AUSTRALIAN INSTITUTE OF HEALTH, LAW AND ETHICS

FIRST ANNUAL CONFERENCE

CANBERRA, 15 NOVEMBER 1996

INAUGURAL KIRBY LECTURE ON HEALTH, LAW AND ETHICS

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The Honourable Justice Michael Kirby AC CMG

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## A UNIQUE COMPLIMENT

Anyone who has held public office for as long as I have - almost exactly 22 years - is bound to collect a few honours, if only for longevity and survival. In my case, I have received more than my fair share. Civil honours. Medals. Honorary Degrees. Fellowship of Colleges. I cannot pretend that I am indifferent to them. They are the rewards for countless hours spent in

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* Justice of the High Court of Australia. One-time Chairman of the Australian Law Reform Commission, Judge of the Federal Court of Australia and President of the New South Wales Court of Appeal. President of the International Commission of Jurists.

contemplation and preparation of addresses such as this. When other, saner, citizens are lifting a glass of Chardonnay to reflect it in the sunshine against a blue sky, I am almost certainly working in my office upon some judgment, article, speech or other worthy enterprise.

The naming of a lecture is something new. I am immensely flattered by it. Yet, as someone who has given countless lectures, all of them carefully preserved, numbered and recorded over the 22 years, I confess to mixed feelings.

First, I am glad indeed that it is not a memorial lecture. To escape the obligation of giving it by such a ruse might be too great a sacrifice. Secondly, I feel guilty for those future lecturers, dragged away from the innocent enjoyments of humanity to prepare such of the succeeding lectures as remain to be given. Why should they have inflicted upon them the burdens which I have so willingly, even enthusiastically, accepted these past two decades? But then I am glad because a public lecture is a means by which one person can convey thoughts which, it is hoped, will be concentrated, for the consideration of a faithful audience. Unless it be given by the Dame from Moonie Ponds or that master of disguise and deception, Campbell McComas, the lecture will, inescapably, have an intellectual flavour. A country which rejoices in its triumphs of excellence in sport insufficiently celebrates the world of intellect, of thought and of ideas. If, in my name, this lecture series endures and promotes public

discussion of contemporary issues of importance for our fellow citizens, that will be a wonderful memorial to my efforts. Because I am an unashamed egg-head, and aspire to contribute to the intellectual debate in this country, I am glad, and grateful, that you have chosen to honour me in this way.

That the lecture is in the field of health, law and ethics is also specially warming to me. Virtually from the start of my public career in the Australian Law Reform Commission, I was required to address the controversies of health, law and ethics. One of the first references given to the Law Reform Commission by the Federal Attorney-General required it to make proposals for law reform in the field of human tissue transplants[1]. That was a most important project, not only for its subject matter but also because it demonstrated that difficult questions, involving health, law and ethics could, in an enlightened modern democracy, be tackled in a public way. It showed that we could achieve results in legislation, not just a report consigned to the too hard drawer or public debate leading nowhere. In the course of the Law Reform Commission's project on human tissue transplants we had to examine many difficult and controversial questions:

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1 Australian Law Reform Commission, *Human Tissue Transplants,* (ALRC 7) 1977, AGPS, Canberra.

* The definition of death;
* The adoption of a regime of donation or a regime of taking - with the privilege of opting out;
* The acceptability of payment for body parts;
* The availability of donation by a legal minor;
* The rights of relatives to over-ride the wishes of the deceased to donate their body, or parts, either for research or organ donation; and
* The then novel development of in vitro fertilisation, the consideration of which was postponed on the footing that it raised legal and ethical problems of a different character from those presented by the donation of particular organs[2].

Many other projects of the Law Reform Commission required me to address particular issues relevant to health, law and ethics. These included the issue of the compulsory reporting of child abuse in the Commission's report on child welfare[3]; the various questions of medical confidentiality raised by the Commission's report on privacy[4]; the privilege attaching to

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2. *Ibid,* xiv.

3 The Law Reform Commission, *Child Welfare* (ALRC 18), 1981, AGPS, Canberra.

4 The Law Reform Commission, *Privacy* (ALRC 22), AGPS, Canberra, 1983.

medical information in the Commission's work on the law of evidence[5] and several others.

