
A Classical-Liberal Response to the Crisis of Bioethics

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Motl Brody, a twelve year old Hasidic Jew, died recently in Washington. During his last days, his life and death were the subject of intense media scrutiny, judicial proceedings, and bioethical commentary. His transition from life to death was marked not by the private mourning of friends and family, but by cost-benefit calculations and legal wrangling. The legal, economic, and bioethical considerations are symptoms of a larger conflict between how religious communities and medical science handle the difficult business of death. More than an end-of-life decision, however, Motl's death reflects a crisis in modern bioethics, a field that has lost its focus and has forgotten ancient lessons about human power and limitations.

There is no agreed-on time of death for Motl. His brain died on November 4, 2008, according to doctors, but his heart and lungs continued to pump with the help of a ventilator and numerous drugs until November 16. Because his brain had died, the medical community declared him dead. Because his heart and lungs continued to function, the Orthodox Jewish community believed him to be alive. This conflict over definitions of life and death resulted in legal and ethical struggles that occupied his family and doctors for the last two weeks of his life. Doctors at the hospital asked to be allowed to take him off life support because he had absolutely no chance of recovery, and by some accounts his brain was actually decomposing. His parents, however, wanted the doctors to wait until his bodily systems as a whole shut down.

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The doctors, failing to convince Motl's parents, asked a judge for permission to stop treatment. No judicial decisions were made in the case, and the hospital eventually backed down, but not before the bioethics community became involved and made comments to the press that underscored how out of touch and ultimately irrelevant most of bioethics is to those who are affected by new biomedical technology.

An Associated Press article written while Motl was still alive gives at its end a throwaway line by Arthur Caplan, the bioethics expert at the University of Pennsylvania who is often quoted in reports of this sort. Caplan believes that doctors should be able to end life support over the objections of religious parents, arguing, "Doctors are well within their rights to say, 'We are stopping.' . . . I don't think medicine can become subservient to religious, spiritual or mystical hopes and beliefs concerning how to manage death."¹

At first glance, Caplan's position may seem valid, even commonsensical. The boy's brain is decomposing, and he has no chance of recovery. Putting an end to this condition might be seen as both merciful and cost effective. Perhaps doctors really do know best; perhaps they are the impartial observers who can override parental partiality to secure a more just outcome for everyone. Yet, for many, the idea that we entrust to doctors the power of life and death over the objections of patients and their families, placing medical definitions of health and well-being ahead of other human values, is tantamount to putting absolute power into a new package.

The conflict over Motl's death is emblematic of the odd relationship that modern bioethics has with the very institution it is supposed to monitor. Bioethics, in practice, has done little more than rubber-stamp the biomedical community's decisions, coming down against biomedicine only in the most extreme cases. Although this approach is not inherently wrong—doctors may already be making the right decisions, so who needs a watchdog?—history has demonstrated the problems associated with unlimited power, whether it is wielded by government or by doctors.

The Crisis of Bioethics

Modern bioethics faces several crises, all interrelated. Roughly speaking, we may say that bioethics faces a crisis of purpose, a crisis of principles, a crisis of expectations, and a crisis of authority. In the first case, bioethics is no longer entirely sure what it is supposed to be doing. What purpose does it serve? The answer seems obvious at the simplest level: bioethics should help us identify ethical principles to control or at least influence medical decision making. In reality, the picture is much more complex. Ira Carmen (2005), a former member of the Recombinant DNA Advisory Committee, developed a "constitutional politics model" for understanding the committee's purpose and how it would make its decisions. He proposed seven different options, with

1. For the article written while Motl was still alive, see Associated Press 2008c. See Associated Press 2008a for the follow-up article.

the committee's members serving as the final decision makers, the interpreters of statutes, the consensus builders, the "protectors of the moral order" (2005, 19), the promoters of scientific innovation, the facilitators of scientific self-monitoring, and judges, performing ad hoc balancing tests on the various rights and duties involved. These purposes clash with one another. In some cases, they are impractical, and in others they are potentially illegitimate. Bioethics has a hard time determining whether it is supposed to be a watchdog or a judge, a proponent or a neutral observer. In the end, theorists' own political and social values enter the picture, leading to the field's odd split into "mainstream" bioethics and "conservative" bioethics. Each side typically spends time talking over and around the other rather than engaging in serious debate. Mainstream bioethicists tend to support the medical establishment or to see themselves as ad hoc balancers, whereas conservative theorists tend to see themselves as protectors of the moral order and human dignity broadly.

