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Antinomies of Autonomy: German Idealism and English Mental Health Law

Der derzeitige Zustand der Gesetze in England und Wales, die sich mit der psychischen Gesundheit befassen, weist eine Reihe systematischer Antinomien auf. Dies sollte nicht als ein Fehler in der Gesetzgebung angesehen werden. Diese Rechtsantinomien spiegeln vielmehr eine tiefer liegende antinomische Struktur wider, die dort wirksam ist, wo Pflegeberufe in einem weitgehend liberalen Rechtsumfeld praktiziert und reguliert werden. Anliegen dieses Beitrages ist es, diese antinomischen Strukturen zu identifizieren und zu prüfen, inwieweit die post-kantianische idealistische Tradition für eine Auseinandersetzung mit dieser Problematik argumentative Mittel zur Verfügung stellt.

§ 1: Kerrie's Antinomy

On the afternoon of 17 September, 2007, a 27-year old Norfolk woman called an ambulance and was transported to the accident and emergency ward at a local hospital. She had ingested approximately 350 ml of antifreeze. The main ingredient in antifreeze is ethylene glycol, a toxic substance; 350 ml is a potentially lethal dose. The indicated treatment for ethylene glycol poisoning is renal dialysis, which in this instance would almost certainly have saved the woman's life. But she refused to consent to treatment. Arriving at the emergency room, she presented a hand-written note in which she explained that she had drunk antifreeze in an attempt to end her life, and that she had come to hospital not to be saved, but in order that she might die comfortably, and not alone at home. Over the following hours she repeatedly refused all life-saving treatment. She died in the early hours of the morning of 19 September.

The woman's name was Kerrie Wooltorton. Her case came to public attention upon the publication of the Norfolk County Coroner's report, and has been a subject of controversy ever since. Much of the dispute has centered on the question of what the law dictates for a case of this sort, and in particular which legal framework is appropriate for navigating this tragic circumstance. Some have argued that the Wooltorton case should be approached by way of the *Mental Health Act* (MHA) of 1983. The MHA establishes the power to "section" mentally disordered individuals who are a danger to themselves or to others and to treat them involuntarily. Kerrie Wooltorton had been diagnosed with borderline personality disorder, and had a long history of self-harming behaviour; it is plain that she was a danger to herself. Accordingly, some have

argued that she ought to have been sectioned and given life-saving treatment without her consent.

Others, including the Norfolk County Coroner, have taken a different view. They have viewed the Wooltorton case through the lens of the *Mental Capacity Act* of 2005 (MCA). The MCA is a new piece of legislation, rooted in a series of landmark court rulings in the 1990s. These court rulings, together with the statute that followed in their wake, are meant to ensure that competent adult patients have a right to refuse unwanted medical treatment. In one much-cited 1997 case, Justice Butler-Sloss ruled that an adult has "the absolute right to refuse medical treatment, for any reason, rational or irrational, or for no reason at all".[1] Butler-Sloss's formulation was itself adapted from a 1992 case in which Lord Donaldson wrote that "[the patient's right of choice] exists notwithstanding that the reasons for making that choice are rational, irrational, unknown or even non-existent".[2] But these rights are in one crucial respect conditional: an adult has the right to refuse treatment *if she has the mental capacity to do so*. Where capacity is lacking the rights of the patient must give way to forms of surrogate decision-making and duties of best-interest care.

The MCA defines the threshold concept of mental capacity as follows. A person has the capacity to make a decision for herself if she is able to "understand and retain" the information relevant to the decision, is able to "use or weigh" that information in reaching a decision, and is able to "communicate a choice". The Norfolk County Coroner and the medical personnel on hand at the hospital were unanimously in agreement that Kerrie Wooltorton satisfied this standard: she understood the diagnosis of ethylene glycol poisoning and the purpose of the proposed dialysis, she was able to "use and weigh" that information in reaching a decision, and she emphatically communicated her choice. Accordingly, they argued, she had a right to refuse treatment, even at the cost of her life. Moreover, to treat her without her consent would have amounted to a form of assault.

