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BIOETHICS AND LAW: A DEVELOPMENTAL PERSPECTIVE[1]

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ABSTRACT

In most Western countries, health law bioethics are strongly intertwined. This strong connection is the result of some specific factors that, in the early years of these disciplines, facilitated a rapid development of both. In this paper, I analyse these factors and construe a development theory existing of three phases, or ideal-typical models.

In the moralistic-paternalistic model, there is almost no health law of explicit medical ethics and the little law there is is usually based on traditional morality, combined with paternalist motives, the objections to this modal are that its paternalism and moralism are unacceptable, that it is too static and knows no external control mechanisms.

In the liberal model, which is now dominant on most Western countries, law and ethics closely cooperate and converge, both disciplines use the same framework for analysis: they are product-oriented rather than practice-oriented; they use the same conceptual categories, they focus on the minimally decent rather than the ideal, and they are committed to the same substantive normative theory in which patient autonomy and patient rights are central. However, each of these four characteristics also result in a certain one-sidedness.

In some countries, a third model is emerging. In this postliberal model, health law is more modest and acknowledges its inherent and normative limits, whereas ethics takes a richer and most ambitious self image. As a result health law and ethics will partly diverge again.

[1] This article is partly the result of a common research project on Ethics and Law at the Center for Bioethics and Health Law, Utrecht University, the Netherlands, and has profited from many discussions with my colleagues participating in that research group. I had the opportunity to present the basic ideas of this paper on various occasions: at a conference organized by the Center for Bioethics and Health Law and at seminars at the University of Copenhagen, Denmark and at the Ersta Institute for Health Care Ethics, Stockholm, Sweden. I am grateful to many colleagues who presented helpful suggestions on these occasions, as well as to the two readers of *Bioethics*.

1 INTRODUCTION

In most Western countries, health and law and bioethics are strongly intertwined.[2] This situation can be found in various spheres. In the public debate, legal and moral issues are connected in many ways. Legal and ethical discussions influence each other so strongly that they can sometimes hardly be distinguished. Ethicists discuss and criticise the law on abortion or on euthanasia. Government-installed committees chaired by moral philosophers present recommendations on legislation on embryo research that are largely based on ethical analysis. Conversely, lawyers openly discuss ethical questions and intervene in the public moral debate. Legal categories (like doctrines of self-determination and patient rights) sometimes strongly determine and even structure the public debate concerning organ transplants and medical experiments.[3]

In law and legal practice, there are many references to ethics and to moral norms. The Council of Europe has even drafted a 'Bioethics Convention' (which has recently been renamed as 'Convention on Human Rights and Biomedicine'). In statutory provisions we find references to open norms, like 'the care of a good caregiver', which can only be substantiated by an appeal to morality.[4] In judicial decisions, we may find explicit reference to standards of medical ethics, for instance, in cases concerning euthanasia.[5] Acting according to the standards of medical ethics is regarded in the Netherlands as one of the criteria for a justified appeal to *force majeure* in cases of euthanasia.[6] Consequently, ethicists act as expert witnesses in courts

[2] My analysis in this article is primarily based on the Dutch and American situations, because I know them best and because they seem to be the two countries in which the liberal model (as sketched below) has gained most support and in which the postliberal tendencies are most clearly to be seen. Yet, the intertwinement of bioethics and health law is a broader phenomenon, which can be found in most of the Anglophone countries and many European countries as well. For the US, see Schneider, C.E. 1994, 'Bioethics in the Language of the Law', *Hastings Center Report*, July–August 1994, 24, no. 4 p. 16–22.

[3] Trappenburg, M., *Soorten van gelijk. Medisch-ethische discussies in Nederland* (diss. Leiden), Zwolle: W.E.J. Tjeenk Willink, 1993 argued that, in the Netherlands, these two topics are a 'legally structured territory', which means that it has been impossible to introduce other problem definitions and normative notions in the public debate than those dictated by legal doctrine. Cf. also Schneider op. cit.

[4] Cf. Burg, W. van der, P. Ippel, et al., 'The care of a good caregiver. Legal and ethical reflections on the good health care professional', *Cambridge Quarterly of Health Care Ethics*, Vol. 3, nr. 1 Winter 1994, p. 38–48.

[5] Cf. the two court decisions mentioned in Davis, D. 1995, 'Legal trends in Bioethics', *Journal of Clinical Ethics*, 6 1995 p. 187–192, one in the US and one in the Netherlands.

[6] For the Dutch situation on euthanasia, see Battin, M. *The Least Worst Death: Essays in Bioethics on the End of Life*, New York: Oxford University Press, 1994. 130ff.

on criminal cases concerning euthanasia.[7] A very interesting phenomenon is the institutionalised character of ethics committees and ethical review boards. In many countries such committees and boards are acquiring a legal basis and their positive advice is (or is expected to be in the near future) a precondition for official permission for medical experiments and animal experiments. Thus, paradoxically, they have to make judgements on ethical rather than legal grounds, yet these judgements have legal status. This semi-judicial role for ethics committees seems to blur the distinction between morality and law quite radically.

Finally, the academic disciplines closely co-operate. Doctrines of euthanasia and abortion, of informed consent and the right to privacy, of restrictions on experiments with embryos have all been developed in close co-operation between ethicists and lawyers. In ethics textbooks, legal cases are used as examples.[8] Legal textbooks refer to writings by moral philosophers to support legal doctrines, or even have ethics in their book titles.[9]

This strong connection between law and ethics is rather unique. There is probably no other field of law — with the exception perhaps of animal law and animal ethics, which may be regarded as a subfield of bioethics in a broad sense — where the connection is so strong and explicit. It is remarkable that this phenomenon can be found in many Western countries, though not in all (France and Sweden seem to be important exceptions here[10]) and not everywhere with the same intensity.[11]

and Griffiths, J. 1995 'Recent Developments in the Netherlands Concerning Euthanasia and other Medical Behavior that Shortens Life', *Medical Law International*, 1 1995 p. 347–386.

[7] In some court cases on euthanasia and other issues, Dutch ethicists have acted as expert witnesses; in many other cases, lawyers and judges have explicitly quoted ethical opinions. For instance, in the Dutch case referred to in note 5 above (the case at the Court in Alkmaar concerning a severely handicapped neonate), a professor in medical ethics, Inez de Beaufort, submitted an elaborate expert opinion on the ethical issues involved. It should be added that, in the Netherlands, expert witnesses are considered to be fully impartial, their expenses being paid by the courts, rather than to be witnesses on behalf of and paid by one of the parties. For a critical reflection on the latter role in the US legal system, see Caplan, A.L. 1991, 'Bioethics on Trial', *Hastings Center Report* 1991 p. 19–20.