At least a part of this crisis of purpose is that bioethics has a difficult time finding principles on which to ground its arguments. Vague terms such as *patient autonomy*, *physician responsibility*, *human dignity*, *nonmaleficence*, and *beneficence*, among others, tell us little about how to apply these principles in real-life situations. None of them is an absolute good, and although they all are very good in the abstract, their "abstract perfection is their practical defect," as Edmund Burke once commented about human rights ([1790] 1999, para. 242). Knowing that patient autonomy matters tells us nothing about what to do when a patient has left unclear directions or when he happens to be mentally disabled. These principles also make it too easy to polarize debates. Someone arguing for patient autonomy finds it easy to disregard the views of those whose primary concern is physician responsibility; those concerned with social or economic pressures and other utilitarian issues are left defending themselves against charges of callousness. In fact, all of these values deserve protection. Balancing and preserving them in tension with one another constitute the difficult missions of bioethics, missions that many bioethicists have jettisoned or ignored.

The crisis of principles ultimately causes a crisis of expectations. We as a society (and as bioethicists) see the role of bioethics in perhaps too optimistic a light. Without robust principles on which to base our decisions, it is difficult to believe that individual bioethicists or bioethics committees will ever play a large role, at least as the final authority, in informing patient care. Yet when bioethicists discuss these matters in the public eye, they, like Caplan, seem to see themselves as a final moral authority. Bioethical principles are so often ignored in practice because bioethics is necessarily a contingent, applied ethics. We cannot separate the principles from the specific circumstances in which patients and doctors find themselves. A decision to end a life in one case may be unacceptable in another similar case merely because the family is different or the amount of pain is different or the religious beliefs involved are different. Thus, bioethics needs to acknowledge that it will always be an imperfect ethics and that low expectations are perhaps both more realistic and more fruitful as a starting point for moral debate.

In part, our expectations about the relevance of bioethics are disappointed in practice because of a crisis of authority. No one is entirely sure in this brave new world who is holding the reins. The complex relationships among individual patients, families, doctors, hospitals, bioethicists, regulators, and policymakers create serious difficulties in determining where, if at all, bioethical practitioners fit in, where bioethical principles enter the debate, and where, if at all, such principles are controlling. In one compilation of essays on end-of-life decision making, the contributors come to completely different conclusions on where final authority lies (Blank and Bonnicksen 1993). For three essayists, the final decision rests with the doctors, who hold the final “moral authority” for patient care. Another author argues that the hospital and its agencies hold the final authority for end-of-life decisions, and another stresses the importance of statutory controls. The patients and their families’ wishes typically come last in this analysis.

Giving patients the final authority is certainly problematic. The most commonly cited issue is the patient’s lack of objectivity. Yet, in reality, we find no real pattern of patient or family abuse. The major court cases dealing with end-of-life decisions vary drastically with regard to the desires of patients and their families. In some cases, we are talking about ending life-preserving care, whereas in others the question is whether to continue possibly futile treatments. It does not seem, therefore, that patients and their families consistently choose either death or life. More probable is that patients and their families respond to their particular situations, their religious beliefs, their basic values, the intensity of pain, and the patients’ quality of life, making intensely personal decisions about how to deal with death. If so, discussions of who has final authority for medical discussions are fundamentally wrongheaded or at least oversimplified. More important, bioethicists, for all their talk about who is the final authority in biomedical decisions, ignore the very real problem that all authority poses, which is how to control it.

A Classical-Liberal Bioethics

Bioethics can benefit from principles gleaned from the centuries-old debate over how to limit power. Classical-liberal thought, starting with early-modern liberals such as John Locke and moving to complex, culturally informed observers such as Baron de Secondat Montesquieu and Edmund Burke, concerns itself primarily with the problem of how to deal with power wielded by imperfect humans. Power is a problem in classical-liberal thought primarily because it threatens individuals’ lives and liberty, which are considered foundational moral goods. On the foundation of individual freedom, classical liberals have built up various institutional and social controls over governmental power, including constitutionalism, federalism, the rule of law, checks and balances, independent judiciaries, and the manners and mores of a free people— independence from and suspicion of government power, voluntarism, and broad “social capital.” By allowing individuals the freedom to make decisions about their

lives, we create a spontaneous order that supports freedom and self-government. Because of the importance of individual freedom, classical liberals assume that absolute power in any form is dangerous and must be controlled.

How are the problems we face with biomedicine similar to those posed by government power? In a mundane way, the powers that governments and doctors wield are necessary parts of modern life. Most classical-liberal thinkers follow Locke in his belief that government is a necessary good (or evil, depending on your viewpoint) and that the goal of constitutionalism is to find the safest balance between anarchy on the one hand and absolute, arbitrary power on the other. More than the simple balance between impotent government and omnipotent government is the balance society must strike in arranging human goods and values. Goods such as security, liberty, equality, and community must be arranged, ranked, preserved, and harmonized with (or at least held in uneasy balance) each other, taking proper account of the peculiar circumstances of time and place that make any given balance necessarily imperfect, contingent, and impermanent.