I propose to approach the case of Kerrie Wooltorton – and some other related cases – by making use of the notion of a legal antinomy. An antinomy is a distinctive form of contradiction; it comprises a pair of arguments, each sound, but yielding inconsistent conclusions. A body of law is antinomial insofar as it yields antinomies in this sense. The notion of an antinomy will of course be familiar to readers of this *Jahrbuch* from Kant's account of the dialectic of reason. Kant was concerned with antinomies of pure reason: the circumstance where reason itself leads us to contradictory conclusions; this was what Kant famously described as "the euthanasia of pure reason" (KrV, A 407/B 434). My use of the notion of an antinomy is indebted to Kant, but

1 *Re MB* [1997] EWCA Civ 3093.
2 *Re T* [1993] Fam. 95.

I shall not follow his lead slavishly. In particular, I am concerned here with antinomies of positive law rather than of pure reason, and I am concerned in particular with antinomies that yield contradictory *obligations*. Formally, the antinomies that concern me consist of a pair of sound arguments that together entail a conjunction of the form "S is obliged to φ and S is obliged to not-φ", where S is a person and φ is the name of a particular action. The Wooltorton case threatens to yield such an antinomy, where φ is the action of performing (or authorising) renal dialysis and S is the responsible medical officer on duty at the time of Wooltorton's hospital admission.

In what follows I shall argue that current mental health legislation in England and Wales exhibits systematic antinomial tensions. I show that these antinomial structures are not a quirk or defect of the legislation but are intrinsic to the reality that these laws seek to regulate. Throughout my aim will be to draw on the resources of the post-Kantian idealist tradition in trying to understand these antinomies and in thinking about how they can be managed. Before going further, however, I do need to be clear about one point. This essay is not an interpretation but an appropriation of German idealist texts. I operate at a considerable distance (some may say: a scandalous distance) from the historical texts themselves, and I am quite ready to adapt canonical doctrines where doing so serves my purposes. I take this liberty out of the conviction that the Kantian and post-Kantian tradition provides us with the most important sustained consideration of the significance of antinomial structures, and that certain lessons from that tradition can play an important role in clarifying and improving our current situation. If the result is in certain instances more like a crude cartoon than a finished portrait of the canonical heroes, that is a price I find worth paying.

§ 2: Two Unworkable Kantian Strategies

One of Kant's own strategies with the antinomies of pure reason was to identify a defect in the reasoning that generates the contradictory conclusions. Recall that this was Kant's tactic in diagnosing the first and second antinomies in *The Critique of Pure Reason*. An antinomy requires two *sound* arguments for contradictory conclusions; if one or the other of the pair is unsound then the antinomy is only apparent. We find a number of variants on this strategy in the literature that has grown up around the Kerrie Wooltorton case. At the coroner's inquest, several witnesses testified that Wooltorton was not suffering from a mental disorder of the sort that would warrant an MHA section.[3] Alter-

3 The coroner reports: "Everyone was asked by me whether Kerrie was exhibiting any symptoms of a mental disorder or disability and the answer was very clearly in every case was no [...]" (Armstrong, 2009).

natively, one could claim that an MHA section provides only for involuntary treatment *of a mental disorder*, and that renal dialysis is not itself a treatment for a mental disorder. In either case the legal argument for compulsory treatment would be unsound. Others have argued that Wooltorton's psychological state left her unable to "use or weigh" the relevant information about her decision situation. If this is true then the argument for honoring her refusal would be unsound. It has also been argued that the MCA itself explicitly provides for blanket deference to the MHA in cases of conflict, so that no antinomial obligations can possibly arise.[4]

I do not myself find any of these defusing strategies conclusive. Consider the first two together. We have already seen that Wooltorton had been diagnosed with borderline personality disorder. That condition is the subject of much controversy in psychiatric circles, but it is listed in the authoritative manuals of psychological disorders, and self-harming behaviour is one of its chief manifestations. The courts have ruled that "treatment for a mental disorder" can include treatment for the physical consequences of harm that are the result of that disorder.[5] Under the circumstances, then, there is a strong prima facie case that § 3 of the MHA applies: Wooltorton suffered from a mental disorder of a nature or degree that warranted hospital treatment, and she was a danger to herself.

