THE AUTONOMY MONOCULTURE

A Review of *Bioethics in a Liberal Society*

by

Hiram Caton

The Autonomy Monoculture

"There's a divinity that shapes our ends, rough hew them how we will."

Shakespeare

by
Hiram Caton

Max Charlesworth's *Bioethics in a Liberal Society*[1] may fairly claim to be an Australian perspective on bioethics. Through his service on a variety of state and national ethics committees, through his teaching, lecturing and writing, the author has exercised considerable influence. This offering is in part prompted by his experience. Its principal aim is to help correct paternalistic tendencies that diminish autonomy in Australian health services.

This intention is signalled by the "liberal society" designation of the title. Such a society is characterised by "unconditional respect, as Kant would say, for personal autonomy, and that carries with it a respect for ethical pluralism and a resistance to the state and the law intervening in the realm of personal morality or ethics" (pp. 153, 1). The idea of autonomy "is blindingly obvious . . . it simply means that if I am to act in an ethical or moral way I must choose for myself what I am going to do" (p. 10). Moral agency is accordingly defined as "conscientiously and deliberately decid[ing], for serious reasons, [what I shall do]" (p. 35). Again, "the right to control and determine our lives and to decide how we shall live . . . is what is meant by autonomy" (p. 36). From these positive characterisations a list of negatives is derived. Autonomous individuals do not submit to the judgments of others. They do not accept the ethical doctrine of any party or church. They reject custom, habit and tradition as reasons for action or ethical judgment. They do not acquiesce in fate or

---

[1]Max Charlesworth, *Bioethics in a Liberal Society*, Sydney: Cambridge University Press, 1993. Pp. 172.

chance or nature's course—a matter of particular importance for the ethics of end-of-life decision making (p. 33).

How can a social ethics be extracted from the rock of such adamantine individualism? In Australia, individualism was long identified with laissez-faire economics and its Let-Them-Perish social ethics. Ethical thought in labor and in church circles—dominant intellectual influences until recently—equated liberal ethics with a personalist apologetic for capitalism. The idea that the liberal society unconditionally respects all persons was contrasted with the realities of dehumanising class dominance. The reality of market freedom was said to be economic exploitation. In a word, liberal ethics was perceived to preach laissez-faire in morals.

The religious, by contrast, said that ethics began with duty while socialists said that it began with solidarity. To them it was blindingly obvious that founding ethics on freedom was a formula for moral vandalism, much as the free market was formula for ruthless social triage. A world in which the state were deprived all ethical legitimacy was said to be a world of absurdity and paradox. J. S. Mill's shocking dictum, in *On Liberty*, that "all restraint, qua restraint, is evil," brought the logic of liberal ethics into the clear. Herbert Spencer's attacks on "misguided philanthropy" were no less telling. In correspondence with Mill about the proper sphere of government, Spencer declared that "the drunkard in the gutter is exactly where he ought to be." Spencer reasoned that the drunkard had *chosen* drink. The "law of equal freedom" gives effect to social triage only when philanthropists abstain from meddling to save abused or handicapped children, criminals, and other maladapted types. Meddling loads the public purse with an impossible financial burden and dishonors the drunkard's free choice to drink.

The haste of ex-socialist countries to implement free market thinking has driven from Australian ethics all but the shadows of the old mistrust of liberalism. Charlesworth alludes to it in passing remarks denying that liberal ethics is atomistic and anti-social. He endorses welfare state paternalism in saying that the liberal society has an obligation to ensure equal opportunity for the exercise of autonomous choice (p. 5).

The author does not make it as clear as he might that liberal theory today is split into warring camps. One camp, which we may call "socially responsible liberalism,"

rests on the thought of John Rawls, Ronald Dworkin, and others. Its antagonist is the market-oriented libertarianism of Hayek, Friedman, and Nozick. Libertarians affirm—as does Charlesworth—that freedom is the "supreme value" of the liberal society (p. 1), and that the individual is the locus of ethical choice. Socially responsible liberals, by contrast, constrain freedom by creating an obligation upon society to promote the equal welfare of all citizens. The postulate generates the notion of justice as fairness. It also creates a second ethical subject, "society," more fundamental than the individual.