Many of the enduring challenges of biomedicine are similarly about balance. Very few people argue for a complete abandonment of the modern biomedical project. What we want is a balanced biomedicine, one that is capable of saving human lives and preserving human health, but that simultaneously recognizes the limits of human power and virtue. In addition, biomedicine must balance human goods that cannot be ranked permanently because of the vicissitudes of time and place. Health and life need to be ranked and harmonized with dignity, religious and moral concerns, ethical considerations, long-term consequences, equality of access, and patient autonomy. These rankings and harmonies are always imperfect and impermanent because they rely on human nature and the human condition broadly for their meaning, both of which are imperfect and contingent.

A second way in which biomedical and governmental power resemble each other is that both are dangerous to individuals. The kind of power that both wield extends into the most basic kinds of human desires, including survival and reproduction. Any power that touches these fundamental goods has the potential to become tyrannical. One does not need to look beyond the twentieth century to encounter the horrors of unbridled governmental power. Yet those horrors came hand in hand with progress, and it was precisely this progressive hope that led us to forget the tyrannical nature of uncontrolled governmental power. Ironically, our very optimism led us to reject the protections against tyranny that might have prevented the terrors of Nazism and communism.² The twentieth century is thus paradoxical in at least two ways. The hope for progress led to immeasurable human suffering, but unprecedented economic growth and a flourishing biomedicine saved millions of human lives.

2. See Chantal Delsol's excellent discussion of the paradoxes of the twentieth century in *Icarus Fallen* (2003) and *The Unlearned Lessons of the Twentieth Century* (2006).

The twentieth century's odd paradoxes—oppression and slaughter side by side with technological innovation and the alleviation of much human suffering—are also visible in the microcosm of biomedicine. The eugenics movement in the United States alone brought about the forcible sterilization of more than sixty thousand Americans, and state eugenics laws such as Virginia's served as the basis for Hitler's racial cleansing some twenty years later (Reilly 1991). Human experimentation and the killing of disabled infants were only some of the atrocities committed by supposedly benign, benevolent doctors and researchers in the United States and western Europe. Meanwhile, the progress of biomedicine (in some cases driven forward by these same abuses) has reaped enormous benefits for most people. Infants do not die of diarrhea, malaria, and measles in the numbers that they used to because we have simple and effective tools to prevent dehydration, cleanse malarial breeding grounds (and treat the disease once contracted), and vaccinations that prevent the most common and deadly childhood illnesses. The power of biomedicine, like the power of government, is useful and beneficial, yet dangerous when not carefully circumscribed.

It is no coincidence that the most egregious abuses of biomedicine and biotechnology occur when both governmental and biomedical power are at their height. The eugenics movement's greatest excesses were characterized by unflinching trust in scientific experts such as Harry Laughlin and unfettered optimism about government's ability to solve human problems. Naive trust in doctors and government officials led us to cast aside basic protections such as checks and balances, federalism, pluralism, and the like as impediments to progress and opened the door to horrifying abuses. When these two kinds of power coincide, even those individuals with a duty to check the government's powers find themselves swept away by the intoxicating possibilities of progress, as the U.S. Supreme Court's decision in *Buck v. Bell* (1927, 274 U.S. 200, Docket Number 292) reminds us. Both governmental and biomedical power need to be limited for the protection of individual rights and well-being, and government's entanglement in biomedicine should be carefully scrutinized.

Another similarity between the power of government and the power of biomedicine is that both ultimately deal with the power of life and death. The decisions made by doctors and governmental agents are sometimes banal, as in debates over minor side effects or lower-level staffing decisions. These kinds of powers, though necessary, are not the focus of most classical-liberal theory. The aspect of both governmental and biomedical power that requires the most scrutiny and the most important limitations is the power that both government officials and doctors have to end human life. Government claims a monopoly of the legitimate use of coercive force, and we see this monopoly as good and necessary as long as we can control the monopolist. Similarly, doctors make life-and-death decisions every day, and these decisions are irreversible. Any person or agency that holds the power of life and death needs to be monitored and controlled. The question, of course, is, By whom?

The question of authority is thus integral to debates over both governmental and biomedical power. It is a long-held (though ultimately questionable) assumption

that power needs to reside in some final authority who, however limited and hedged in by institutional and social controls, has the final say. The conflict between limited power and sovereign power has been dealt with at length elsewhere, but the same conflict arises in our discussions of how to regulate biomedicine. We ultimately need some way of resolving conflicts, and a final sovereign moral authority seems to be the easiest approach. Yet the existence of a final sovereign authority creates its own problems of control and legitimacy, which ultimately place us right back where we started. We find ourselves facing the Hobbesian dilemma of controlling the controller. I lay out a few alternatives here, but I cannot promise that a classical-liberal approach to bioethics leads to a clean or neat conclusion; in fact, one of classical liberalism's great strengths is its tolerance of imperfection and its recognition that because the problem of power is ultimately a human problem, it may have no clear or concise solution.