[8] For example, most of the case material in Beauchamp, T.L. and J.F. Childress, *Principles of Biomedical Ethics* New York: Oxford University Press, 1994: 509f. is based on court cases.

[9] Cf. Mason, J.K. and R.A. McCall Smith, *Law and Medical Ethics*, London: Butterworths, 1994.

[10] In France, the idea that bioethics should be the subject of a specialised (philosophical or theological) discipline has met strong resistance. In Sweden, both health law and bioethics are still in a premature stage and, partly as a result of its legal positivist tradition, the relation between the two is rather weak.

How should we explain this? A superficial explanation may be that the field of biomedicine is extremely morally sensitive. Though there is a core of truth in this in the sense that, more than in other fields, we perceive normative problems explicitly as moral problems, it is not the only explanation. Environmental issues also have a strong moral dimension — they concern literally matters of life and death, especially for future generations; yet, environmental law usually has a much more instrumental character and is not, or only slightly, connected to the discipline of environmental ethics. The structure of the welfare and social security system and the basic tax structure are of great moral importance, yet ethicists seldom discuss them — and if they do, their work is considered to be of no legal relevance at all.[12] So there must be some other explanation.

A historical perspective may be illuminating here. The strong connection between health law and bioethics is only of a relatively recent date; it seems to be the result of a set of very specific factors that, in the early years of these disciplines, facilitated a rapid development of both.

In this paper I will analyse these factors and, on the basis of that analysis, construe a developmental theory existing of three phases or ideal-typical models of relationships between bioethics and law. First, I will sketch the older phase, which we may call the moralistic-paternalistic model. In this phase, there is almost no health law or explicit medical ethics, and the little law there is is usually based on traditional morality, combined with paternalist motives. The second phase, which is now dominant in most Western countries, may be called the liberal model. In this model, law and ethics closely co-operate and converge. In some countries, we can see a third model emerging, a post-liberal one, in which law and ethics partly diverge again.

2 THE MORALISTIC-PATERNALISTIC MODEL[13]

Until the sixties, bioethics or health law did not yet exist as independent disciplines in most Western countries. This does not

[11] Moreover, the connection exists only in a specific part of health law; the part that is concerned with the bureaucratic organisation of the health care system usually has little connection to ethics.

[12] For other examples of how fields of law are connected to morality, see Lee, S. *Law and Morals*, Oxford University Press, 1986, 18–21.

[13] The models developed here are ideal-types. Though the essentials can be recognised in reality as characteristic ways of ordering the normative dimensions of health care practice, reality is more nuanced, and usually combines elements of various models.

mean, of course, that the medical profession was amoral, but normativity was implicit in medical practice rather than being extensively elaborated by lawyers and ethicists.[14] Medical ethics was the ethics of good medical practice, of being a good doctor. For this there was no elaborate body of guidelines and rules, neither in moral philosophy, nor in law. Theoretical or philosophical reflection on medical issues usually did not address the public at large.

Professional practice was strongly paternalistic. Doctors were expected to act for the good of the patient and to know what this good was, both in the moral and in the non-moral sense of the word. Patients were often not given full information about the diagnoses of their illnesses, especially if the prognosis was dim. Insofar as the determination of the patient's good demanded moral evaluation, this was seldom explicitly acknowledged, nor need it be, because the moral norms were considered non-controversial, being based on a traditional (usually religious) morality that was largely accepted by all in society, or by all in the subgroup to which both doctor and patient belonged.[15] In a sense, we might even say that moralism and paternalism were not clearly distinguished, simply because the moral evaluations, involved in judgements about the patient's good, were so uncontroversial that they largely remained implicit.[16]

Specific rules of health law were virtually non-existent, though in many countries some form of disciplinary law existed. The law largely upheld and respected professional autonomy, and only marginally interfered with medical practice. It upheld a great deal of discretionary power for doctors. Especially in the field of psychiatry, both the law and the medical profession were strongly paternalistic; the patient's best interest, as judged by the psychiatrist, was the basic criterion for non-voluntary treatments and institutionalisation. Of course, there were some rules in criminal law, prohibiting abortion, euthanasia, (assisted) suicide and various sexual practices like adultery,[17] prostitution and homosexuality. The justification for these

[14] This sketch is partly based on Kuitert, H.M. *Mag alles wat kan? Ethiek en medisch handelen*, Baarn: ten Have, 1989.

[15] The latter addition is essential because in strongly segmented societies like the US or the Netherlands, on some issues no broad, social consensus existed, but only a group consensus within the group of Roman Catholics or within the group of orthodox Protestants.

[16] Kuitert, op. cit.: 66 expressed this by saying that, from the profession's point of view, the technically necessary and the morally obligatory are 'interfolded' as it were and often cannot be distinguished.

[17] When artificial insemination by donors was introduced, many countries discussed whether this should be regarded as a form of adultery and, hence, as a criminal offence. Cf. Mason and McCall Smith op. cit.: 53.

prohibitions was often directly moralistic: they were considered immoral by traditional morality.

This brief and much too simplified sketch suffices to illustrate the relationships between law and morality in this model. Insofar as law dealt with moral issues involved in medical practice rather than leaving them to the medical profession, it was directly moralistic and paternalistic. Insofar as it gave discretionary powers to the autonomous profession, it sanctioned paternalism and moralism of that practice, and thus was indirectly moralistic and paternalistic.

The model has clear advantages. It works efficiently because external legal and bureaucratic interference is marginal and doctors can simply make their own decisions, without having to discuss them extensively with patients or staff. As long as their decisions and actions are embedded in a morally decent traditional practice and are accepted by all as authoritative, good medical treatment is guaranteed.

However, it may be clear that many of the implicit presuppositions of this model are no longer acceptable or valid in modern societies.[18] Firstly, the idea of medical and legal paternalism has come under attack. The general emancipation process in which citizens claim their own rights and freedom, has not left medicine untouched. The simple confidence in psychiatrists, knowing what is good for their patients, has been shattered. Withholding information about the true nature of a disease is no longer deemed acceptable. Both as a result of the general trend towards emancipation which started in the sixties and as a result of specific factors in the field of biomedicine, patients claim their rights and want to control their own lives. Secondly, and partly connected to the criticisms of paternalism, the moralism of doctors and of the law has come under attack. Traditional morality has changed rapidly, resulting in a more pluralist character of modern societies. The sexual revolution, leading to more liberal attitudes towards various sexual practices, is just one example of this. Free citizens want to control their own medical and psychiatric treatment because it is up to them to decide which treatment is for their good, not only in a non-moral sense, but also in a moral sense. They claim the freedom to decide whether they want to have a child or not and whether abortion is morally justified. Finally, they want to decide themselves whether further suffering is an acceptable part of their dying process of whether they want to avoid further suffering through euthanasia or assisted suicide.