Society is a collective entity, ontologically quite distinct from the choosing individual. It is also armed with coercive powers to enforce the many legal and welfare measures meant to promote equality, e.g., non-discrimination and equal opportunity legislation. As an ethical subject, society combines the uncontrolled free will of the individual subject ("sovereignty," that is, being everybody's boss) with a paternalistic duty to care.

For libertarian liberals, society as subject is a fancy way of sanctioning age-old bureaucratic despotism in ostensible liberal dress. They decry the inconsistency of ontologically distinct ethical subjects, and argue that conflicts will be resolved not justice but by the greater might of "society." Socially responsible liberals are said to espouse a monster theory to legitimate the a monster Leviathan imposing visions of the good espoused by aggressive minorities.

Socially responsible liberals counter this criticism by limiting society's coercive obligations to a short list of consensual "basic goods" defining the welfare agenda. Further, society is construed as an impartial arbiter of social and political contests over the private, "perfectionist" goods sought by individuals and groups. The arbiter's role is to see that no group imposes its notion of the good on the non-consenting majorities.[2] Socially responsible liberals claim that society as ethical subject is only a policeman to keeep the playing field level.

The rejoinder complains that this solution is purely verbal. The impartial arbiter smuggles a private morality and a disputatious utopia into the supposedly innocuous

---

[2]The most recent statement of this position is John Rawls, *Political Liberalism*, New York: Columbia University Preess, 1993.

list of basic goods. Critics also complain that the impartial arbiter construct has no empirical reference. The idea is found in the jurisprudential notion of "the legislator," and secondarily in the common law notion of "the reasonable man." But courts today are not perceived, even by themselves, to be impartial. The Australian High Court and the U.S. Supreme Court state that judges do and should make law active participants in social change. Critics call it 'culture wars," and decry the danger to liberty.[3]

Charlesworth's study does not confront this bundle of contradictions at the heart of liberalism. He is a pragmatic liberal who changes tack between socially responsibility and libertarianism as occasion may suggest, always with a view to boosting the stock of individual choice within the ambience of paternalistic welfare institutions.

The source of his autonomy concept is a combination of classical liberal thinkers and Existentialist conceptions of self. He commends Jean-Paul Sartre's "ethics of authenticity," whose first commandment is "always act as one who is self-determining and responsible for what one does" (p. 14). Its corollary is that the attempt to evade freedom, by seeking confirmation in the collective certainties of creed, party, or nation, is "bad faith." Does this mean that the authentic individual never takes direction from the boss, and hence belongs to the ranks of the self-employed (Sartre) or the unemployed (the flower children)? We are not told. In any event, Sartre's spiritual exercises to liberate the self from the repressive bourgeois mentality blends easily with reprobation of the "tyranny of the majority" and "despotism of custom" that Mill claimed was the "standing hindrance to human development." The common people, Mill said, are capable of no genuine moral agency; they are limited to "ape-like imitation." Sartre expressed a similar thought in his *mot*, "Hell is other people." The beatific state is Me.

Despite the author's assurances, the autonomy he evokes is the flamboyant delinquent that it ever was. Defiance of authority, contempt of the everyday, literary tantrums, and wilfulness are not auspicious ground for ethics. Medical ethics begins

---

[3]See J. D. Hunter, *Culture Wars: The Struggle to Define America*, New York: Basic Books, 1991, and John Gray, *Liberalisms: Essays in Political Philosophy*, London: Routledge, 1989.

with duties: to heal and to comfort, and to abstain from retaliation even when autonomous patients throw tantrums in Casualty. These duties are perennial. But in addition, medical practice is not the free profession that it once was. Practice is integrated into a "health care system" heavily prescriptive of the circumstances of patient care. Many institutional norms must be observed; patient rights must be respected with the eye of the lawyer; the battle with health bureaucrats and committees is constant; resource allocation is distorted by the politics of consumer group pressure, and so on. Autonomy hardly seems a relevant ethics for care-givers operating in such an environment. The "therapeutic state," as the health system is sometimes called, is not liberal in the author's sense.

This is acknowledged. The health system is said to be "depersonalised" and "there is a strong tendency towards bureaucratic paternalism and a real danger that the autonomy of the patient will be devalued" (p. 58). And not only the patient: also medical staff, as Charlesworth is careful to note. From whence does the bureaucratic paternalism stem? In large measure it is the effect of society as ethical subject implementing its commitments to promote a perfectionist vision of the good, called welfare.