Classical-Liberal Assumptions

The use of classical-liberal principles to correct the faults of bioethics requires that we start with some basic classical-liberal assumptions about the human condition. Classical liberalism builds on a view of human nature, which allows its assumptions and the principles that follow to apply to a broad range of human phenomena. The Hobbesian and Lockean states of nature are only one example of the attempt to strip humanity down to its basic desires as a way of understanding what motivates human behavior. Such an approach accomplishes two things: it tells us what is most worthy of protection in human life and where the greatest dangers to those goods come from. Most classical-liberal thinkers move well beyond the simplistic state of nature, however, and later classical liberals follow the highly complex, culturally and sociologically informed theories of thinkers such as Montesquieu ([1748] 1989), Burke, and Adam Smith ([1776] 1904). These later thinkers and statesmen were less concerned with how humans act in isolation and more concerned with how humans act given the constant influence of culture, norms, manners, mores, religion, law, and family, not to mention environmental, demographic, and international pressures.

Despite different approaches to discovering the patterns of behavior that make up what is known as human nature, most classical liberals come to basic agreements about what those patterns are. First, humans have limited virtue. One of the common criticisms of Thomas Hobbes's view of government is that after describing human life as "solitary, poor, nasty, brutish, and short," he then goes on to rectify this situation by proposing the iron hand of a benevolent Leviathan (see Hobbes [1651] 1996). The problem of absolute power for most classical liberals is that one cannot assume the ruler's benevolence any more than one can assume his next-door neighbor's benevolence—indeed, one can assume it even less because power tends to corrupt. Humans are not naturally virtuous. This condition does not imply that we are necessarily antisocial. Many classical liberals emphasize (Burke and Smith most eloquently)

the importance of sympathy and social emotions in human life and note that as social creatures we are naturally other regarding. However, our social tendencies always compete with our individualistic nature, which creates a constant tension.

Instead of assuming virtuous actions, classical liberals assume that humans generally act in their own self-interest (or what they think that interest is). The most famous formulation of this view is, of course, Adam Smith's observation in *The Wealth of Nations*: "It is not from the benevolence of the butcher, the brewer, and the baker that we expect our dinner, but from their regard to their own self-interest. We address ourselves not to their humanity but to their self love, and never talk to them of our own necessities but of their advantages" ([1776] 1904, 26–27).³ Just as we do not expect our neighbors and leaders to act out of selfless virtue, neither should we expect researchers and doctors to do so. From South Korean researcher Hwang Woo-Suk, who used his research assistants as egg donors and faked the outcome of cloning experiments,⁴ to court cases alleging that transplant doctors hastened the death of patients in order to harvest their organs,⁵ doctors and researchers are hardly paragons of objective benevolence. Not that doctors are bad people; they are simply people. Doctors, like others, have the same concerns about professional status and research agendas, and they have the same subjective views that all humans do, based on religion, upbringing, personal beliefs, and so on. In this light, the logic of bioethicists such as Caplan, that medical decisions about how to "manage death" (whatever that means) should not be subservient to religious or spiritual beliefs, looks suspect. One of the major protections we have against the abuse of power in general is that that power is made subservient to other human values, whether religious or otherwise.

A second facet of human nature is people's limited knowledge. F. A. Hayek's famous essay "The Use of Knowledge in Society" (1945) condenses many of the arguments made by thinkers such as Smith, arguing that the primary reason for supporting the creation of a spontaneous order through the free movements of individuals is that human knowledge is fragmented and dispersed among all individual actors rather than centralized and easily accessible. Because human knowledge is finite and incomplete, it makes sense to allow individuals to use their highly specific albeit imperfect knowledge rather than to trust a central actor to pull together those fragments, determine what he thinks is the best course of action, and implement it before there is a change in the circumstances that justify such action. The most obvious example of this principle in action is the market price system, although the phenomenon is a wider social one and not limited to economic principles. The principle has taken off on the Web, where "wikis" and other examples of somewhat spontaneous orders demonstrate how individuals' decentralized knowledge can be

3. The same sentiment is expressed in Smith's *Lectures on Jurisprudence* ([1766] 1982, 2:220).

4. For a very brief overview of the Hwang Woo-Suk case, see Sang-Hun 2009.

5. See Associated Press 2008b.

more efficient and useful than the centralized knowledge of a small group of scholars or analysts.

Our lack of comprehensive or even cohesive knowledge means that any bioethics will always be fragmented, incomplete, and rooted in particulars. All bioethics is attached to specific incidents of time and place, and one cannot lump people into categories based on disease, age, or race because other factors will always play an equal or more important role in how that patient sees his life, understands human flourishing, and wishes to approach death. This specificity makes bioethics a complex and frustrating field of study, but it is this complex only because it mirrors the richness and intricacy of human life. A nonmessy bioethics fails to do justice to humans and their medical marvels.