These criticisms on paternalism and moralism set the background for most of the current literature on law and morality, like the Hart-

[18] Cf. Kuitert, op. cit.: 64–71.

Devlin debate, culminating in Feinberg's four-volume series on the moral limits of the criminal law.[19] There are, however, other elements of the moralist-paternalist model that, though they have attracted less direct attention from moral philosophers, are equally important reasons for abandoning the model. A third objection to the model is that it is too static and does not provide solutions to the problems that arise as a result of changes in society, technology and health care practice. Societal structures and processes are changing so rapidly that an appeal to the moral tradition and trust in a gradual adaptation of implicit morality to changing circumstances simply is no longer adequate. Professional morality would soon loose contact with social reality if it were not an explicit object of open, critical discussion, reflection and adaptation. (This phenomenon of losing touch with social reality can most clearly be seen in the deep cleft between the static official Roman Catholic moral doctrine on sexuality and the practice of most believers who simply ignore the official doctrine.) Technology poses many new problems to which traditional morality does not offer answers — issues like embryo research, organ transplants and the treatment of severely handicapped newborns that in the past simply would not have survived. Health care practice has changed from a practice in which the individual physician had a personal relationship with a patient to a situation in which teamwork and interdisciplinary co-operation are normal. Each of these three essential changes makes it necessary to make moral norms and values explicit so that they can be discussed, critically analysed and adapted to new circumstances or new opinions. They also make the need for law more clearly felt, to guide those developmental processes and to prevent excesses as a result of normative uncertainty. When traditional morality no longer provides adequate guidance, and a new morality is still developing, we can no longer put our trust completely in the medical judgement because the risk of erring is too great.

These latter remarks already point to a fourth criticism of the model. It knows no checks and balances, no external control mechanisms. Even if almost all medical professionals act in a decent or even highly laudable way, there will always be the need to correct the small minority of practitioners who do not. In a small-scale profession with strong mechanisms of social control, it may be largely

[19] Cf. Dworkin, R. (ed.) *The Philosophy of Law*, Oxford University Press, 1977. Feinberg, J., *The Moral Limits of the Criminal Law* New York: Oxford University Press, Vol. I *Harm to Others*, 1984, Vol. II *Offence to Others*, 1985, Vol. III *Harm to Self*, 1986, Vol. IV *Harmless Wrongdoing*, 1990, and Dworkin, G. (ed.) *Morality, Harm, and the Law*,Boulder: Westview Press, 1994.

adequate to trust informal and internal methods of correction and control, e.g. through disciplinary proceedings. But in a more anonymous large-scale medical practice this simply does not suffice. Moreover, it does not give the patients adequate protection against and compensation for medical malpractice. The Nazi experiments are often mentioned as the primary reason why the need for control became felt. But other situations also gave rise to the demand for legal control of medical practice, especially in the field of psychiatry. Everyone with power runs the risk of abusing it; the more power the medical profession is given by modern technology, the greater the need for control and checks and balances. In combination with the growing emancipation of patients, this has led to increasing direct legal intervention in medical practice.

These four critical objections to the moralistic-paternalistic model are the major factors that have led to its abandonment in favour of a new model, the liberal model. It is important to understand that the reasons for abandoning it are not only new normative opinions on paternalism and moralism, but that the changes are also responses to developments in Western society and in medical practice itself. The old model is simply no longer functional in various respects. This means that a reactionary return to this model — even if someone were to suggest this and defend it from a normative point of view — is likely to be counterproductive, simply because the social context in which it once worked no longer exists.

3 THE LIBERAL MODEL

Each of the four objections to the paternalistic-moralistic model suggests, by contrast, characteristics of an alternative model. Both the anti-paternalism and the anti-moralism criticisms suggest a model that explicitly recognises and protects patient autonomy and patient rights, and that is based on a more equal relationship between physicians and patients. Because autonomy and rights are so dominant in this new model (partly as a reaction against the old paternalism and moralism), I will call it the liberal model.[20]

The third objection I mentioned is that the old model is too static, because it is based on an implicit professional morality that can only

[20] Beauchamp and Childress op. cit.: 78 consider the postulates of individual autonomy, rights against the state and neutrality towards conflicting values to be the central elements of liberalism. My conception of liberalism here is both broader and narrower. Neutrality is not essential, but the concept of rights applies also to other institutions than the state and to other individuals, like health care professionals.

very gradually adapt to new circumstances. This point suggests that the professional morality should be made more explicit and should be an object of ethical reflection, discussion and reformulation in the light of changing circumstances. Changes in society, technology and health care practice result in the need for bioethics as a discipline that supports this continuous process of reflection, discussion and reformulation. Changes in health care practice, moreover, require that medical ethics is broadened to bioethics or health care ethics, and that medical law is broadened to health care law, so that both include all health care professions (like nurses) and the organisation of the health care system as a whole. Changes in society require that bioethical discussions are not confined to health care professionals, but that health care consumers are involved as well, which means society as a whole. All these rapid and radical changes, but especially those in technology, clearly demand more than superficial ethical analyses, which means that we need specialists to make them; in other words, we need bioethics as an independent (philosophical or theological) discipline.

Finally, the fourth objection mentioned above is that the moralistic-paternalistic model does not provide adequate mechanisms of control and correction, let alone the protection of patients and third parties. The most obvious institution for control is the law. This means that new legislation and regulations are needed in a practice that, so far, has not been used to much external regulation. This almost automatically leads to the establishment of a new field of law with its own specialists in health law as a new professional discipline.

In the transformation process from the moralistic-paternalistic model to the liberal one, the new disciplines of bioethics and health law profit from a close co-operation.[21] They have many things in common: no firm theoretical ground to stand on, demanding tasks and, as is usual in a starting period, a very small number of competent ethicists and lawyers. Moreover, both disciplines often — though not always — have to struggle against the resistance of settled interest groups, especially physicians. But most importantly, they have a common mission: to elaborate the liberal programme in a theoretically satisfying way and to implement it in health care practice.

