Re MB* [1997] 2 FCR 541 the English Court of Appeal said that a competent woman was entitled to refuse a Caesarean even if it meant that the child would die. Butler-Sloss LJ, with whom Saville and Ward JJ agreed, said (at 561, emphasis added):

The law is, in our judgment, clear that a competent woman who has the capacity to decide may, for religious reasons, other reasons *or for no reasons at all*, choose not to have medical intervention even though ... the consequence may be the death or serious handicap of the child she bears or her own death.

Thus, in *Re MB* Butler-Sloss LJ opined that, until the child is born, it does "not have any separate interests capable of being taken into account" when the court considers an application for a forced Caesarean section.

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<sup>148</sup> *Rogers v Whitaker* (1992) 175 CLR 479 at 490.

<sup>149</sup> Engelhardt, n 105, p 317.

<sup>150</sup> Young, n 121, p 450.

<sup>151</sup> Young, n 121, p 450.

<sup>152</sup> Englehardt, n 105, p 319.

<sup>153</sup> Kerridge et al, n 2, p 215.

<sup>154</sup> Kerridge et al, n 2, p 215.

<sup>155</sup> Note that the pregnant woman needs to be competent for this to be the case.

Arguably the leading case in this area of law in the United Kingdom is *St George's Healthcare NHS Trust v S* [1998] 3 WLR 936. In this case a 36-week-pregnant woman refused medical treatment because she wanted to have her child born “naturally” even though she understood that the baby would die without intervention and she herself might die or become severely disabled. She was detained under the *Mental Health Act 1983* (UK) (later found to be unlawful) and continued to refuse treatment. During this detention she wrote a very articulate letter expressing her wish for nature to “take its course”. Notwithstanding this fact, the hospital authority obtained a court order authorising treatment without her consent. She was anaesthetised and the baby was delivered by Caesarean section.

Judge LJ based his judgment on autonomy and self-determination issues. His Honour found that that each individual has the right to refuse medical treatment when competent (at 950). He arrived at this conclusion notwithstanding the fact that the unborn child at 36 weeks was described as being viable, alive and human, but importantly not a separate entity from its mother (at 957).

As this case discussion has demonstrated, the interests in the pregnant woman's autonomy take precedence over the interests of the fetus. As the next part of the article will show, the United States follows a similar approach to the United Kingdom.

### **United States**

The early case law in the United States, like the United Kingdom, concentrated on what was in the best interests of the fetus rather than the mother's right to refuse medical intervention.<sup>156</sup> Recent case law, however, supports a pregnant woman's right to refuse treatment. In *Re AC 573 A 2d 1235* (1990) the District Court of Columbia Court of Appeals held that, unless there are “truly extraordinary or compelling reasons”, the mother's right of refusal will remain predominant over the rights of the unborn child (at 1252). The reasoning in *Re AC* was affirmed in *Re Baby Boy Doe* 632 NE 2d 326 (1994). In this case the mother was 37 and-a-half weeks pregnant and therefore the unborn child was viable. Medical evidence opined that if the child was not delivered by Caesarean section straightaway it would either die or experience brain damage. While the Supreme Court of the United States did not provide any reasons for declining the petition, the Appeal Court of the District Court of Illinois provided its reasons for the refusal of appeal. The latter court followed and arguably extended the scope of *Re AC* when it held that the woman's right to autonomy and self-determination overrode any other consideration such as the best interests of the fetus (at 334).

The courts in both the United States and the United Kingdom have dealt with forced Caesarean cases using similar principles. In the recent cases, both jurisdictions have found that the mother's legal and ethical right to refuse treatment should take precedence over the best interests of the unborn child even if the fetus is at the stage of viability. The courts in both jurisdictions have indicated that, even if the pregnant woman does not have a legitimate religious or cultural reason for denying the treatment, this does not mitigate the woman's right to only have medical treatment to which she has consented.

It is important to note that even though these cases are not binding on Australian courts, they do hold persuasive value, and are therefore useful in determining how courts in Australia would adjudicate this issue. To the author's knowledge, there are not any cases dealing with forced Caesareans in Australia.<sup>157</sup> However, in research sponsored by the Australian Medical Association,<sup>158</sup> Seymour opined that, when a pregnant woman is competent and properly advised, the law should never be used to override her refusal of treatment.<sup>159</sup>

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<sup>156</sup> *Jefferson v Griffin Spalding County Hospital Authority* 274 SE 2d 457 at 459 (1981). In this case the defendant, who was 39 weeks pregnant (full-term), had a medical condition that would result in the fetus almost certainly dying during natural childbirth and the pregnant woman only had about a 50% chance of surviving. In fact, the court found that a fetus has a right to life when it reaches the age of viability and as a result the state had the ability to override the mother's autonomy. The court was also influenced by the fact that the mother was “due to begin labour at any moment ...that as a matter of fact the child is a human being fully capable of sustaining life independent of the mother”.