But it is not so much my work in the Law Reform Commission that has stimulated my thinking in recent years on the topics of your concern. Instead, three developments have captured my attention. They remain of close interest to me. They are:

1. The ethical and legal questions presented by the advent of the HIV/AIDS epidemic;

2. The ethical and legal questions presented by the Human Genome Project and the Human Genome Diversity Project; and

3. The complex public policy questions raised by the attempts to apply ethical principles to the allocation of healthcare resources and, in particular, to adopt cost-benefit analysis in the context of healthcare.

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5 The Law Reform Commission, *Evidence* (ALRC 26), AGPS, Canberra, 1985.

Each of these questions has significant importance for the politics of healthcare in Australia and beyond.

My awareness of the AIDS epidemic was stimulated by the invitation which I received to address one of the early national conferences on AIDS[6]. In the way of these things, one conference led to another. I was soon appointed to the World Health Organisation Global Commission on AIDS. I began to know some of the leading scientists, epidemiologists and ethicists working in the field of HIV/AIDS. I also began to see the sharp edge of the epidemic in the illness and death of close friends who became infected with the virus. I could also see the exhaustion of their families, partners and healthcare workers.

My involvement in genomic issues has been more recent. It arose out a conference which I attended in Bilbao, Spain. At that conference there were four Nobel Laureates whose work was instrumental to the early development of the Human Genome Project. This is the greatest scientific cooperative project in history. I was astonished both at the remarkable scientific potential of the work, as described, and at the almost total lack of public knowledge and debate about the ethical

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6 M D Kirby, "AIDS Legislation - Turning Up the Heat" (1986) 60 ALJ 324.

implications. In particular, the ignorance within the legal profession of the Human Genome Project and of its many legal ramifications required, as it seemed to me, correction and redress. I suppose that it was my early exposure to Methodist parsons that led me to assume the self-appointed mantle of the educator of the Australian legal profession on some of the issues presented by the advances in genetics. I wrote up the conference in Bilbao, Spain. My article was published in the *Australian Law Journal*[7]. I began to talk on the topic at conferences[8] and on the radio[9]. Probably because I had been critical of the Human Genome Organisation for failing to ensure that the ethical debate proceeded with the same energy as the scientific research, I was invited last year to join the Ethics Committee of the Organisation. I will shortly be proceeding to San Francisco for a meeting of that body. Then, out of the blue,

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7 M D Kirby, "Legal Problems: Human Genome Project" (1993) 67 ALJ 894.

8 eg M D Kirby, "The Human genome Project and Society", unpublished address to the Federation of Asian and Oceanian Biochemists and Molecular Biologists, 7th Congress, Sydney, 28 September 1995; M D Kirby, "Bioethics, the Human Genome Project and Our Future", unpublished address to the Australian Bioethics Association, Fourth National Conference, St John's College, Brisbane, 25 September 1995.

9 M D Kirby, "The Challenge of the Human Genome Project" (1996) 9 *Australian Biologist* at 103. The subject was also dealt with in the Australian Broadcasting Commission's programme Ockham's Razor and in a programme of the Law Report in October 1996.

the Director-General of UNESCO asked me to join the International Bioethics Committee. This is the body which is preparing a Draft *Convention on the Human Genome*[10]. I hope to attend a meeting of the Legal Committee of that body in Paris in late December.

Out of recognition of the importance of medical and healthcare issues for the future of human rights, the International Commission of Jurists has accepted my recommendation that it adopt, amongst its future human rights concerns, the following topics of relevance to health, law and ethics:

1. The human rights of homosexual and bisexual men and women;

2. The human rights of drug users and drug-dependent persons;

3. The human rights of people infected with HIV/AIDS; and

4. The human rights of future generations, including of the human species as it will be affected by the Human Genome

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10 UNESCO, Preliminary Draft of the *Universal Declaration of the Human Genome and Human Rights.*

Project, by modern information technology and by other contemporary technological developments.

APPEARANCE & REALITY

You could say that the foregoing tale of issues of health, law and ethics, of which I have briefly reminded you, demonstrates what can be done by a somewhat pushy individual who sees futuristic topics before others do and runs with them, making every post a winner. I confess that it looks a little that way, viewed in retrospect. But that is not the whole story.