[21] Cf. Leenen, H.J.J. 'Vijfentwintig jaar gezondheidsrecht', in: J.H. Hubben and H.D.C. Roscam Abbing (eds.), *Gezondheidsrecht in Perspectief*, Utrecht: De Tijdstroom, 1993: 21; Clouser, K.D. and Kopelman, L.M. 1990, 'Philosophical Critique of Bioethics: Introduction to the Issue', *Journal of Medicine and Philosophy*, 15 1990, 2: 121–122.

In such a situation, it is only natural that both disciplines collaborate closely and find intellectual inspiration in each other's work. Why not try to construe a theory on informed consent in a common effort by lawyers and ethicists? Why should lawyers not try to build on ethical theories regarding the status of the human embryo when developing suggestions for legislation on abortion or on embryo research? Moreover, it is not only intellectually helpful, but also strategically important to join forces if one of your aims is to change health care practice and opposition is strong.

This sketch may explain why co-operation between both disciplines is stimulated, but this does not mean co-operation is possible. If lawyers are talking about patient rights while ethical analysis focuses on professional virtues and fundamental views of life, co-operation will not be easy. So a further condition for co-operation must be that both disciplines use the same framework for analysis and this is, indeed, characteristic of the liberal model.

Firstly, both health law and bioethics take what I shall call a 'product approach'. When studying law, one may focus on law as a product, which means that one regards law as a system of rules and principles or as a collection of statutes, customary rules and judicial decisions.[22] But one may also focus on the practice of law, on the legal process, on law as an interpretative and argumentative activity.[23] Similarly with ethics: one may focus on moral theory as the construction of principles for the basic structure of society or as the construction of rules and principles for action and, on the basis of this, of concrete moral judgements.[24] But one may also focus on morality as a practice, as an activity in which we are continually interpreting, reconstructing and trying to realise our central moral values.[25] The distinction between law and morality as a product and law and

[22] This approach seems dominant among positivists like Hans Kelsen, but is most obvious in the way many legal textbooks tend to present 'the law' on certain subjects: as a coherent doctrine of norms, based on a collection of legal materials like statutes and case-law.

[23] Lon L. Fuller, *The Morality of Law*, New Haven: Yale University Press, 1969 and Ronald Dworkin (though the latter is sometimes ambiguous in this respect) exemplify this approach. I should add that most philosophical authors try to combine both approaches, but the resulting theories are never fully adequate. The two approaches seem partly incommensurable. Therefore they can, in my view, never be combined in one coherent theory, just as we may regard an electron as particle or as wave, but not as both at the same time.

[24] Examples abound, which shows how dominant this way of thinking is (e.g., Rawls, Hare, Gert).

[25] MacIntyre, A. *After Virtue*, Notre Dame: University of Notre Dame Press, 1981 and philosophers of medicine in the hermeneutic tradition are the obvious examples here.

morality as a practice or process has important implications. In a product view, it is usually easy to defend simple distinctions between law as it is and law as it ought to be, between law and morality, or between positive and critical morality.[26] The product is usually easily identifiable by some test of pedigree or by empirical research. But in a practice or a process view, these distinctions are not so simple; for instance because legal and moral argument cannot be separated, or because most positive moralities include mechanisms of self-criticism and self-improvement by reflection on critical morality.[27]

In the liberal model, both health law and bioethics put strong emphasis on the product rather than on the activity or practice. They try to develop new theories, principles, rules or concrete advice for the new problems that arise (or the old ones seen in a new light): the plight of psychiatric patients, the possibilities and risks of new technologies. Bioethicists try to construct new moral guidelines and suggest solutions for concrete problems and moral dilemmas; often they also try to argue for new legal rules. The product approach is best exemplified by the central role the 'four principles of biomedical ethics' play in the ethical literature.[28] Health lawyers also focus on products in the form of legislation, other types of regulation and judicial decisions. They continually try to construct law as a coherent system of rules and principles. Thus, both disciplines have a similar orientation towards law and morality as a product. This is different from the moralistic-paternalistic model, in which professional morality is that of good medical practice, whereas law mainly consists of a small number of rules and provisions in criminal law and thus takes a product approach.

Secondly, bioethics and health law both use the same conceptual categories. In both disciplines, principles, patient rights, concrete rules and procedures take pride of place. This allows (at least superficially) a translation of legal analysis into moral analysis and vice versa, an essential precondition for successful co-operation.[29]

[26] Cf. Hart, H.L.A. 'Positivism and the Separation of Law and Morals', in: R. Dworkin (ed.), *The Philosophy of Law*, Oxford University Press, 1977, pp. 17–65.

[27] Cf. Brom, F.W.A., J.M.G. Vorstenbosch and E. Schroten, 'Public Policy and transgenic animals: case-by-case assessment as a moral learning process', in: P. Wheale and R. von Schonberg (ed.), *The Social Management of Biotechnology: Workshop Proceedings*, Tilburg University, Faculty of Philosophy, 1996 p. 73–86.

[28] Cf. Beauchamp and Childress op. cit., and Gillon, R. (ed.) *Principles of Health Care Ethics*, Chichester: John Wiley and Sons, 1994. Even many critics of 'principlism' still take a product view, like in the theory of moral rules suggested by Clouser, K.D. and Gert, B. 1990, 'A Critique of Principlism,' *Journal of Medicine and Philosophy*, 15 1990, 2, p. 219–236.

[29] A simple illustration: Some years ago, I was invited to present an analysis of the ethical aspects of a controversial epidemiological research project of HIV

Ethicists can participate in legal discussions because they largely use the same framework (though the precise meanings and roles of the principles and rights are usually not identical in law and ethics, a fact which is too often neglected by lawyers and ethicists alike). Lawyers can make a useful contribution to ethical discussions because legal experience often provides valuable insights into the way in which a moral right like that of privacy could be elaborated.

Here again, there is a difference with the moralistic-paternalistic model, in which professional morality focuses on virtues and on categories like the good doctor, whereas criminal law emphasises strict rules of action. Of course, there is an overlap between the two with respect to material implications, but there is no easy translation from the moral category of the good doctor to the question of whether abortion should be legal.