Let us consider a consensual application of coercion to autonomous delinquents: the administration of criminal law. Dostoyevsky, Nietzsche, Sartre, Genet, and other explorers of "experiments in living" recognised that felons and suicidal persons had reached a certain level of liberation from conventional opinion that must be appreciated by a philosophy that sanctifies the will. Dostoyevsky realized that if individual will is the basis of ethical choice, then everything is permitted. Sartre developed this concept in his drama *Dirty Hands*, where the hero, a revolutionary fanatic, says: "I have dirty hands right up to the elbow. I've plunged them into filth and blood. Do you think you can govern innocently?"[4] It is disappointing that, having quickened interest in autonomy, Charlesworth does not explore the exotic landscapes developed by philosophers who conceded parity of esteem to the Wicked and went "beyond good and evil." We are offered instead some specimens of middle class desire.

---

[4]On the dirty hands problem, see Martin Hollis, "Dirty Hands," *British Journal of Political Science* 12 (1982): 385-398, and Stephen Lukes, "Marxism and Dirty Hands," *Social Philosophy and Policy* 3 (1986): 204-223.

He is even silent about the principal "crime" of Existentialist philosophy, the "deconstruction" of rationality as a tool for institutional control. In other writings Charlesworth promotes "deconstruction" because believe in policy rationality helps legitimate bureaucratic control. Questioning objectivity by showing its derivation from specific collective choices subverts bureaucratic legitimacy. This hide-and-seek game is commonplace among patient advocate groups. Charlesworth doesn't play it in the present study, presumably because he wants to persuade health bureaucrats. He marginally champions patient autonomy against the institutional paternalism without subverting the bureaucrat's legitimacy. His discussions of euthanasia, assisted birthing, and health care resource allocation are meant to illustrate how this may be done.

E u t h a n a s i a . It is an irony of progress that dying has become a "problem" around which a consumer interest has developed. We have life in such surplus that we don't know what to do with it. Since 75-85 percent of OECD populations die in institutions, institution-compatible solutions must be sought. The author's contribution consists mainly of challenging habitual ethical restraints on assisted suicide. He is cheered that the right to assisted death is increasingly recognised among caregivers (pp. 34f, 42). This is a "progress of moral consciousness [that] one has a right to control and choose the way one dies . . ." Since dying is the "most important act" (an Existentialist notion), one should control it (because willing is sacred). Submission to fate, chance, or God denies autonomy. Choice in dying should be encouraged because it promotes autonomy, and "autonomy is something you can't have too much of" (p. 34). No doubt, autonomy is wonderful thing. Anyone can claim that they have it; or that someone spirited their share away. Nobody can tell who has how much of it, nor how they got what they have. Lawyers and psychiatrists can make it appear or vanish, as circumstances require.

Having established by such reasoning a "moral right" to suicide, he infers that "I have a right to ask another to assist me" (p. 37). Undoubtedly; it happens every day.[5] But should it should be legal for the physician to assist? Alternately, should it

---

[5]At a recent conference on euthanasia, an oncologist reported that patient requests for assisted dying were frequent. He advises patients that he cannot comply. However, he offers to prescribe an analgesic with a warning not to take more than

be a legal *duty* for physicians to assist?. The second option has been trialed in proposed euthanasia legislation; Australian doctors will not have it. As for the first option, Charlesworth points to the Netherlands, where physician assisted death is common. Unfortunately, he does not evaluate the Remmelink Report on the practice of euthanasia in the Netherlands. We know from that Report, and the discussions it has provoked, that doctors commonly disregard the guidelines for administering the lethal potion. They often do not obtain the opinion of a second physician. They also often disregard the key distinction between allowed voluntary euthanasia and prohibited involuntary euthanasia. The Van Der Maas survey confirms hear-say that doctors who assist in dying are likely to regard such decisions as part of medical competence and hence see no need for a second medical opinion (the metastatic cancer patient is obviously finished) nor—for the same reason—the consent of the patient.[6]

Autonomy is a double-edged sword. If it creates respect for the wishes of the dying, it also supports the resolve of physicians whose concern for dignity and resources moves them to deal with patients who "stay at the table after the meal is over." As far as I can see, Charlesworth provides such physicians no reason for respecting patient wishes when they are contrary to physician rationality. He endorses Robert Weir's complex administrative machinery for control of assisted suicide (p. 54). But he ignores how the safeguards of the Netherlands machinery have been streamlined in practice. His statement that doctors may not be reduced to hired servants or plumbers (p. 120) gives encouragement to Dutch practice. He requires of patients that they recognise "some degree of justified paternalism where the patient cannot, or is unwilling to, take responsibility for his or her own health-care decisions" (p. 121). The patient must also realise that doctors have duties to the community as well as to patients (p. 141).