I did not ask the Federal Attorney-General, Mr Bob Ellicott, to give the forward-looking project on human tissue transplants to the Law Reform Commission. It was entirely his own idea. He, and not I, must take the credit for seeing the importance of that topic. So it was with the other projects of the Law Reform Commission mentioned. And in any case, each of the projects was led by a distinguished Commissioner and involved a team of highly talented lawyers, with specialist consultants who engaged in extensive community debate. For example, the project on human tissue transplants was led by Mr Russell Scott whose

book *The Body as Property*[11] is a masterpiece. The Commission for that project included lawyers of great reflection who went on to the highest offices in our country. The included Sir Zelman Cowen who became Governor-General and Sir Gerard Brennan who is now Chief Justice of Australia. None of the projects in which I have been engaged has been a one-man-band.

The terrible devastation of HIV/AIDS has called forward excellent and thoughtful work in Australia and overseas, including on ethical[12] and legal[13] issues. My interest in the topic may have been early for Australia. But all I did was to communicate some of the issues that were then being addressed in United States law journals. I suspect that it was no more than the novelty of a judge expressing interest in the ethical and legal implications of the epidemic that occasioned my appointment to the Global Commission on AIDS. But that has led onto involvement in numerous international activities since: most

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11 Viking, New York, 1981.

12 D C Jayasuriya (ed) *HIV Law, Ethics and Human Rights,* UNDP, New Delhi, 1995.

13 J Godwin and Ors *Australian HIV/AIDS Legal Guide* (2nd ed), Federation, 1993. See also D C Jayasuriya, *AIDS - Public Health and Legal Dimensions*, Nijhoff, Dordrecht, 1988.

recently in Geneva in September 1996 at a consultation on HIV/AIDS and human rights[14].

Similarly, it was pure chance that led to my involvement in the meeting on the legal aspects of the Human Genome Project in Bilbao. Before that time, I had been participating in a series of meetings, having nothing to do with the Human Genome organised by a Spanish Foundation concerned with many social questions. It just happened that the Foundation (the BBC Foundation) had previously conducted meetings on the scientific and ethical implications of genomic research. When it decided to convene a meeting on the legal issues, I assumed that my name popped up.

So, far from being a cleverly crafted, well-conceived and pre-planned exercise of rationality, my involvement in each of the projects that took me into fields relevant to the politics of healthcare, has been as serendipitous as the lives of each member of my audience. One thing has simply led to another, just as, in life, one day leads to the next.

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14 The report of that consultation will be published by UNAIDS and the U.N. Centre for Human Rights later in 1996. Cf J Mann and Ors, *AIDS in the World - A Global Report*, Harvard, 1994.

## FIVE ABIDING THEMES

The advent of a lecture named for me has caused me to ask myself what, if anything, I have done to deserve such an honour. That, of course, is for the sponsors, and you, to decide. Perhaps after this inaugural lecture the series will be renamed when the sponsors realise the awful truth that their hero is a mere accident of timing and that there are others with greater deserts for an eponymous lecture. Brennan, Cowen or Scott in the field of human tissue transplants. Charlesworth or Chalmers, Nicol or Skene in the field of genetics. Patterson, Hamblin or Watchirs in the field of HIV/AIDS. Singer, Kühse or Tom Campbell himself in the general field of medical ethics.

A few issues only I have sought to contribute. I will state them, as I think they may be important:

1. ***Open debate:*** The first is that, as civilised citizens, we have an obligation to raise questions concerning health, law and ethics as often and as loudly as possible so that more and more of our fellow citizens will think about them. So that more of our political leaders will realise that they exist. So that it will be understood that they are not issues, as such, for experts only - although expert analysis can help. They are questions upon which every thinking citizen needs to be informed and about which the opinions

of fellow citizens have a legitimacy which must be recognised by the experts;