The claim that Wooltorton lacked capacity is much harder to gauge: a capacity assessment can require considerable professional skill, and that skill must be exercised in a face-to-face encounter with the patient who is being assessed. There are difficulties surrounding such assessments, to be sure, but it is striking that all those who encountered Wooltorton at the hospital were in agreement – and no one seems to have been in doubt – about her capacity when measured against the legal standard. Here it is crucial to note that the law explicitly recognizes that a person may suffer from a mental disorder and nonetheless be possessed of mental capacity.[6] One of the fundamental principles of the MCA approach is that capacity must be assessed with specific reference to the functional abilities of the individual in the face of the relevant decision; one cannot refute the legal presumption of capacity simply on the basis of a generic psychiatric diagnosis. What, finally, about the general claim as to the "trumping" precedence of the MHA? The legal issues here are complex, and for present purposes it is best not to get drawn too far into them. Suffice it to say that the deference of the MCA to the MHA is not wholesale; arguably the specific circumstances of the Wooltorton case fall outside its scope.[7]

[4] Both these arguments were advanced by a pair of forensic psychiatrists commenting on the case in a letter to the *BMJ*: Bashir and Crawford, 2009, p. 988.

[5] *B v Croydon HA* (aka *LB v Croydon* HA) CA [1995] 2 W.L.R. 294.

[6] *Re C (Adult Refusal of Treatment)* [1994] 1 All ER 819.

[7] The argument for trumping would have to turn on the provisions of MCA § 28. That section does in certain respects provide for deference to the MHA in cases of conflict.

Having said all that, there is nonetheless one sense in which the Wooltorton case falls short of a strict legal antinomy. Recall that the schema for a strict antinomy requires a conjunction of the form "S is obliged to φ and S is obliged to not-φ". In the Wooltorton case, we seem to fall short of such a conjunction, if only because the MCA generates *obligations* but the MHA establishes only *powers*. That is, the MCA *obliges* medical staff to respect a capacitous refusal; the MHA provides for the *power* to section but, strictly speaking, it does not *oblige* anyone to do so. If only in this way, the law avoids a flat-out contradiction. But while this is good for the law, it is not particularly helpful for the medical staff on the scene. It is natural to suppose that it is the duty of emergency room staff to use such powers as are available to them in order to save the lives of the patients in their care. To do otherwise is the basic form of negligence. So, if the MHA gives them the power to legally save Wooltorton's life, then there is considerable moral and professional pressure to exercise that power. In this sense, the combination of the MCA and the professional code of conduct would suffice to generate the obligation required for a strict antinomy.

I have argued so far that a Kantian "defusing" strategy does not suffice to show that Kerrie's Antinomy is merely apparent. If we are to get further, then we must dig deeper, and consider the source of the antinomial tension itself. Why does the law generate Kerrie's Antinomy? Is this simply an artifact of badly-worded legislation? Could the problems be solved, as some have argued, by a single unified statute?[8] I want to propose that the antinomial pressures exhibited by the Wooltorton case are in an important sense essential to the law, given its context and the form of relationship the law here seeks to regulate. In particular, I shall argue that a tendency toward antinomy is inevitable where the law regulates vocations of care in a broadly liberal legal environment.

One way to make this point is to consider the competing values that are at work in the respective statutes we have been considering. The primary value that informs the *Mental Health Act* is public health and safety. The modern MHA has its origins in Victorian legislation governing "Asylums, Lunatics and Madhouses". But its basic powers date back to the Vagrancy Act of 1774, which provided for the detention of those who are "furiously and dangerously mad".

It could accordingly be argued that honoring Wooltorton's refusal would in effect be a violation of § 28, if indeed Wooltorton's condition was such as to warrant an MHA section. But this claim might not withstand scrutiny. The relevant portion of the statute reads as follows: "Nothing in this Act authorises anyone (a) to give a patient medical treatment for mental disorder, or (b) to consent to a patient's being given medical treatment for mental disorder, if, at the time when it is proposed to treat the patient, his treatment is regulated by Part 4 of the *Mental Health Act*". But in the Wooltorton case the medical personnel did not "give a patient medical treatment"; they decided not to. So it is hard to see how their actions could be in violation of this section.

[8] See Szmukler et al., 2010.