---

five pills at once. No patient had ever used this indirect assistance. He concluded that the request for death was an oblique cry for solace.

[6]See John Fleming, Euthanasia, The Netherlands, and Slippery Slopes, *Bioethics Research Notes* Occasional Paper, June 1992; John Keown, Down the Slippery Slope: Further Reflections on Euthanasia in the Netherlands in Light of the Remmelink Report and the Van Der Maas Survey, in Luke Gormally, ed., *Euthanasia, Clinical Practice and the Law*, London: Linacre Centre, 1993.

Thus it is acknowledged that autonomies are in competition, and that individual autonomy competes with the basic goods that the society as ethical subject is duty-bound to uphold, coercively if necessary. He mentions as an example of this dilemma the debate about whether standard epidemic containment measures should be invoked to control the transmission of HIV (p. 138ff.). Libertarians contend that the state may not intervene to control sexual practices because sexuality is a private matter. But they also deny that the state has any business protecting homosexuals against private acts of discrimination. Socially responsible liberalism, as we know, has levelled the playing field by decreeing laissez-faire for sexual practices and public interest intervention to prevent private acts of discrimination.[7]

Australia's peak public health body recently launched a study that gives effect to concern about rising suicide rates among youth, schizophrenics, and indigenous peoples. The aim is to "enhance individual and community resilience to suicide and suicide risk factors," identified as social alienation and substance abuse. Suicide is construed to be self-damaging behavior that society is obliged to diminish. There is no hint in the policy documents that suicide should be respected as a decision "conscientiously and deliberately" made for "serious reasons," even though persons in suicidal states are nothing if not serious.

Libertarianism reprobates meddling in this case. In Mill's Faulty Bridge test of permitted intervention on behalf of the perceived good of others, we are permitted to caution, but not to attempt to change the life-style of persons at risk. The duly cautioned suicide dangling from a rope is exactly where she wants to be.

---

[7]No doctrine is dearer to liberalism than the removal of sexual practices between consenting adults from the agenda of public scrutiny and legal surveillance. Measured by this standard, no society today is liberal. The media take an intense interest in private engagements of prominent people, to the point that they may be compelled to withdraw from high office. Similarly with law. Although sodomy has been widely decriminalized in OECD countries, rape within marriage, never before an offence, now is an offence in many jurisdictions. So is spouse battering even when it occurs as sado-masochistic sexualtiy. In addition, sexual harassment and sexist language have been defined as offences. I cannot find in Charlesworth's study any objection of this massive re-entry of the police into the bedroom.

Such talk would shock health bureaucrats. When we assume the persona of the health bureaucrat, intervention is thought to be the appropriate expression of core social values that deem the life of street kids to be self-damaging and unchoiceworthy. This is paternalism, but what is paternalism but the autonomy of fathers as carers? Despite his respect for the wishes of those for whom death is "the most important act," Charlesworth's silence bows to this sentiment.

The autonomy concept, like the closely related informed consent concept, lacks a procedure for deciding when a judgment is autonomous. Charlesworth acknowledges that autonomy is a matter of degree, but he does not provide exemplars of these degrees. Some acts that meet his criteria of autonomous choice are atrocities e.g., Baruch Goldstein's murder of Palestinian worshipers in the Hebron mosque. Given that for the author an autonomous choice is ethically superior to choice made habitually, the Hebron massacre poses a serious problem of the ethics proposed in this study.[8]

Other problems lie just under the surface of the discussion of euthanasia. As is wont with liberal ethics, the focus is the choosing individual in disregard of institutional context. Thus the "progress of moral consciousness" in the Netherlands has been influenced by the charisma of Dr. Pieter Admiraal. He is a cult figure, admired for his candour, courage, wit, and humanity. His influence confined to the Netherlands. I have the impression that he is to Australian pro-euthanasia doctors what R. G. Edwards is to Australian IVF doctors: the font of medical skill *and* ethical wisdom who pioneers a new doctor-patient relation. Characteristically, Dr. Admiraal begins his lectures by declaring, "I have killed a thousand patients." It is not the beginning of contrition but of jubilant vandalism against the old ethic that hallowed the human inhibition on killing. The inhibition can be loosened in many ways, but the most common is to create a solidarity whose *esprit de corps* supports a killing ethic.