Moreover, recognition that human knowledge is always fragmented and incomplete should lead us to question the “trust the experts” approach to biomedicine. Generally speaking, I trust an oncologist more than myself to tell me what to do about a tumor, but I will still ask for a second opinion because doctors, like other humans, are fallible. This fallibility is especially problematic in end-of-life decisions, where mistakes are irreversible. Haleigh Poutre’s case is a chilling example.⁶ After abuse by her adoptive mother and stepfather left her comatose, Haleigh was transferred to the Massachusetts Department of Social Services, which then requested, as doctors advised, to take her off life support. Her condition, they argued, was hopeless. Luckily for Haleigh, a day after the highest court in Massachusetts reaffirmed the order to remove her life support, she became responsive and began to breathe on her own. Her case led to widespread condemnation of the Massachusetts Department of Social Services, but it points to a more disturbing pattern of how quick we are to trust doctors’ expertise, even in life-or-death situations.

In light of oft-demonstrated human fallibility, we should recognize that what many people call miracles are really only the failure of expectations we have about how the world works. Doctors who pronounce a case “hopeless” may have expert knowledge about brain scans, but the human brain continues to defy our best predictions, and the future is almost always unclear. Doctors deal in probabilities, which, however useful in the aggregate, are insufficient warrant for ending an individual’s life. They are neither omniscient nor omnipotent, and therefore they should recognize science’s limits, just as they also recognize its power. Medicine should be made subservient to other kinds of human goods, and it should remain humble about what it can and cannot do. End-of-life decisions in particular should be approached with humility, not hubris, because of their irreversibility and our limited understanding of death.

Humans’ lack of omniscience and omnipotence also relates to the final characteristic of human life that classical liberals recognize, which is its imperfectability. Classical liberalism recognizes that what we call progress is really simply a tentative

6. For an overview of the case, see Associated Press 2006.

balance between anarchy and absolute power, between unbridled liberty and slavery. Progress is always reversible and limited. Medicine, in contrast, is a progressive science by its very nature. The goal is never stasis, but longer lives, better health, fewer fatalities, and so on and on up the rungs of human progress. In our amazing progress, we mistakenly believe that there is an end or a perfect state at which all progress must end. In reality, medical progress may resemble an asymptote: one gets closer and closer in incremental stages to an endpoint yet never actually arrives. Human life is imperfect, and an aura of tragedy hangs over even the happiest lives. This tragedy gives our lives meaning, and it is also ineradicable, so we might as well get used to it.

Some might argue that recognizing imperfection or approaching human life with a kind of humility about human power is simply fatalism, that by recognizing imperfection we deny ourselves the possibility of overcoming it. Yet there is something fundamentally powerful about recognizing our own impotence in the face of tragedy. No matter how hard we try, we will never eradicate disease. Old age, though pushed back, remains inevitable; even Francis Bacon's "New Atlantis" ([1626] 1989) failed to prevent death. Moreover, we will never eradicate the fundamental contingency of human life. Babies will still occasionally choke to death, children will drown while swimming, teenagers will die in car wrecks, and adults will die while skydiving or flying across the Atlantic. We take such risks to explore the world around us; the notion of a life free of them is ridiculous because life without such experiences is not worth living. A flourishing life requires that we take chances, experiment, challenge ourselves, and (eventually) die in the process.

The problem with the modern medical project is that it attempts to eradicate the tragic aspect of life and places that eradication at the forefront of human achievement. However, eradicating common tragedies is more a means of fulfilling ourselves in some more profound way with some riskier project down the road. The child who does not die of malaria in infancy may later risk his life by climbing Mount Everest. This kind of deferment is progress, but it does not eradicate contingency or make human life less tragic. It simply shifts the tragic an inch or so farther into the realm of human choice.

The imperfection of human life and the recognition that tragedy is present at every stage allow us to put the modern medical project into proper perspective. Instead of seeing health and long life as the highest goods attainable, we see them as means to the other ends that humans pursue. The sustainment of one's life in a gulag is not desirable on its own terms; it is desirable because one holds out the hope that by surviving one might eventually be free to live a better life. Similarly, for many, the choice between eking out a few more months in a hospital bed and dying sooner at home surrounded by friends and family is an obvious one. Choosing not to fight until the very end is not fatalism, but recognition and acceptance of the inevitable tragedy, ultimately allowing a person to tie together the loose ends of his life.

Classical-Liberal Institutions and Bioethics

Classical liberalism's assumptions about human nature and the human condition offer us a way of approaching and dealing with the problems of power and authority. Classical liberalism helps us understand and deal with power in at least three ways. The first is by determining who has the controlling interest in a particular decision, often understood as property rights. Second and third, because we need to deal with the problem of who (if anyone) has the final authority over a particular decision, the notions of subsidiarity and polycentricity are helpful: subsidiarity can help to determine where authority lies, and polycentricity supports numerous centers of biomedical decision making.