The modern statute has come a long way from those early beginnings (particularly in the strategies it adopts to insure against abuses), but in one crucial respect there is continuity: one of its basic aims is to protect public health and ensure public order. The MCA has a different normative priority. It finds its place in the tradition of human rights legislation and, as such, places special value on individual autonomy – the ability of individuals to make decisions for themselves. It is inevitable that these two values will come into conflict. Cases will arise in which a concern for public health points in one direction and the respect for autonomy points in another.

But there is a deeper source of the antinomial structures in this area of the law, and this pertains not so much to the values of the two statutory frameworks, but rather to the standpoint or perspective that each statute adopts toward the patient. Or, to put the point more exactly: the two legal frameworks each dictate a perspective that the care-provider must take up toward the potential care-recipient. Taken together these two standpoints in themselves generate antinomial tension. This is a point that requires elaboration.

Consider the circumstance of a psychiatric care-provider who is faced with the decision about whether to section a patient in order to provide involuntary care. Suppose that it is established that the individual suffers from a serious mental disorder and that there is appropriate treatment available that can only be provided in a hospital setting. But the patient does not consent. Should she be sectioned? In such circumstances everything comes to ride on the question of whether the individual in question is "a danger to self or others". How does one go about answering such a question? The first thing to notice is that this is a question about the future. The care-provider is tasked with making a prediction, based on the available information, about the future behaviour of the patient under a variety of possible circumstances. Care-providers are subject to intense public scrutiny if they get the prediction wrong. The crucial point for our purposes is that such a question is posed from what Strawson famously dubbed "the objective attitude".[9] The patient is a complex, partly dysfunctional biological mechanism that will be interacting causally with a complex environment. The task is to make an informed risk-assessment about the likely outcome of such interactions.

Consider now the standpoint prescribed by the MCA. Here the determinative question is not in any obvious way about the future; it is about the standing or status of a presently expressed intention. Here the psychiatric assessor is called upon to view the patient as an (actual or potential) agent. The critical question is, in effect, whether the presently expressed preferences are genuinely

[9] Strawson, 1962.

an expression of the patient's free agency.[10] In this case, the perspective upon the patient is what Kant would call "practical" or "moral".

It is in the tension between these two standpoints, I submit, that we find an important source of Kerrie's Antinomy. If, in Kantian terms, we view Wooltorton "under the idea of freedom", then we treat her refusal as the manifestation of her free, self-determining choice. But when we view her instead through the prism of the MHA – "under the idea of probabilistic risk assessment", as it were – that same refusal shows up as simply one more symptom (effect) of Wooltorton's disorder (cause). Given the right sort of ancillary knowledge, we can extrapolate ahead to the further disastrous consequences to come. So which perspective should we adopt toward Wooltorton? Is she a suffering creature in the grip of a disorder that can be managed? Or is she a moral agent whose choices must be respected? The answer, of course, is *both*. It would be a fateful error to suppose that we can choose between these two perspectives. They both apply, and indeed the clinician is legally bound to take up both of them. The antinomial pressures that we find in the law reflect the antinomial pressures that result from the combination of these two perspectives.

If this much is correct then a second Kantian coping strategy suggests itself. We are not here in the domain of the mathematical antinomies, where the resolution lies in exposing a fallacy. We are rather in the domain of Kant's third antinomy, where the challenge is to accommodate two sound arguments, and to find room for both free agency and causal determination. Kant's own strategy for managing this challenge famously involves a form of dualism: both perspectives are legitimate, indeed requisite; the key is to confine each to its appropriate domain. One version of this dualism notoriously turns on the Kantian distinction between phenomena and noumena: considered as appearances our actions are determined; considered as noumena we are free. But we might also cast the dualism – this seems to have been a crucial part of Strawson's suggestion – as a dualism of theoretical and practical attitudes. Viewed from the theoretical standpoint, the patient's behaviour can be explained and (fallibly) predicted as so much causal output of a complex biological machine in a complex environment. Viewed practically we treat the patient's behaviour as the manifestation of autonomous agency. Freedom prevails from the latter standpoint; determinism (or probabilistic causation) from the former. As long as we do not mix or confuse the standpoints, the two descriptions of the patient need not contradict one another.

[10] This framing of the question of capacity can be found in judicial rulings in disputed cases. See for example *A Local Authority v Mrs A* [2010] EWHC 1549 Fam. In finding Mrs. A lacking in capacity, Mr. Justice Body writes: "I am satisfied that her decision not to continue taking contraception is not the product of her free will" (§ 73).