2. ***New technology: new problems***: The second is to be alert to the constantly changing mosaic of the legal and ethical issues relevant to healthcare. To realise that the great engine of our time is science and technology and that it has extremely important and constantly changing implications for healthcare. No sooner do we think that we have reached a solution to one vexed topic (say, artificial insemination donor) that another (say, human tissue transplantation or in vitro fertilisation) comes along. No sooner are we done with this than still further problems present (say, legislation on euthanasia or the puzzling dilemmas of genomic research). The ethical dilemmas in the field of healthcare are unending. Science and technology promise that, far from becoming simpler, they will become much more difficult. And they will be unyielding. They will relentlessly continue to present themselves. Those that are interested must be ready to meet them. They should develop techniques for their consideration and solution, realising that solutions are rarely final because, with changing technology, come changing dimensions of the problems;

3. ***Inaction is a decision***: The third is to appreciate that to do nothing is, in effect, to make a decision. To do nothing

about HIV/AIDS is to condemn fellow human beings, without vaccine or cure, to infection through ignorance or because society is unwilling to take the hard decisions that will contain the spread of the virus. To do nothing about in vitro fertilisation is to paper over the cracks of the ethical and legal dilemmas raised and to ignore the substantial questions of resource allocation which the technique presents. To do nothing about the future lines of genomic research may be to countenance animal/human hybrid experimentation or manipulation of the germ-line of the human species. It may be to permit the creation of a "super-species" and genetic developments that cannot easily be foreseen. The four Nobel Laureates at the Bilbao conference I mentioned joined in an appeal to the final session of the conference urging a moratorium on all experimentation which would affect the human germ-line. Genomic experimentation should be restricted to living patients who stand to benefit (and are at risk of suffering) from it. The human rights of future generations should be left intact at this stage of human knowledge. Yet unless law, perhaps international law in the form of the UNESCO Convention, can provide effective prohibitions, what is there (save funding controls) to prevent scientists in the quest of fame, fortune or simple curiosity, from pursuing their experiments as they think fit? It is extremely important to realise in the field of modern medical research that to do nothing is to make a decision. It does not leave

things as they are. This is because science and technology are constantly changing the reality of this world;

4. ***Assisting democratic institutions***: The fourth is the importance of helping our institutions to cope. Those who, like myself, believe in the essential wisdom of democratic institutions and are servants or supporters of Australia's democratic Constitution, must assist our democracy to face the dilemmas and puzzles of recent developments in health, law and ethics. These dilemmas present novel challenges to the organs of democracy which they find it difficult to solve. Recent debates in Australia (including some still current) demonstrate the strong passions which can be engendered, on both sides. They can encompass issues involving the legal and ethical ramifications of healthcare. The debates concerning the state of the nation's abortion laws surfaced in the High Court in an appeal from a New South Wales Court of Appeal decision in which I had participated[15]. The settlement of the appeal means that we will not have a decision of the High Court on the topic, at least at this time. It is worth commenting that there is no immediate evidence that the democratic

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15 *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47 (CA).

legislatures of Australia are rushing to fill the gap or to examine and settle the expressed doubts. On the contrary, they seem only too prepared to leave abortion law alone. This seems to be so despite significant and relevant changes in social attitudes and medical practice in recent decades. Similarly, the issue of access to medical records in the possession of private practitioners was the subject of court decisions, including recently of the High Court[16]. That was also on appeal from an earlier decision in which I had participated judicially[17]. The High Court rejected the attempts to extend, in this country, an enforceable legal right such as had been found in other jurisdictions[18]. In Australia, it seems, the provision of such a right must await legislation. Although the former Federal Government had foreshadowed such legislation, its passage is now uncertain. Important questions are therefore raised in Australian courts. There, judicial decision-makers cannot usually avoid the provision of answers. The democratically

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16 *Breen v Williams* (1996) (as yet unreported).

17 *Breen v Williams* (1994) 35 NSWLR 522 (CA).