Most early and classical liberals see private-property rights as the major protection we have against government intrusion in our lives. Locke's *Second Treatise* ([1689] 1988) describes the right to property as a "fence" to our self-preservation, and the right to property has always been a central part of any system limiting the power of government. James Madison, in his 1792 writings on government, clarifies the relationship between property and power: "where an excess of power prevails, property of no sort is duly respected. No man is safe in his opinions, his person, his faculties or his possessions." Madison argues that a person owns his conscience and beliefs, and he defines property as "that dominion which one man claims and exercises over the external things of the world, in exclusion of every other individual." He then argues, "In its larger and juster meaning, [property] embraces every thing to which a man may attach a value and have a right; and *which leaves to every one else the like advantage*" (1900, emphasis in original). Property in this interpretation includes property in one's conscience, one's body, and one's decisions about health and well-being.⁷

Just as the right of property limits the arbitrary power of government, it plays an important role in limiting the power of doctors and bureaucrats over patients. Property has been broached by many thinkers in various forms as part of the puzzle we face in piecing together a more humane and reflective bioethics. Some bioethicists believe patient decisions are ultimately a kind of property; theorists such as Susan Wolf argue about end-of-life decisions that "the decision *belongs* to the patient" (1990, 34, emphasis in original). Ownership of decisions rests on the notion of autonomy that is at the root of classical-liberal theory and, at least ostensibly, at the root of modern bioethics.

Property operates as a barrier to power because of its component right of exclusion. This right is developed by clarifying who has the primary legitimate interest in the property in question. Property does not provide one with absolute authority over one's goods, but it does communicate to others that an individual has a

7. For an excellent discussion of the relationship between property and freedom and of property's organic roots, see Pipes 1999.

compelling interest in that property and thus a right to defend it. Thus, property rights clarify who has the controlling interest in decisions made about the property in question. A notion of self-ownership, although necessarily limited, helps to clarify the primary interests at stake in bioethics. Just as we have not managed to determine conclusively where private-property rights end and community interests begin in traditional property law, the extent of one's ownership in one's own decisions and body will be determined over time in a trial-and-error process, much as English common law gradually developed a system of property rights.

It is unclear precisely how far the notion of property rights will get us in determining the rights patients have and the kinds of moral limitations we may place on biotechnologies broadly speaking. Like all property, property in one's body or decisions is not a complete or perfect right. One is limited by moral, legal, and economic principles (such as the "externalities" our decisions impose on others), and the patient's "ownership" of his final decision may conflict with the duties that physicians have to their professions and their individual beliefs and convictions. Thus, property will not give us all the answers we seek. A property right over beliefs and decisions is merely one barrier to power, not the only barrier. Classical liberals believe that more than one institution is necessary to prevent the misuse of government power, and, likewise, more than one principle or value is necessary to protect the myriad rights and interests involved in bioethical debates. We ultimately need a set of principles and institutions that protects patient autonomy, human dignity, and physician responsibility on numerous grounds and in numerous ways. Nevertheless, ownership in one's body and decisions, although not comprehensive, plays an important part in limiting the medical establishment's power and protecting individual liberty.

If property is a way to specify who has the controlling interest in a particular decision, we also need a way to specify who has the authority to make a particular decision. As those of us who live in a representative democracy know well, one's interest in a decision does not necessarily authorize one to make that decision. Here the newly resurrected concept of subsidiarity is useful (Delsol 2003).⁸ The theory of subsidiarity supports placing the authority for decisions at the lowest possible level. The American federal system, in which zoning laws are left to local governments, whereas national defense and common currency are handled by the central government, exemplifies this approach. The assumption is that different levels of decision making are best equipped to handle different problems, depending on their scale. Local governments or individuals should handle local problems, and a central authority should handle national problems.

Subsidiarity is one arrangement for dealing with complex issues posed by biotechnology and biomedicine broadly. Situations that affect one individual or a family might be left to the patient in conjunction with his or her doctor. Broader questions,

8. Delsol has written extensively on subsidiarity, although none of these works is available yet in English. See, for example, *L'Etat Subsidaire* (Delsol 1992).

such as human-experimentation protocols and whether to allow human cloning, which may affect a broad swath of the population or future generations, might be handled better by a national body, perhaps by statute. Biomedical decisions have varying scales, just as political decisions do. Subsidiarity helps us understand that government regulation is not always (or even usually) the best answer. Some decisions are best left up to individual patients and their doctors, and ethics committees and boards in hospitals can help to resolve conflicts that arise.

Subsidiarity is required because we lack omniscience. Subsidiarity relies on the classical-liberal assumptions of incomplete knowledge and localized interest. Local decision makers (a patient, his family, and his doctors) will be most familiar with the circumstances of a case and whether the patient's best interest is being represented, which helps to alleviate the Hayekian problem of knowledge. Decisions about patient care in general and about end-of-life decisions in particular should not be made by central authorities (including courts) unless there is evidence of force, fraud, or mental infirmity in the case. Although individuals may lack specific knowledge of treatment options and of the pros and cons of particular treatment protocols, they have the most comprehensive knowledge of their own life circumstances, their own financial and social support networks, and, most important, their own values and beliefs about what constitutes a flourishing human life.