Thirdly, both health law and bioethics concentrate on what is minimally necessary rather than on the ideal situation or the perfect doctor.[30] In a situation in which a quick transformation is deemed desirable or even necessary, it is wise to start with the minimum, for making practitioners comply with this minimum may already be a major achievement. If doctors are not used to give full information to their patients, the most urgent task is to make at least a decent minimum of information available; only in a later stage it may make sense to aim for more perfectionist standards of giving information. If the general idea of legalising abortion is still controversial, it may be wise to stress the woman's right to free choice and leave the more subtle moral questions — like the precise conditions under which an abortion is morally justified — out of the public debate. As long as the minimally decent has not been realised, it may not be very effective, even counterproductive, to aim for the excellent. Again, this guarantees good co-operation in the liberal model between health law and bioethics because law is not an adequate instrument for enforcing excellence. There is a standard saying which states that law is a minimum morality. I think this saying is not entirely correct, if only because it is not very useful to conceptualise law as a form of

infection. On this occasion I noticed that the analysis by the legal expert was almost identical to mine, with one major exception: his appeal to the authority of law. The basic principles from which we both started — respect for physical integrity and for privacy — are laid down in the Dutch Constitution as constitutional rights. When, on another occasion, I was invited to discuss both the ethical and the legal aspects, it was, therefore, no problem to integrate these into one coherent story.

[30] The trend to structure the physician-patient relationship in a contractual form is also a sign of this minimalism. Cf. May, W.F. 'Code and Covenant on Philosophy and Contract?', in: S. Gorowitz et al. (eds.), *Moral Problems in Medicine*, Englewood Cliffs (New Jersey): Prentice Hall, 1983; Schneider op. cit.: 18.

morality; yet there is an important core of truth in it. The higher we get on the continuum from the morality of duty to the morality of aspiration, the less effective law can be.[31]

Thus, health law and bioethics both take the product view; both use the same conceptual framework and both focus on the minimally decent rather than on the ideal. These three characteristics are largely formal characteristics. But the most important factor that guarantees successful co-operation is the fourth one (which is closely connected with the other three factors); they are both committed to the same substantive normative theory. Patient autonomy and patient rights — in other words liberalism — are central to the modern bioethical and legal discourse.[32] Because bioethics and health law share this commitment to liberal values, they not only speak the same language, but also take similar stances, at a more theoretical and at a more practical level. Moreover, a theory based on autonomy and patient rights offers simple solutions for most of the problems that were central in the early days of bioethics and health law. On abortion and on euthanasia, on the plight of psychiatric patients and on medical experiments, the paradigm of patient rights gives a clear and simple answer: the patient has to decide.[33] Against the traditional background of moralism and paternalism this is real progress. Moreover, autonomy means that individuals are entrusted with the responsibility for moral dilemmas rather than the law, or society as such. Thus, the more subtle and controversial moral issues are effectively removed from the public sphere. This makes it much easier, in modern pluralist societies, to reach an overlapping consensus on the moral issues that remain in the public sphere; who would oppose patient autonomy as such?

4 PROBLEMS OF THE LIBERAL MODEL

It may be good to stress at this point that this is only an ideal-typical sketch of a model. There is no country that has fully implemented the

[31] The distinction between the morality of duty and the morality of aspiration is at the core of Fuller op. cit. and also Selznick, P. *The Moral Commonwealth: Social Theory and the Promise of Community*, Berkeley: University of California Press, 1992. The implications for the health care professional have been elaborated in Van der Burg and Ippel et al., 1994, 'The care of a good caregiver. Legal and ethical reflections on the good health care professional', *Cambridge Quarterly of Health Care Ethics*, Vol. 3, nr. 1 Winter 1994, p. 38–48.

[32] Cf. Ippel, P. 'Gezondheidsrecht en gezondheidsethiek', in: W. van der Burg en P. Ippel (ed.), *De Siamese tweeling*, Assen: Van Gorcum, 1994; Schneider, op. cit.: 18.

[33] With respect to abortion, this conclusion only follows once it has been decided that the foetus is not a full person.

liberal model, if only because its shortcomings are too obvious. Many countries are still only starting its implementation; Sweden, perhaps, is an example. In strongly pluralist societies, like the US and the Netherlands, it seems to have been most effective for obvious reasons: the more a society is characterised by moral pluralism, the less a policy of legal moralism is possible. Even within one country or legal system there may be important differences. Thus, so far, most countries have been non-liberal on the subject of euthanasia and physician-assisted suicide, even those that have been very active with respect to patient rights in general.[34]

Yet, I think the conclusion is warranted that, in most Western countries, the liberal model currently is or is becoming the dominant approach to bioethics and health law. The basic ideas have now been successfully elaborated theoretically and have gained broad support. They have won legal recognition — patient rights have been laid down in statutes or even been included in constitutions and international human rights treaties.[35]

The success of the liberal model now also seems to be the reason for its decline: once the most important advantages of the model have been realised, the disadvantages become clearer and are beginning to weigh more heavily. Especially in the recent ethical literature, we can find a great deal of criticism that stresses the objections to the liberal model.

For, effective and attractive as this model may be, it does have major disadvantages as well. Each of the four characteristics that are responsible for the liberal success result in a certain one-sidedness. The focus on product may neglect practice, the way in which the rules and principles can effectively be interpreted and implemented. Ethical theory and legal doctrine may sometimes be satisfactorily elaborated at a certain reflective distance of the practice, if only because there may be good reasons for changing the practice. But in the end, it is the practice that counts, rather than the law in the books or the ethical

[34] In some cases, of course, the opposition against (partly) legalising euthanasia is liberal as well; consider, for instance, the argument that it will lead to situations in which the elderly will feel under pressure to ask for euthanasia and for that reason, in order to protect their autonomy, we should not legalise euthanasia. Most objections, however, are non-liberal, like reference to the sanctity of life or protecting the distinct medical ethos that doctors should never kill.

[35] Cf. the Patient Self-Determination Act in the US, or the new Constitutional clauses in the Netherlands on privacy and physical integrity. In Leenen et al., op. cit., a broad study of health law in most European countries, it is argued that there has been an 'emergence all over Europe of a social and cultural reassertion of the values of individual freedom and self-determination that sustain the concept of patients' rights' (at vii).

principles in the textbooks, and if the elaboration of ethical and legal doctrine overburdens practice, we should be careful. And, indeed, we can hear complaints from practitioners and ethicists alike implying that medical ethics has lost touch with reality, or that health law has become a threat to good medical practice.[36] Even though some of these complaints are based on caricatures and misperceptions or simply on practitioners' dislike of external interference, I think it is important to see the core of truth in it. And it is likely that the more the product is elaborated in ethical theories and positive law, the more strongly the tensions with the demands of practice will be felt.