---

[8]Although Goldstein acted alone, his community responded to his deed by elevating him to sainthood. From the age of six, boys of this community often rehearse, in play and song, the valor of killing "Arabs." The word as they speak it conveys the same feeling as "niggers." Their indifference to the suffering of Palestianians is complete. Given this social climate, did Goldstein act autonomously, or did he act on behalf of the community, conditioned by it? I doubt that ethics can decide this question, if indeed it is decidable.

Military codes of honor, and to a lesser degree police codes, exemplify what is meant. Dr. Admiraal trains a new army of *ethical* soldiers by denigrating the fecklessness and timidity of the old civilian medical ethic. He imbues his fledglings with the exhilarating confidence of sickness police who accept that terminating life is integral to the physician's art. They accept the moral challenge of autonomously deciding life and death for those in their care.

The self-indoctrination of Admiraal's disciples is thorough. Having persuaded themselves of their benevolence and higher sense of justice, they are immune to warnings about the German euthanasia catastrophe, even though their contemporary German colleagues document that the German doctors also believed that their hands were clean.[9]

It is not the style of this work to examine the deeds of autonomous agents that might cause disquiet. Charlesworth does not examine the promotion of permissible homicide by ethicists. A discussion of Michael Tooley's 30 day probationary period in which new-borns must demonstrate their fitness or die, and the exhortations of Helga Kuhse and Peter Singer on lethal compassion, is noticeably missing. The author's one comment on the slippery slope is that "there is a fine but important line between the patient making his or her own decision . . . and the physician making the decision while taking into account the patient's wishes" (p. 55). This mild caution is unlikely to raise dust. It will do little to dissuade those who have already slipped down the slope. Legal or bureaucratic accountability has little deterrent effect: since the autonomous person is, literally, a law unto himself, mere statute is a cage for cuckoos. In the Netherlands doctors account for about 20 percent of annual mortality. That figure could be extended upward . . . with a good conscience and no prosecutions.

Assisted Reproduction. Assisted reproduction is the area of medical service in which the autonomy principle has enjoyed some of its most splendid triumphs. It was among the elective services whose multiplication in the Fifties and Sixties paved the way for entrepreneurial medicine and its ethical flagship, patient

---

[9]Till Bastian, ed., *Denken-Schreiben-Töten: Zur neuen 'Ethusanasie-Diskussion*, Stuttgart: Hirzel, 1990. See also Robert Proctor, *Racial Hygiene: Medicine Under the Nazis*, Cambridge: Harvard University Press, 1989.

autonomy in medical decision making. On the old paternalistic model, the doctor was obliged to advise on the appropriateness, safety, and moral propriety of procedures. But that was time-consuming and provocative to patients who knew their mind. Autonomy stream-lined decision making to a "You want it, you've got it" the bottom line. If later patients wanted to undo the tubal ligation or vasectomy, well, that can be done too. Nevertheless, procedures paternalistic beneficence remained the underlying rule for the doctor-patient relation and patients continued to rely on their doctor's advice. How could it be otherwise?

Autonomy has not triumphed in Australian assisted reproduction. A national ethics body on which Charlesworth served recommended a middle way between rejecting surrogacy and endorsing the surrogacy contract. It recommended "controlled surrogacy," i.e., controlled by bureaucrats. Social welfare ministers declined to accept the committee's recommendation. While in vitro fertilisation is widely offered here, embryo experimentation is banned in some states and closely guarded in others. Fetal reductions are carried out, but they draw no applause. The field is harried by feminists who tirelessly document every mishap and potential mishap, and who deplore patriarchal control of women's bodies.

Charlesworth argues that only demonstrable harm countervails the liberal presumption of laissez-faire in reproductive choice. He would lift the ban on surrogacy and on assisted reproduction to single women. He quotes in support an American lawyer who extols the multiple freedoms afforded by assisted reproduction.

> Availability of the expanded set of choices invests individuals with greater control over their genetic, biological and psychosocial destiny and hence greater autonomy. The Constitution must protect decisional autonomy in procreation because our concept of liberty requires that the government leaves individuals free to determine issues so core to personhood.