But these celebrated Kantian dualisms cannot help us with Kerrie's Antinomy. The problem is not that they introduce some rather heavy metaphysical baggage; set that concern aside for the moment. The more fundamental problem is that the clinical situation itself requires the clinician to adopt *both* these perspectives in the *same* medical encounter. This is the challenge of practicing the caring vocations in a liberal legal context that places a high value on the human rights of care-recipients. It is not open to the care-provider simply to see the patient as a "creature in need", nor can the care-provider somehow oscillate between one view of the patient as a rights-bearing person and another view of the same individual as a complex biological mechanism. The challenge is to occupy both perspectives at once without falling into antinomial contradiction.

§ 3: A Brief and Extravagant Fichtean Excursus

In looking for a way to meet this challenge, I propose to begin with what will undoubtedly seem an extravagant thought. Consider a framing of Kant's third antinomy in the sparse vocabulary of Fichte's *Wissenschaftslehre*. One the one hand (thesis) we find ourselves with what we might call the formula of autonomy: *the I determines itself*. On the other hand (antithesis), we have the principle of determination by something other: *the I is determined by the not-I*. For the Fichtean, we are committed to treating both of these principles as true, despite the obvious tension between them. The two principles are jointly constitutive of the status of finite rational subjectivity; they are both transcendental conditions on the possibility of judgement and action. The Fichtean seeks a resolution of the tension that avoids the Kantian dualisms: both principles must be true in the same world, in the same circumstance, from the same point of view. Can these requirements possibly be met?

This is where we come to the extravagant thought. Suppose it were the case that the not-I which determines the I were itself determined by the I. Imagine, if you will, that you are a kind of God: you have made the not-I exactly as you decided it should be, and you now allow yourself to be determined by the not-I you have made. There is, undoubtedly, something disturbingly solipsistic about such a thought. Nonetheless there would be, in such a circumstance, a certain kind of formal reconciliation of thesis and antithesis, determination-by-self and determination-by-other. For under such an extraordinary circumstance the I would indeed be determined by the not-I. We thus satisfy the requirements of determinism. But this deterministic moment would not itself compromise the freedom of the I, since the not-I that determines the I would itself be determined by the I. The circle is closed.

A Fichtean approach to the antinomy of freedom and determinism seeks to exploit this extravagant thought. It involves, first, a recognition of the permanent tension between thesis and antithesis. We finite beings will never find

ourselves in the circumstances of the solitary god whom we have just described. But the Fichtean strategy for addressing that tension is ultimately not metaphysical but practical; it is a form of striving. The finite Fichtean subject *works* on the not-I, ever seeking to determine the world in accordance with its judgement as to how it ought to be. By remaking the world in this way, the gap between thesis and antithesis progressively closes: the I comes closer and closer to the point where self-determination and determination-by-other coincide.

I have described this Fichtean thought as extravagant. We might say that it combines Promethean ambition with Sisyphean absurdity. For of course the envisaged point of unity can never be obtained: in this sense Fichtean striving is unending. It is certainly not easy to see how such an extravagant thought could possibly be useful in finding our way through the all-too-concrete medico-juridical antinomies of the psychiatric clinic or accident and emergency ward. By definition the circumstances involve a state of affairs where things are *not* the way they ought to be. But might there nonetheless be some way in which a suitably domesticated variant of the extravagant Fichtean strategy might be put to use in taming the antinomies we have uncovered?

§ 4: Polly's Antinomy

On 30 March, 2009, Polly, aged 48, was involved in an automobile accident. She suffered a serious head injury and was taken unconscious to the hospital. Her medical condition was stabilized, but she did not regain consciousness. She was kept alive by life-supporting medical equipment which provided artificial nutrition and hydration. For the first few days in the hospital her breathing was supported by an artificial ventilator; subsequently a tracheostomy was performed, and she regained the ability to breathe on her own. Polly was unconscious for several months but then emerged into what is medically described as a "minimally conscious state".