The second characteristic of the liberal model, the emphasis on principles, rights, rules and procedures, has received so much criticism lately that I will not elaborate on it. Whatever the suggested alternative is, like virtue ethics or ethics of care, they show that ethical analysis only in terms of the liberal model neglects certain dimensions of moral experience.[37]

The third characteristic, minimalism, results in the neglect of perfectionist dimensions of morality and law. In my view, however, perfectionist standards and ideals are essential to bioethics and also to law, though in a different way. We cannot fully understand a profession, unless we realise that it is partly oriented towards some professional ideals.[38] If this is true, then the rise of liberalism led to a morally impoverished image of professional morality and needs to be complemented by richer analysis.

The fourth characteristic, the substantive orientation towards liberalism, may seem to be the most controversial to attack. Do criticisms of liberalism not automatically lead us back to an anti-liberal moralistic position? I do not think so. We should distinguish two shortcomings of the liberal emphasis on rights and autonomy. The first shortcoming is that it simply does not give an answer. It seems to me that this is the case with many issues that we have to confront once liberalism has been realised. Autonomy and rights are of little relevance to the problem of embryo experimentation. When

[36] Cf. Vandenbroucke, P. 1990, 'Medische ethiek en gezondheidsrecht: hinderpalen voor de verdere toename van kennis in de geneeskunde?', *Nederlands Tijdschrift voor Geneeskunde* 1990, 5–6.

[37] Cf. Shelp, E.E. (e.a.) *Virtue and Medicine: Explorations in the Character of Medicine*, Dordrecht: Reidel 1985, and the literature inspired by Gilligan, C. 1982, *In a Different Voice: Psychological Theory and Women's Development*, Cambridge, Mass: Harvard University Press, 1982.

[38] Cf. Campbell, A.W. 'Ideals, the Four Principles and Practical Ethics', in: R. Gillon, *Principles of Health Care Ethics*, Chichester: John Wiley and Sons 1994, 241 makes a related point: we cannot fully understand moral principles unless we see that they are connected to more fundamental ideals. Cf. Van der Burg and Ippel et al. op. cit.: 42.

discussing preconception sex selection of children, ethical analysis based on the autonomy of the parents only seems to give part of the story because we cannot neglect the wider context of discriminatory social attitudes. Once we accept that abortion should be a free choice for women, the real problem for them is still there: whether or not to have an abortion in their specific situations. We cannot understand the full ethical dimensions of prenatal diagnosis, unless we understand what it means for women to have a 'tentative' pregnancy,[39] and unless we see what having a handicapped child may mean in this specific woman's biography. The liberal framework does not offer adequate possibilities to analyse these richer dimensions; yet, as long as it is not made absolute it need not prevent us from adding other elements.

Thus, one type of shortcoming of liberalism is that it simply does not enable us to address certain dimensions of a situation. This could, in principle, be solved by supplementing liberalism with richer perspectives, as many authors are currently trying to do. A more problematic shortcoming is that, at times, liberalism presents us unacceptable solutions for a problem and effectively excludes other ways of conceptualising the problem.[40] If we take autonomy as the primary basis for moral and legal judgements, we may find that we have inadequate legal mandate to treat schizophrenic patients in the early stages of their illness, or to prohibit euthanasia or assisted suicide in cases where we do not think it morally justified. (An example could be a patient in a very early stage of cancer demanding euthanasia, even though there are still reasonable chances of curing it.) If we make liberalism too dominant in law, this may lead to a legal doctrine that does not allow enough space for professional autonomy in those cases where patient rights become counterproductive. The rise of preventive medicine may have to do with too much emphasis in law on the liberal model and its rights orientation.

Each of the four characteristics of the liberal model thus corresponds with a certain one-sidedness. A further central characteristic of the liberal model, as I have sketched it, is the close co-operation between health law and bioethics. The advantages of this co-operation were most important in the early years of these disciplines, but once they have become settled, the disadvantages begin to weigh heavier. To put it more simply, a too close co-operation may lead to a neglect of important differences between law and morality. Law is an institution with a distinct role and distinct functions in society. This leads to specific possibilities and limitations of what law can and cannot achieve. For instance, the use of force and

[39] Cf. Rothman, B. Katz *The Tentative Pregnancy*, New York: Viking, 1986.
[40] As suggested by Trappenburg op. cit.

sanctions, which is often associated with law, means that law usually has more effective instruments than morality, but it also means that legal regulation is often perceived as threatening by physicians.[41] Both effects should be assessed when discussing legislation, and often this type of evaluation means that we should not enforce moral duties through law. Similar illustrations can be made about the specific possibilities of morality, which may be neglected if ethics is too closely connected with law.[42] For instance, morality should also give guidance in situations where law leaves full discretion to autonomous decision making by patients or physicians; it can only do so if ethics is not too closely associated with law.

5 THE POSTLIBERAL MODEL

We may conclude that the more the liberal model is realised, the stronger its disadvantages become clear. This suggests that it will be succeeded by a different model. As that alternative model is still only in an emergent and implicit state, only a tentative sketch is possible. Just as it was possible to predict the outline of the liberal model partly from the defaults of its moralistic-paternalistic predecessor, it is possible to predict the outline of the postliberal model partly from the defaults of its liberal predecessor. The extrapolation of criticism must be strongly evaluative, because criticism can be met in various ways. Before going into details, however, some preliminary remarks should be made.

A first point I would like to stress is that, despite the criticisms, the advantages of the liberal model are substantial. We should not give up the idea of patient autonomy and go back to paternalism and moralism; anyway, this is not likely to be a feasible alternative. So the new model should include the liberal model, elaborate on it and perhaps in some minor ways correct it rather than replace it by a completely new model. Thus, the new model should be postliberal rather than anti-liberal.

Secondly, the disadvantages mentioned above need not have the same implications for law and for ethics. It is very likely even that the criticisms lead to different reactions for health law and for ethics. For instance, health law should, in my view, largely stick to liberal minimalism and, in some respects, become even more minimalist so as to leave more room for perfectionism in the exercise of professional

[41] Cf. Mason and McCall Smith op. cit.: 14–17; Schneider op. cit.: 21–22.

[42] For similar criticism, see Holm, S. 1994, 'American Bioethics at the Crossroads: A critical Appraisal', *European Philosophy of Medicine and Health Care*, 2:2, 1994, p. 6–31.

autonomy, whereas bioethics should incorporate perfectionist ideas more directly. The answer to the criticisms will differ, precisely because health law and bioethics are different, and one of the criticisms of the liberal model is that it does not adequately acknowledge these differences.