18 See eg *R v Mid Glamorgan Family Health Services Authority; Ex parte Martin* [1995] 1 WLR 110; [1995] 1 All ER 356 (United Kingdom); *McInerney v MacDonald* (1992) 93 DLR (4th) 415 (Canada); *Cannell v Medical and Surgical Clinic* 315 NE 2d 278 (1974) (United States).

elected parliaments have not always been so forthcoming. As the recent cases on abortion and access to health records have demonstrated, these are topics upon which passions are easily raised. Interest groups can soon be attracted on each side of the debate. Strong arguments can be expressed, some of them resting on rational discourse; some resting on dogmatic or religious belief; and some grounded in emotion and deeply held feelings. Alas, these tend to be either the topics which democratically elected politicians prefer to leave alone. Or they attract passionate and conflicting opinions which engender more heat then light and result in an impasse in the democratic lawmaking process which brings little credit to the legislators. Such inaction may be inescapable in some topics. But as a general response to the legal and ethical controversies of public health, it is neither good for health nor for the democratic character of our society. This is why new means are needed to assist in promoting rational discussion and the provision of principled solutions for difficult problems. The Law Reform Commission, and similar specialist and interdisciplinary bodies, provide one model of the kind that is needed. I like to think that the Australian Institute of Health, Law and Ethics will provide another and additional model.

5. ***The intellectual challenge***: Finally, to engage in these debates is worthwhile in itself as an intellectual exercise.

It is also intensely fascinating. This is because the legal and ethical issues of public health are extremely interesting and important topics. They tend to touch deep wellsprings of human existence. One must not stereotype. However, my own experience has been that the people engaged in medico-legal-ethical questions, relevant to health, are extremely interesting and highly stimulating colleagues who can see the importance, high controversy and subtlety of the questions presented for answer. The dilemmas that are posed are worthy of attention. Because they concern basic questions of life and death, of pain and human suffering and, now, of no less than the future of our species, they are specially worthy of attention. For me, they present a never ending kaleidoscope of intriguing problems. Humanity has its intelligence in order to puzzle its way to informed answers. That is why I am specially glad that this Institute has honoured me by this lecture. I hope that some of the themes of my own life in this area will continue to inform the lectures that may follow.

## THE POLITICS OF HEALTHCARE

I realise that the theme of the 1996 conference of the Institute is the politics of healthcare. When a judge - especially a Justice of the High Court of Australia - hears the word "politics", he or she tends to take cover. Especially when it is revealed that politicians will be taking a (most proper) part in the conference.

And especially when it is remembered that healthcare is one of the most hotly debated political topics in this country upon which there are legitimate differences of opinion reflected in party-political programmes. I was reminded of this when I saw the recent headline in the Canberra Times[19]: "Opposition to Fight Limit on Medicare Numbers: Lee". Rationing health care is always a sensitive topic. So I must tread with care.

It would be inappropriate for me to enter too deeply into the politics of healthcare, at least so far as the political choices involved are those which are bound up in the healthy party disputation which is a feature of our democracy. In such matters, most of you are much freer than I am. Nevertheless, in a general sense and without partisan commitment, it is possible for us to recognise, in recent years, a growing understanding that the allocation of healthcare resources has an ethical dimension which sometimes presents itself in a legal case and which is ultimately the source of competing political strategies, advanced for popular endorsement.

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[19] The Canberra Times, 4 November 1996, p1.

In 1990, the National Health and Medical Research Council of Australia, in its Discussion Paper on Ethics and Resource Allocation said:

> "In the allocation of any public resource our concern should be primarily with justice. This involves giving to each person his or her due. In allocating healthcare resources our concern is largely with the distributive justice - to distribute among members of the community those benefits and burdens due to them. The basis of distributive justice is the notion of fairness. The most appropriate criterion for a fair distribution of resources would appear to be those of equity and need. More specifically, a just allocation should offer equal treatment to those whose needs are similar. In other words, each person is entitled to enjoy an appropriate share of the sum total of resources available according to their need. However, the need which justifies one person's entitlement must be a need which can be fulfilled in a way compatible with fulfilling the similar needs of others"[20].

The problems of ethical decision-making in the allocation of healthcare is as ancient as the allocation of the scarce resources of medical and nursing attention and of available therapies. The triage in every modern hospital represents the daily application, in the most basic way, of the allocation of scarce healthcare resources. Recently, writers have been attempting to reduce the norms to be applied to the problem of allocation to scientific formulae. A typical analysis is that of M C Weinstein and

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20 NH & MRC Australia, *Discussion Paper*, AGPS, Canberra, 1990.