I suspect that Charlesworth quotes American constitutional opinion because such stupendous valorisation of individual choice is unusual among our lawyers. He might have quoted the soaring poetry of Peter Singer's *The Reproduction Revolution*,

but Singer's views are not discussed in relation to this or any other subject—a notable silence for a book on Australian bioethics.[10]

The bottom line of autonomy in assisted reproduction is lucrative entrepreneurial medicine. The model for would-be Australian surrogacy services is the legally water-tight, piled carpet California surrogacy business. The California experience seems to refute, decisively, the feminist anxiety that the surrogate contract exploits vulnerable women to their detriment. Why is this promising data discussed? Probably because California is not in good odor as an appropriate model for Austrlian ethics. Family services hold to the "child as client" and "the best interest of the child" in opposition to reproductive services. As for the community view, national consultation revealed an aversion to the surrogacy contract as smacking of trade in babies.

There is currently a push, by ethicists and reproductive clinics, to roll back the 1991 Australian decision against surrogacy (it happened to coincide with a French court's termination of 10 years of tolerated surrogacy). The push is not likely to succeed. The birth of infants to post-menopausal women, followed by news that Edinburgh doctors intend to harvest ova from aborted fetuses, produced a backlash. The Australian Medical Association (and the French government) have declared against reproductive services for post-menopausal women. When journalists tested the concept of harvesting the ova of aborted fetuses, the reported public reaction was horror.

Rationing Benevolence. The third section of Charlesworth's book is about resource allocation, or as headline writers now call it, rationing. Socially responsible liberalism and free market liberalism propose very different solutions. Deregulation, and some element of User Pays, is the pathway of market-oriented solutions. In addition, the complex apparatus of the Quality Adjusted Life Year

---

[10]Charlesworth states flatly that utilitarianism is "philosophically incoherent" (p. 151). Mill is rescued from his own ligitimation of personal liberty by appeal to its social utility. Liberty, the author states, is an "intrinsic good" independent of social utility (p. 113).

(QALY) purports to offer a rational method for assisting treatment decisions. QALY is to such decisions what the market is for social decisions: an impartial arbiter. The data on individual patients are fed into the QALY algorithm and a list of value-weighted choices emerges from the computer, uncontaminated by physician bias and purified by thousands of cost comparisons. It seems an intelligent and just triage system.

Charlesworth is a critic of quality of life decision making. It confounds, he says, two senses of quality, the biological sense and the quality of life as experienced (52ff.). A life that seems miserable to the impartial observer may yet be precious to the person who lives it. His example is the Nazi euthanasia program administered to the mentally ill and to children with disability. One is reminded as well of Dostoyevsky's comment on his experience of epilepsy: "You all, healthy people, can't imagine the happiness which we epileptics feel during the seconds before our fit . . . I would not exchange it for all the joys that life may bring!"

I agree with the thrust of Charlesworth's criticism. QALY justice, like the lottery, does indeed allocate impartially. But the decisions that the QALY randomizer makes is a function of values built into the algorithm. For example, a current fashion among health promotion bureaucrats is to "compress" morbidity from two years to one. As resource competition intensifies, social worth criteria could easily be given greater weight in the QALY algorithm, and morbidity could be "compressed" by adding curare to decision options. Charlesworth does not contest QALY on the ground of justice but on the ground of autonomy: it ignores patient participation in decision making. But what if the patient is of diminished competence? Is the wish of the intellectually handicapped child, if any, to prevail over the QALY-informed prognosis of the physician? The Nazi doctors didn't think so and most utilitarians don't think so either. Charlesworth's proposed alternative is the Substitute Judgement test, which is that the authorised decision maker put herself in the place of the patient and ask:

> would the infant wish to lead such a life if it had the capacity of choosing for itself? Is there a chance, however slender, of the child doing something, however minimal and for however brief a time, with its future life despite its physical disabilities; or are those physical disabilities so grave that it could not possibly give any worth or value of human meaning to life? Willy nilly

> we have to make decisions for such children and impute judgments to them (p. 52).

This looks like a loaded question. If, excersizing our autonomy, we ask the question differently, it becomes that Substitute Judgment blurs the fact that *we* do the judging. Is it not bad faith to shift the responsibility from ourselves to a non-competent patient? The relevant ethical question, it seems to me, has been grasped by Dr. Admiraal, the utilitarians, and the Nazi doctors: am I as a physician or ethicist prepared to assume responsibility for terminating life that is without social worth, knowing that there are many such lives?