A constant tension inheres in bioethical analysis because someone at some time needs to make a decision about the extent or cessation of treatment, and it is unclear who that final decision maker should be. The problem of authority is a question not merely of the level at which the authority exists, but also of whether in certain cases any final authority exists. Political and bioethical theorists tend to assume that some final authority must act to resolve disputes, but there are alternatives. "Polycentricity" is a new name for an old system that has more than one center of authority or no center of authority at all (Polanyi 1951; Ostrom and Allen 2008).

Polycentric orders resemble a web, with each part connected to every other part. When one part of the web shifts, the rest of the web shifts in response. Polycentric decisions are less about making final decisions in specific cases and more about the gradual evolution of norms and values by society as a whole, which allows for the flexible response of individuals to specific situations. The evolution of the common law in England illustrates a polycentric order; no one person organized or hierarchically determined what the law would be. Instead, the decisions and principles were spun out over time, with web strands reaching out into different areas of law, touching distinct judges, and extending both backward and forward in time. If subsidiarity focuses on vertical levels of decision making, polycentricity focuses on both vertical and horizontal decision making, with no one central authority and with decisions that occur gradually over space and time.

Polycentric orders are useful because they allow for constant adaptation to changing circumstances and do not recognize a single sovereign authority. Moreover, such a system allows for both vertical and horizontal interaction. A family's decision

to end a comatose patient's life might be attended by doctors, hospital bioethics committees, and religious leaders, with each party adapting to and shifting his position in response to the others' actions. Moreover, should the decision end up being contentious, other hospitals, physicians, and the public at large may change their own behaviors, altering the outcomes of similar cases without statutory or legal intervention.

The case of Baby L illustrates polycentricity in action (Paris and Reardon 1993). Baby L was denied treatment by her doctors against her mother's wishes. Her mother wanted any and all medical care to be given, but her doctors believed such futile treatment would violate their professional oath to do no harm. The case made it to court when the mother failed to find any doctors willing to provide Baby L with the care she required. The eventual intervention of a doctor who was willing to care for Baby L made the case moot and resolved the legal conflict (although not the underlying moral conflict). A polycentric society allows for a pluralism of values that supports both horizontal and vertical interaction between actors. What one doctor believes violates his professional responsibilities may not be considered a violation by another doctor, who may rank those responsibilities differently. Thus, polycentricity allows individuals to step in when they see others making a decision they would not make and preserves for doctors and patients the moral autonomy that is sacrificed in simplistic legal or single-authority systems.

Until recently, when bioethics committees became more popular, courts were (and still are in many cases) the final authority in particular cases. One might ask, of course, why the courts are not the ideal forum for resolution of contentious cases. For one thing, in specific cases, the courts often err. Motl Brody and his family were lucky that he died before the appeals process was completed, whereas Haleigh Poutre was lucky that she recovered before the courts reached a final decision. In Motl's case, his parents were spared the responsibility of taking him off life support against their convictions. In Haleigh's case, her stepfather's appeals prevented her premature starvation.

Apart from the desirability of a specific outcome, court decisions are generally undesirable in biomedical disputes for at least two reasons. First, they are usually adversarial, with both sides claiming to be right and assuming the other to be wrong. Decisions made in the bioethical context represent tragic dilemmas rather than claims of right. Is the medical community wrong in determining a standard of death that makes sense, given finite resources and scientific beliefs about the mind-brain connection? Of course not. Is the Jewish community wrong to determine a standard of death that takes into account family members' obligations to the ill and their beliefs concerning the afterlife? Of course not. Neither is right or wrong, and neither side can prove the other wrong. We are thus at an impasse, not because one side refuses to see the light, but because both sides represent important aspects of the human condition. The court system cannot and should not decide how to rank these conflicting human goods.

Second, court decisions ostensibly deal with legal matters rather than with moral, ethical, and practical concerns. Although judges deal with the latter concerns all the time, their expertise lies in the law. They are not relationship experts, medical doctors, pain specialists, or religious leaders. The legal issues at stake here are usually not the primary source of conflict. Having a court decide that the Massachusetts Department of Social Services has the authority to take a little girl off life support does not solve or even take into account the underlying moral conflict at the root of the problem. Moreover, judges' legal training rarely if ever extends into the complex web of bioethical principles, which makes judges more likely to trust medical experts and thus renders them poor watchdogs against biomedical excess.

The courts do have a role to play, of course, and that role is to interpret the law and to help prevent force or fraud. They can be an important protector of the rights of individuals, especially those who cannot speak for themselves. Courts play a role in protecting minors, the disabled, and the elderly from possible abuse and in interpreting living wills and other legal documents that individuals leave behind. The courts are generally set up well to handle these functions, and as they become more accustomed to dealing with biomedical conflicts, they will develop precedents and principles to guide their decision making, which will add predictability and legitimacy to their decisions.