W B Stason[21]. They attempted the expression of a formula which would take into account direct and indirect costs of hospitalisation, physician time, medications, laboratory services, counselling and other ancillary services together with a component for the adverse effects of treatment and another for savings in healthcare, rehabilitation and custodial costs resulting from the prevention or alleviation of disease. In their equations, a component was also allowed for the cost of treating diseases which would not have occurred if the patient had not lived longer as a result of the original treatment. The writers then compare these costs with quantitative measures for the increase in the expected number of life years. They acknowledge that it is necessary to inject a controversial factor for "quality-adjusted life years". This unscientific, or at least unmeasurable, factor injects matters of opinion upon which there could be no consensus.

Whilst this approach is an interesting one, and has the benefit of identifying some of the considerations which might otherwise be taken into account only subconsciously, it could not pretend to be a complete analysis. For example, it makes no

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21 M C Weinstein and W B Stason, "Foundations of Cost-Effectiveness Analysis for Health and Medical Practice" 296 New England J Med 716 (1977) quoted in W J Curran and E D Shapiro, *Law, Medicine and Forensic Science,* 3rd ed, Little Brown and Co, Boston at 726.

provision for opportunity costs involved in providing a particular treatment or technology to a particular patient. Nevertheless, as economists have increasingly come to dominate political life in societies such as Australia's (including in the law and in healthcare) it is inevitable that the politics of healthcare will take on more and more of the jargon of economic cost analysis. So we should all be aware of it. Politicians and officials certainly are.

There is a danger in this development, as every person working in the healthcare field with real human patients quickly realises. Equations fail to measure the precious quality of the individuals concerned to those who love them. They cannot look on them as simply the consumers of an economic resource. In purely economic terms, it could possibly be argued that we would do better to withdraw entirely public funds from the in vitro fertilisation programme. Similarly there are doubtless some who would argue, on cost/benefit grounds that we are not spending the health dollar effectively on the highly expensive therapies available to improve the quality of life and prolong the existence of people living with HIV/AIDS. The decisions which we make on these topics are complicated by the fact that we know individuals who have experienced the great suffering of childlessness and the exquisite joy of childbirth by the IVF process. We also know courageous friends and their wonderful carers who live very day in our midst with HIV or AIDS. It is this additional ingredient - the human factor - that adds to the complications of attempts to reduce the allocation of healthcare

resources to a scientific formula. Even if it could be done, there would remain acute and continuing problems. Might there be greater benefits to society, as a whole, in spending scarce resources on other technologies or therapies for different people? In the spending of funds on prevention rather than on the treatment of ill-health? In the spending of funds on education or on beautification of the environment? Or in just reducing the $8 billion budget deficit in the hope of stimulating more jobs that will get young people off the streets, reduce civic despair, prevent the emergence of a permanent underclass and reduce the incidence of drug-dependence, crime and other evidence of social escapism.

These are the reasons why many commentators on this subject see it as vital to expose the dilemmas which are faced by individual healthcare workers and by society as a whole. Various writers express this thought[22]:

> "At present these decisions are taken by large numbers of physicians working in isolation, and the result is a haphazard aggregation of individual decisions. Effectively, society is represented in the decision-making process by samples of one, which ... is unrepresentative and thus inescapably unsatisfactory. Society should not ask doctors to

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22 P A Lewis and M Charny, "Which of Two Individuals Do you Treat When Only Their Ages are Different and You Can't Treat Both?" in J Med Ethics, 1989, 15 at 18.

> bear the burden of decision-making, not only because it is inefficient but also because the choices (as distinct from the implementation of those choices) should have a social rather than a professional base."

We may not agree that it would necessarily be a step in the right direction to turn all such choices over to a depersonalised social base, for fear that this would be grounded entirely in economic rationalism. Nevertheless, it is increasingly recognised that, in the allocation of the scarce resources available for healthcare, some decisions must be made which will have implications down the line for individual healthcare providers and their patients. Today those providers may even be policed by computer monitoring of prescription patterns and by caps on medical and other health benefits. At least the national and even international triage is now an issue which is out in the open. Healthcare workers have stopped "covering up for an inadequate health service". Increasingly, they bluntly disclose the choices that have to be made, including between, for example, the risk of the death of a particular patient and the scarce resources available to prevent or reduce the risk of such death[23]. Professor B V Johnstone contrasted the openness