<sup>157</sup> Skene, n 80, p 102.

<sup>158</sup> Skene, n 80, p 102.

<sup>159</sup> Seymour J, *Fetal Welfare and the Law* (Australian Medical Association, 1995) p 104.

## Refusal of respirator treatment cases

The refusal of life-sustaining treatment cases also suggest that autonomy is of great importance to consent. In *Re B (Adult: Refusal of Treatment)* [2002] 2 All ER 449 Dame Elizabeth Butler-Sloss found that a competent adult patient has the right to refuse medical treatment even if that means that he or she will die. She stated that “the doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering the primary question whether the patient has the mental capacity to make the decision” (at 474).

Furthermore, Dame Elizabeth Butler-Sloss stated that “unless the gravity of the illness has affected the patient’s capacity, a seriously disabled patient has the same rights as the fit person in respect for personal autonomy” (at 472).<sup>160</sup> This judgment thus demonstrates that autonomy generally prevails over beneficence and sanctity of life as the right of the patient overrides the desire of the medical staff to keep her alive.<sup>161</sup> Her Honour, however, did make the poignant point that even though Ms B did have this right, she did encourage her to reconsider her position when she described her as a “splendid person” who would “have a lot to offer the community at large” (at 473).

This case embraces complex and interesting ethical issues. For example, Kass has declared that “I do not think that the language and approach of rights are well suited either to sound personal decision-making or to sensible public policy in this very difficult and troubling matter”.<sup>162</sup> Furthermore, he stated that “my body and my life, while mine to use, are not mine to dispose of”.<sup>163</sup> On the other hand, Illich has suggested that “society, acting through the medical system, decides when and after what indignities and mutilations [the sick person] shall die ... Western man has lost the right to preside at his act of dying ... Mechanical death has conquered and destroyed all other deaths.”<sup>164</sup>

While there is little case law in Australia on this issue, a number of High Court decisions would suggest that the preceding cases would be followed. For example, *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218 at 233 suggests that there is a need for consent to render medical treatment lawful. *Rogers v Whitaker* (1992) 175 CLR 479 also speaks of the need to warn patients of all of the material risks in a proposed treatment so as to gain informed consent. We now turn to Jehovah’s Witness cases to investigate how the courts have dealt with autonomy and consent in this context.

## Jehovah’s Witness cases

There are often conflicts between Jehovah’s Witnesses and health care professionals over blood transfusions. This conflict generally stems from the doctors’ belief that it is in the patient’s best interest to have a blood transfusion, but the patient will not accept it for religious reasons.<sup>165</sup> Kerridge et al state that conflicts of this nature have been dealt with in three ways: “coercion, deception or through attempts at mutual respect for both patient and physician autonomy”.<sup>166</sup>

For example, when coercion is utilised, Kerridge et al state that the courts will often accept this on the basis that parental autonomy is not unlimited and that children should not be “martyrs to the parent’s beliefs”.<sup>167</sup> It is necessary to note, however, that in the event that a child of Jehovah’s Witness

<sup>160</sup> This statement countered the possible criticism that courts have too readily found patients incompetent in previous cases and reverted to the principle of paternalism while paying lip service to autonomy. See Manning J, “Autonomy and the Competent Patient’s Right to Refuse Life-prolonging Medical Treatment – Again” (2002) 10 JLM 239 at 240.

<sup>161</sup> Manning, n 160 at 241.

<sup>162</sup> Kass L, “Is There a Right to Die?” (1993) 23 *Hastings Center Report* 34 at 34.

<sup>163</sup> Kass, n 162 at 39.

<sup>164</sup> Illich I, *Limits to Medicine: Medical Nemesis: The Expropriation of Health* (Marion Boyars, London, 1976) p 210.

<sup>165</sup> Kerridge et al, n 2, p 221.

<sup>166</sup> Kerridge et al, n 2, p 222.