This suggests a third point. Law and ethics should become more independent and distinct. The reasons for co-operating so intensely have become less important and the disadvantages of the close connection are becoming more visible. This means that critical reflection on and empirical study of the distinct roles of law and morality have become more urgent and that only on the basis of this we may be able to make adequate judgements about the desirable relationships between law and morality. In the future model, the relationships will probably be more loose than they are in the liberal model. Therefore, I will discuss the implications for law and for morality separately.

During the liberal phase, health law undergoes quite radical changes and elaborations, culminating in some form of codification or, at least, the establishment of a generally recognised body of legal norms of precedent. It seems to be time for the stabilisation and refinement of, and critical reflection on, such a body of norms. A further development of law beyond the liberal model, based on various forms of theoretical study and reflection, should proceed along three lines.

1. One line of development should be based on reflection on the integrity of law as a whole. As a result of its strong connection with bioethics in the liberal model, health law runs the risk of becoming isolated from adjacent fields of law. This may imply that its doctrines become inconsistent with the legal system as a whole.

I will illustrate this with an example from Dutch law.[43] In Dutch health law, constitutional rights have been interpreted in a way that significantly differs from the role they have in constitutional or criminal law. Constitutional rights are usually regarded as a corrective mechanism against the abuse of power by government. In the health law doctrine, constitutional rights and underlying principles like the right to self-determination and the right to health care are seen as the basis for the legal doctrine. If, however, what is meant to be primarily a corrective mechanism on official action is misconstrued as the primary basis of all legal responsibilities, things

[43] This example has been elaborated in Van der Burg, W. and H. Oevermans 'Grondrechten in het gezondheidsrecht', in: W. van der Burg and P. Ippel (ed.), *De Siamese tweeling*, Assen: Van Gorcum, 1994: 187–203.

are turned upside down. Health law doctrine should start with the primary goal of medicine, i.e. the cure and care of the patient, and then construct constitutional rights as a protective countermechanism or as a symbolic point of orientation. If you make rights the basis of health law, as the liberal orientation on autonomy and patient rights has at least a tendency to do, then you loose contact with the primary goal of health care. Thus, the liberal rights orientation may, if taken too far, lead to results that are contrary to its primary aim: serving the patient's interest.[44] It seems to me that closer contact with traditions in adjacent fields of law and less intense contact with bioethics might have prevented this, and could have led to a better health law.

This example shows how the separation of health law as a distinct subfield of law — though in itself not objectionable — may lead too far, especially if health law is too strongly connected to bioethics. A stronger orientation of health law towards the legal system as a whole and to the integrity of law may lead to significant corrections in health law doctrine and especially to a more modest role of the law.

2. A second line of health law development should be based on a further reflection on the societal role, functions and limitations of law in general and of health law in particular.[45] As a result of its orientation towards bioethics, health law may become too ambitious and thus counterproductive in trying to change medical practice. But law is not always effective and it has often many side-effects that should be taken into account. This problem of effectiveness and side-effects is particularly important in the context of biomedical practice. Legal control is difficult, if only because medical confidentiality often shields the profession from external intervention. Thus, traditional models of enforcement are usually not effective unless the profession itself largely co-operates voluntarily — the problem of illegal euthanasia practices in many countries may be an example. Simple instrumentalist views of law often just do not work; in order to influence professional practice, the communicative function of law should be stressed.[46] Moreover, the side-effects of legal intervention may be far-reaching: relationships of trust could be damaged.[47]

Thus, both the directly intended effects of legislation and the

[44] This critical reappraisal of the rights orientation is what is now happening, indeed, in Dutch health law. Its 'founding father', H.J.J. Leenen, has gradually retreated from his earlier stance that these rights are the 'pillars' of health law; compare the first (1978) and third (1994) editions of his *Handboek Gezondheidsrecht*.

[45] Cf. Schneider op. cit.

[46] Cf. Legemaate, J. *Recht en realiteit: Juridische normering en het therapeutisch proces* (oratie Rotterdam), Houten: Bohn Stafleu Van Loghum, 1994: 23.

[47] Cf. Mason and McCall Smith op. cit.: 16–17.

indirect effects or side-effects should be counted. For instance, if legal regulation both leads to the desirable goal of enforcing patient rights and to the unintended result of defensive medicine because doctors feel threatened by the law, we should balance these two effects before deciding in favour of legislation. We should also consider possible alternatives for state regulation, such as instituting (partly) independent regulatory bodies in which both the public and the profession are represented; forms of self-regulation and convenants between the state and the business sector (a common practice in environmental law in many countries) may also be a good alternative.

3. A third line of further health law development should be based on the development of normative theories regarding the limits of state and law. As I have mentioned earlier, most of the current theories only focus on the moral limits of criminal law. Normative theory on the proper limits of tort law or administrative law is still lacking. There are some strong political positions, obviously, but these are often highly ideologically coloured (especially by strong anti-state sentiments) or merely pragmatic. What we need is more nuanced theoretical work on what the state should or should not do and what the law should or should not regulate if we take ideals like the rule of law or democracy seriously, and especially how then this should be done. When is civil law and when is criminal law adequate? When should we leave issues to internal self-regulation? The case of surrogacy presents a good example. Presumably, criminal sanctions will not only be partly ineffective but, according to most authors, also unjustified.[48] How the law of contract or internal hospital regulations should deal with the issue is still open then.

For each of these three lines of health law development we need a certain reflection on and distance from biomedical practice: studies in political philosophy, in the sociology of law, and in general jurisprudence and the philosophy of law will be necessary. But in each of these fields there seems to be the same trend: in a postliberal model, health law should be more modest and should show self-restraint and acknowledge its inherent and normative limits.[49]

With respect to ethics, the general trend seems to be different. I will only give a very simple indication here, because I am primarily

[48] According to Mason and McCall Smith op. cit.: 70, in the Anglophone world, almost no legal system has criminalised the procedure as such — Queensland being the exception.

[49] Mason and McCall Smith op. cit.: 16 seem to suggest that in the English courts this self-restraint is now, indeed, being practiced, whereas they had expressed their fears as to the contrary in a previous edition.

interested in the relationship between law and ethics. For this purpose it suffices to see that, in whatever direction we may expect and hope the development in ethics to go, it will presumably always be a direction away from law.