Those who answer in the negative are obliged to propose alternative solutions to allocation dilemmas. Charlesworth's solution is community consultation, along the lines of the Oregon plan. He is aware that consultation is a messy process worrisome to the tidy minds of planners. The mess doesn't worry him because he sees patient autonomy protected by it. However, all community consultation presupposes identification (usually by health bureaucrats) of a set of values in whose terms the consultation is structured. Yet the liberal society, according to Charlesworth, has abandoned core values in favor of value pluralism. What is the basis for consultation if no core values or basic human goods enjoy a putative consensus?

Australian allocation discussions do not suffer from such value anemia. We have surfeit of value agendas driven by health bureaucracies, ministerial leadership, budget constraints, the medical profession and consumer interests. It is heroic indeed to visualise the outcomes of this process as the rational result of deliberation; or to propose that a single touchstone, like autonomy or beneficence, will answer for all our problems.

C o n c l u s i o n . The interpretation of autonomy advanced in this study stems from a philosophical subculture of the Anglo-Germanic ethnic community. It is an attempt to capture in reflection the rebellion whose popular vocabulary was the ecstatic language of Revolution. Its central conception is the polarisation that sets self-control in opposition to social milieu, in its many layers as upbringing, custom, law, institutions, or society.

The Self's negative relation to Other is integral to the creation of the open vistas signified by the phrases "experiments in livings" and "social change." These vistas are ingredient to that uniquehistorical phase of rapid all-sided change called "progress." An ethics for such an era needed to be Protean. An ethics that leaves the determination of the content of ethical practice to the will of each is suitably Protean, for it is a prescription for laissez-faire in morals.

Such openness may exalt imagination, but it may also depress it by an anguished vision of the nihilist Void. Existentialist philosophers have enriched our understanding of the *condition humaine* by describing this subterranean consciousness. They have also instructed us by the choices they made while experiencing the Void in its full force. Kierkegaard resolved his "sickness unto death" by the leap of faith. Sartre cast himself on the altar of the Communist Party. Martin Heidegger discovered that the "ecstasis" of National Socialist was salvation from the non-being of the everyday. Albert Camus chose suicide by crashing his car. These choices are instructive not least of all because they differ in no way from choices made by millions without the benefit of philosophical reflection.

It is well that this experiment with ethics has been tried, because it confirms by its fruits the soundness of other ethical traditions in which autonomy is conceived to be in need of social support for its nurture and practice. I have in mind the discipline of the monastery, of pietist schools, of craftsmen's guilds, of contemporary professional training. These diverse nurturings have in common that they conceive ethics as a competence governed by what the virtue ethics tradition calls *habitus*—a fixed disposition to act in a regular way. Thus the master craftsman is not, as the artist of today, one who expresses his creative impulse, but one who skillfully executes according to a prescribed plan. This conception does not exclude innovation and change, as the lives of St. Ignatius and Mahatma Gandhi show. But it is characterised by the notion that ethics is practice rather than theory, and that the practice is a specific competence, or craftsmanship, acquired only through discipline of thought, of heart, and hand. Autonomy is achieved by passing through the ranks of apprentice to journeyman to master. Discipline and custom are not hindrances to autonomy, but its condition.

Virtue ethics is the default ethics of institutions and professions because regularity, predicability, and competent practice are essential. Competence in ethical decision

making is possible only within the setting of *habitus*. One important witness to that effect is that the revival of ethics over the past three decades has been driven by "dilemmas" arising within specific professional horizons. The multitude of "dilemmas" as experienced by governments encourages the search for general-purpose decision making machinery. The development of Rational Choice Theory (the theoretical arm of economic rationalism) has been one response to this cry for help. Ethical theory has been another.

A general purpose decision making machine capable of dealing with the complexity and contingencies of actual operating systems has yet to emerge. What we see in "health system management" is a bewildering mixture of ad hoc arrangements, interest competition, localism, compromises, politicking, and media orchestration. "Management" in these circumstances comes to little more than putting a hopeful face on "muddling through." If the philosophical touchstone, a general purpose ethical decision maker, is a phantom, the default basis for ethical decision making, *habitus*, emerges as the only viable ground.