For the sake of bioethics and for the sake of the courts themselves, courts should not become involved in cases in which there is no question of force or fraud or in cases in which moral and ethical principles, rather than legal principles, are at stake. Involvement in such cases does nothing to raise the stature of the court system, creates resentment on the part of the public, and risks turning complicated dialogues about beliefs and values into simple win-lose dichotomies. It is precisely this legal approach to extralegal conflicts that makes discussions of biomedical issues so polarizing and therefore in the long run damages individual lives and deaths.

Toward a Classical-Liberal Bioethics

What would a classical-liberal bioethics look like? My answer may not reassure those who seek "paradigms" and "frameworks" because a classical-liberal bioethics will be messy, complex, and imperfect. It will be marked by humility, a recognition of the importance of individual interests, and the belief that a centralized sovereign authority (such as the courts or legislatures) is not the best agent for achieving the delicate balance that must be struck to preserve patient dignity and autonomy, physician obligations and responsibilities, and broader social interests. A classical-liberal bioethics will support individual conscience while recognizing the existence of social interests. It will eschew central decision making (and thus easy answers) in favor of localized, individualized, and polycentric decision making that evolves gradually over time rather than being imposed on individuals (whether patients or doctors) from above. A classical-liberal bioethics will be a pluralistic, polycentric order that

acknowledges patient autonomy while providing support by experts from the medical community, religious leaders, ethicists, and counselors, but it will reject any of these actors as the ultimate decision maker. Bioethics ultimately needs to recognize the limitations imposed by the human condition and the complex desires and values that make up human nature. Such a bioethics will be unwieldy, messy, and frustrating, much like human life, but only a bioethics that resembles human life in these ways can best inform decision making about health, life, and death.

A classical-liberal bioethics differs from a conservative bioethics in that it supports individual freedom rather than primarily promoting the preservation of human dignity or conforming bioethics to certain religious principles. Classical-liberal bioethics also differs from mainstream progressive bioethics in that it eschews government power over (and perhaps even government funding of) biomedical research and decision making in favor of a spontaneous order. The progressive approach tends to favor positive law and bureaucratic regulation rather than the thoughtful, gradual “common law” that classical liberalism supports. Progressive bioethics also tends to be anti-individualistic in origin, relying heavily on technocrats and “experts” to guide policy. Finally, *classical-liberal bioethics* is not *libertarian bioethics*, despite the common and erroneous conflation of the two terms.⁹ Classical liberalism recognizes limits on the power of science, and it is completely incompatible with the “deep” libertarianism that rejects even informal social controls over individual behavior. It especially eschews the progressive fervor of some radical libertarians who believe unrestricted science holds the key to human perfection. A classical-liberal approach supports the freedom of individuals but recognizes that no man is an island and that the value of freedom must be balanced and (if possible) made compatible with the myriad other values that promote human flourishing. Most important, classical liberalism is inherently suspicious of perfectionist theories in any form.

Classical-liberal bioethics hopes to create a kind of bioethical common law in which thoughtful individuals reacting to specific cases make decisions over time that influence but do not bind decision makers in similar but not identical cases. This common law will be more akin to customary law than to common law, however, because the courts will play a minimal role. The decision makers in this common law will be patients, doctors, families, and members of society at large, all of whom will interact as connected strands on a web, reacting to and learning from those who came before them, correcting perceived injustice by crafting localized rules and regulations that come from the intuitions and values of the people themselves.

One potential drawback, among many, of such a system is its heavy reliance on the manners and mores of the people themselves (on what is now called “social capital”), who must be willing to criticize and judge the decisions that patients, doctors, hospitals, and policymakers make and to change their own behavior in response to other individuals’ decisions. This process requires an educated citizenry

9. For an example of libertarian bioethics, see Ronald Bailey’s discussion in *Liberation Biology* (2005).

that rejects the polarizing arguments of bioethicists who seem to want to convince people that no human values rank higher than mere health.¹⁰ Therein lies the challenge for classical liberals and those who question the broad modern scientific project: in the end, the decision about where we go in biomedicine generally relies on everyday people's moral intuitions.

Engaging people's minds may ultimately be the true calling of thoughtful bioethicists, who will create discussion, help elucidate complex problems, and help prepare members of the public for the time when they too must confront inevitable human tragedy. A classical-liberal bioethics thus solves the crisis of bioethics by providing people with a purpose, principles, and realistic expectations, and it relocates the ultimate decision-making authority in the people as a whole. Let us not trust the famous proverb that says, "He who founds on the people, founds on mud." Let us hope that human moral intuition rests on something more solid.

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10. See Daniel Klein's discussion of the effect that policy has on public morals and personal and individual responsibility in *The Challenge of Liberty* (2006).

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