<sup>167</sup> Kerridge et al, n 2, p 222.



parents needs a blood transfusion (and all other options have failed), it is necessary for the doctor or hospital to apply for a court order in order to get this consent.<sup>168</sup>

In relation to deception cases, in a 1991 survey of 242 members of the European Society of Intensive Care Medicine, 26% of physicians stated that, in a hypothetical Jehovah's Witness case, they would transfuse a child patient without informing the parents that they had done this.<sup>169</sup>

In regard to ethical considerations, it is clear that, under the model of shared decision-making, neither coercion nor deception is acceptable.<sup>170</sup> This sentiment was strongly asserted in *Malette v Shulman* (1990) 67 DLR (4th) 321 where Robins JA in the Ontario Court of Appeal held that "the principles of individual autonomy compel the conclusion that the patient may reject blood transfusions even if harmful consequences may result and ... if the decision is generally regarded as foolhardy" (at 330). Thus, even though the state has a strong interest in protecting the "lives and health of its citizens", this does not "override the individual's right to self determination" (at 333). Robins JA drew a distinction between citizens being subjected to medical procedures to eradicate a potential health threat as opposed to competent adults refusing individual life-preserving medical treatment (at 333). This would indicate that, if it is for the common good or for the good of the community as a whole, the state can compel people to undertake medical examinations or treatment, but this power is not conferred on the state when it is only an individual's wellbeing at stake. This statement may also indicate that a distinction may be drawn between an act and an omission. This point of difference appears to be generated from the idea that "to deny individuals freedom of choice" will only serve to lessen "the value of life" (at 334). Thus, in most scenarios, the interest to refuse consent to medical treatment overrides the preservation of life and health and the protection of the integrity of the medical profession (at 334).

### **Legislation**

In limited situations legislation does enable medical practitioners to undertake medical treatment without obtaining the patient's consent.<sup>171</sup> Generally, however, the legislation in New South Wales aims to promote individual autonomy in relation to consent.<sup>172</sup>

Advance directives also help to promote individual autonomy. An advance directive is a statement by a competent person that at a time in the future they intend to refuse medical treatment, at a time that he or she may no longer be competent to make such decisions.<sup>173</sup> New South Wales does not have advance directive legislation but the instruments can be valid under common law.<sup>174</sup>

In most scenarios it is clear that autonomy overrides other considerations such as public interest considerations and preservation of life issues in relation to consent. Even in cases where third-party interests are at stake (forced Caesarean cases) and where the patient will die if he or she does not undergo the recommended treatment, the patient is still entitled (when competent) to exercise her or his autonomy and refuse to consent to the medical practitioner's recommendation. This demonstrates how important the ethical notion of consent is in the informed consent legal context.

### **CONCLUSION**

The first half of this article concentrated on the interplay between law and bioethics. The definition of bioethics and the different range of approaches were discussed, as well as the different regulatory

<sup>168</sup> Kerridge et al, n 2, p 222.

<sup>169</sup> Kerridge et al, n 2, p 222.

<sup>170</sup> Kerridge et al, n 2, p 222.

<sup>171</sup> Skene, n 80, p 98. For example, in relation to people with a psychiatric illness, for people who cannot take care of themselves and in some emergency situations: see eg the *Mental Health Act 1990* (NSW), s 27.

<sup>172</sup> For example, s 33(3) of the *Guardianship Act 1987* (NSW) suggests that incompetent patients covered by s 33(2) of the Act may refuse treatment in advance or at the relevant time.

<sup>173</sup> Biegler P, Stewart C, Savulescu J and Skene L, "Determining the Validity of Advance Directives" (2000) 172 MJA 545 at 545.

<sup>174</sup> Biegler et al, n 173.

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options that are available for bioethical issues. In addition, whether the law should be used to achieve the goals of modern bioethics was discussed. The relationship between bioethics and the law was canvassed. This section demonstrated how bioethics and law relate to each other. It was suggested that even though bioethics and law are interrelated, the two disciplines should maintain their separateness. It was suggested that this is of fundamental importance as a separate bioethical or moral structure needs to be maintained so that laws can be judged against it. In relation to the different regulatory approaches, different regulatory systems are appropriate for different issues.

The article has demonstrated the relationship between law and bioethics with reference to consent and autonomy. The case law in this area emphasises the importance of bioethical principles such as self-determination and autonomy as opposed to considerations of the best medical interests of the patient and possibly a third party. This shows how important key ethical principles have become within both domestic and international legal systems. It also demonstrates how important the law's function is in promoting the values of modern bioethics.

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