The four general characteristics of the liberal model that I discussed earlier, and their concomitant shortcomings, have been strongly criticised in recent ethical literature; they should each be complemented to develop a richer, pluralist view of ethics. Some authors have argued for replacing (some of the characteristics of) the liberal model in ethics, but most critics have taken an intermediate position. They want to supplement the liberal model with elements that it has neglected rather than construing a completely new model. Many representatives of the liberal model have accepted the challenge and have tried to include elements of the criticisms or to emphasise non-liberal elements that so far have not received due attention. It seems that we are heading towards an enriched and pluralist view of ethics.[50] We should not only study the product in the form of theories, but also analyse good practice. Studies based on rights perspectives and principlism should be supplemented by studies based on, e.g. virtue ethics or ethics of care, simply because each of these alternative approaches has its own blind spot. The minimalism that was adequate in the early days of bioethics can now be enriched by going beyond the minimum and reflecting on the ideal of good medical practice. Finally, the strong orientation on individual rights and autonomy — which may still be quite acceptable in legal philosophy — should be nuanced and supplemented by views in which the full dimensions of the good life and of the good society at large are elaborated.[51]

An example may make clear what I mean. If we look at the relationship between patient and doctor, we need a plurality of approaches for an adequate ethical analysis. We should both look at minimum standards or duties that every doctor should always respect, and to maximum standards or professional ideals that he should aspire to. We should, as in the liberal model, analyse the actions of

[50] There is a growing recognition of the need for a plurality of methodological and normative-ethical approaches; see, e.g., Gustafson, J.M. 1990, 'Moral Discourse About Medicine: A Variety of Forms', *Journal of Medicine and Philosophy*, 15 1990 p. 125–142, and even Beauchamp and Childress op. cit.: 111. See also Van der Burg, Ippel, et al., op. cit.

[51] Even in legal philosophy, however, the liberal rights orientation will not always be adequate, as R. Dworkin's *Life's Dominion*, New York: Alfred A. Knopf, 1993, shows. The most ardent supporter of rights theories had to switch to value theories in order to present an adequate analysis of legal issues connected to bioethics.

the physician in terms of rules, principles and protocols as well as in terms of the rights of the patient — but this is only part of the story. We should also articulate what a virtuous doctor is and we need a perspective of an ethics of care to supplement the contractualist (and therefore minimalist) understanding of the relationship between patient and doctor. So, to understand all the relevant aspects of the norm of a good caregiver, we need indeed a plurality of ethical approaches. Focusing on only one or two approaches, as in the liberal model, leads to a reductionist and distorted picture of this highly complex phenomenon.[52]

As a result of these two trends in health law and bioethics, we may expect (and should support) a divergence between the legal and the moral point of view. If law, generally speaking, should be more modest and conscious of its inherent and normative restraints, whereas ethics should rather take a richer and more ambitious self-image, the two diverge.[53] If ethics is to go beyond liberalism, to address the ideal as well as the minimum and so on, whereas law sticks to the minimum and to liberalism, or even partly retreats from it in the light of a better understanding of its specific role, further divergence will become necessary. Loosening the bonds between law and bioethics is thus the result of developments in the postliberal phase. In a sense, it is also a condition for a further development of both health law and bioethics. For as long as both are so closely connected, it will also be difficult for each to go its own way. If the public moral debate on abortion is closely linked to the debate on the desirable legislation or judicial decisions, an open moral discussion on how this freedom should be exercised will be frustrated. Legal freedom does not imply a full moral license. The motives of a woman requesting abortion may be legally irrelevant, but the request is not morally neutral, let alone that it is emotionally easy. To help women (and men) handle these difficult decisions which they face, a public moral debate can be important, but this will only work if there is no suspicion of hidden agendas to change the law.[54]

The same goes for law. If health law tries no longer — often in vain or quite forcefully — to justify each and every single rule in moral terms, it may be easier to get a workable practice. The example of embryo legislation has been mentioned above. It seems to me that we will only make progress in the legislative debate once

[52] Cf. Van der Burg and Ippel et al. op. cit: 40.

[53] Schneider op. cit. makes a similar point.

[54] Schneider op. cit.: 21 gives a similar example: the question whether we have a moral obligation to donate blood tends to be restructured as the question whether there should be a legal obligation.

we see that legal rules and legal lines, like a three-months or a fourteen-days line in rules on embryo experiments or abortions, need not be directly justifiable in moral terms — law knows many arbitrary lines.[55] The law as a whole should be as morally justifiable as possible, but this does not mean that we should be able to give a direct moral foundation to each individual statutory rule or judicial ruling seen in isolation.

6 CONCLUSIONS

In this paper I have sketched a developmental theory of the relationships between health law and bioethics. This theory can give us a good understanding of why, in many Western countries, health law and bioethics are so closely intertwined. Understanding the specific historical setting that facilitated this close connection may help us recognise the time for a new phase in which the bonds are loosened. Obviously, a sketch that is meant to outline some general trends in all Western countries must be either too vague or will not fit readily in some countries. Indeed, this is only an ideal-typical sketch of three models: no country fully embodies or once embodied either of the three models. Yet I would hold that central elements of the first two models can be found in the historical development of these countries that I know best: the Netherlands and the USA, and probably also in most of the Anglophone world and Germany. The third model is more tentative; it is an emergent model, and perhaps, in some respects, I have misinterpreted some of the current tendencies; perhaps I fell victim to wishful thinking.

Presently, most of the Western countries are still in the process of realising the liberal model. What does my analysis mean for those countries? Should they stop this development and try to skip the liberal phase, because of the criticisms? Some of the critics of the liberal model seem to suggest so: we should go back to Aristotle or back to traditional morality. In my view this would be the wrong reaction, and I think this development approach shows why.

There were good reasons to leave the pre-liberal phase. Going back to old times will not help us, because the old model is no longer functional in modern societies, and is no longer acceptable to the public at large in pluralist cultures. A regression to the pre-liberal phase is nevertheless possible, even though it will not be very effective. Just like Nonet and Selznick (1978) argued in their developmental model of law that there can be 'two ways law can

[55] C. Van der Burg, W. 1996, 'Legislation on Human Embryos: From Status Theories to Value Theories', *Archiv für Rechts – und Sozialphilosophie*, 82: 1 1996, 73.

die', there may be two ways liberalism can die: regression to pre-liberalism and progression to post-liberalism.[56] I suggest that we take the second way, and incorporate the sound parts of the anti-liberal criticisms into the postliberal model, rather than simply abandon the liberal model.

In order to preserve the valuable core of liberalism, we should go beyond it.

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[56] Cf. Nonet, P. and Selznick, P. *Law and Society in Transition: Toward Responsive Law*, New York: Harper and Row, 1978: 115.