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23 E D Ward, "Dialysis or Death? Doctors Should Stop Covering for an Inadequate Health Service" in J Med Ethics, 1986, 12 at 61.

which is now occurring with the alternative which formerly obtained:

> "Physicians, acting as gate-keepers, exclude some patients on a priori economic grounds based on government policies. Physicians might conceal the economic and political reasons for the policy behind statements that the patient is not suitable, or simply not mentioning the availability of the treatment. Such a process would violate justice in excluding the patient from being a participant in the decision. It would be morally questionable in inducing the physician to violate the requirements of his moral agency, specifically to forego the role of advocate for the patient, and to fail to honour his trust relationship with the patient"[24].

These are the reasons why many commentators on legal and ethical issues of healthcare advocate openness about the politics of healthcare decisions. Professor Margaret Somerville, an Australian now living and working in Canada, expressed this thought well. In a paper with the provocative title "Should the Grandparents Die? - Allocation of Resources with an Aging Population"[25], Professor Somerville concluded:

> "Unfortunately, we may not be able to find any 'right' answers - ones that harm no-one - in

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24 D V Johnstone, "Justice and Cost-Containment in End Stage Renal Disease", 3 J of Contemp L and Policy 65 at 84 (1987).

25 M A Somerville, "Should the Grandparents Die? - Allocation of Medical Resources with an Aging Population, 14 Law Med and Healthcare 3-4, 158.

> allocating medical resources with an aging population. We can, however, use 'right' decision-making principles and processes. General goodwill and personal conscience and integrity are essential traits but not sufficient approaches or safeguards in dealing with the issues raised. Examined cognitive and emotional responses and structures and disciplined procedures are also necessary. To develop these is one of the major challenges for contemporary health law and ethics. Such development is essential in the search for answers to the companion question of 'should the baby live?' and 'should the grandparents die?'. These answers will reflect some of the most important aspects of ethical and legal tones of our communities are we prepare to enter the 21st century"[26].

Some observers argue that an intuitive approach to decision-making and reasoning on these questions is more reliable and less self-deceptive than attempts to adopt scientific formulae informed by economic postulates and expressed in complicated equations. Yet the danger of intuition and generalised reasoning (such as we are used to in the courts) may be that their procedures mask unexpressed pre-conceptions, misunderstandings and prejudices. They may obscure assumptions and disguise the premises for decision-making. Just as technology reflects a more scientific world, so should our ethical decisions. They should aspire to greater precision, clarity and accuracy, at least in the procedures which we adopt. In the

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26 *Ibid,* at 163. See also G J Agich and G E Bagley, "The Price of Health" reviewed G Bevan in J Med Ethics, 1988, 14 at 53.

end, resource allocation, whether individual, national or international, involves a leap of human judgment. That may ultimately involve intuition. However, such decisions will be better made, and more likely to be just, if they are made after the accurate exposure of the most relevant pre-conditions for their making. Not only will that course submit those pre-conditions to individual and social criticism and possible change. It will also impose on the decision-maker a discipline and self-scrutiny which the vital importance of healthcare decisions demands from a civilised society. So that is where ethics enters the political debates about health care. It is why the work of this Institute is so important and potentially influential.

## CONCLUSION: AN AGENDA FOR DEBATE

I conclude as I began. In a life of many public opportunities and privileges, few have pleased me more than the decision of this Institute to name a lecture for me. I hope that the lecture series will encourage the pursuit of some of the themes which I have mentioned. Enlivening public debate on the legal and ethical issues of healthcare. Involving our fellow citizens as well as the experts. Enlivening the procedures of our democratic polity. Engaging the stimulating and interesting colleagues who make up this Institute in dialogue with each other, and with society, about the acute dilemmas that face humanity. Promoting a knowledge of the wonders of science and medical technology and their relevance to ethical decisions.

The dilemmas we have faced to date will be as nothing in comparison to those just around the corner in the new millennium. Of one thing we can be sure. There will be no shortage of topics for this lecture series. I am proud to have been asked to give the first. Those in the future will address topics which we cannot even imagine and dilemmas of the greatest difficulty and importance which confront our nation and face our species.