Prior to her accident, Polly had been a fiercely independent woman. She led an adventurous life, travelling the world; her favorite pastimes included sailing and mountain-climbing. Her family describe her as someone who celebrated her physical strength and valued her independence. In cartoons and poems she described herself as a free spirit, someone who hated to be tied down or to be dependent on others; she wanted to be able to "fend for herself". In one of her notebooks she recorded that she imagines dying young while doing something exciting, that she does not want to be less able or to know that she is slowly going downhill. "Life is not measured by the number of breaths we take, but by the moments that take our breath away". Polly was also politically active, and (among other things) a persistent critic of medical paternalism, heroic medical measures, and the like. She even wrote a how-to pamphlet about advance decision-making, although she never completed a formal advance-decision docu-

ment herself. Polly's family and friends agree that, given a choice, the Polly they knew would have preferred to die rather than survive in such a way as to be wholly dependent on care-providers, family, and the medical establishment.

Early on in the course of her care, members of Polly's family began to raise the question as to whether Polly would have wanted the sorts of life-preserving measures that were being provided to her. Would she have wanted to go through the ordeal of treatment and rehabilitation to achieve whatever degree of "recovery" might be possible? But the medical staff responsible for Polly's care were not prepared to countenance such questions. Their vocation is to save lives; several of them have vivid memories of patients who have emerged from a coma and gone on to regain some level of independence. From their perspective it seemed far too soon to give up on Polly. Over the course of two years following the accident, Polly's condition did marginally improve. Nonetheless she has been left with profound multiple mental and physical disabilities and is still dependent on artificial nutrition and hydration and round-the-clock assistance.

If Kerrie's Antinomy arose in the case of a patient who had capacity, Polly's Antinomy emerges in the case of a patient who lacks it. For at least as long as Polly was unconscious, and almost certainly long thereafter, Polly lacked the capacity to make treatment decisions for herself. In such circumstances the MCA requires someone else to make decisions on her behalf; call this "surrogate decision-making". The surrogate decision-maker might be a citizen providing first-aid at the scene of the accident; it might be the senior member of the paramedic team that arrives to provide assistance; later it might be the senior consultant in a brain trauma unit or a judge in the Court of Protection. So what should be the basis of such surrogate decisions? About this the law is also clear: surrogate decisions made on behalf of an incapacitous patient must be made *in the patient's best interest*. This is a familiar principle of medical ethics, the so-called principle of beneficence.

Earlier we considered the antinomial tension that arises because of the different values and perspectives that inform the MHA and the MCA. But we are now in a position to see that there is a tendency toward antinomy within the MCA itself. The tendency derives from the statute's commitment to two overarching principles: the principle of patient autonomy and the principle of beneficence. Both principles are deeply rooted: the former in the commitments of liberal law, the latter in the constitutive values of the vocations of care. But there are certainly circumstances where the two principles pull in opposite directions. In the terms of our schema, the principle of beneficence might yield an obligation to phi where the principle of autonomy would yield an obligation to not-φ. So how does the statute manage this threat of antinomy? Its crucial mechanism lies in its insistence on a bright line separating two circumstances. Under the law, any particular person at a particular time facing a particular decision *either has or lacks capacity*. For the capacitated patient, the principle of autonomy reigns supreme; for the incapacitous patient, the principle of beneficence takes priority.[11] By this contrivance the statute serves two principles without generating antinomial obligations.

But of course reality is not always so tidy. Naturally there will be grey areas and borderline cases; there will also be circumstances where capacity fluctuates. Suppose that Polly had been conscious and possessed capacity when the paramedics arrived at the accident scene. Under the law she would have the right to refuse treatment, even if the paramedics concluded that treatment was clearly in her best interest. But then Polly loses consciousness and capacity. What should the paramedic team do then? Here is a first circumstance where Polly's Antinomy makes itself felt. Should they honor her capacitous refusal and let her die by the roadside? Or, must they now act in accordance with their judgment as to her best-interest, even if that means acting against her express wishes? If they decide to treat under the best-interest principle and Polly returns to consciousness during the treatment, should they once again desist if she demands that they do so? These questions defy easy answers precisely because of the antinomial tensions within the statute.

Polly herself did not possess capacity at the accident scene and the Emergency Services Team who responded did not have occasion to be troubled by antinomy. They carried out their vocation of care, doing what they could to stabilize Polly's condition and transporting her to the hospital. But as her care progresses, the antinomial tensions certainly make themselves felt. Is a tracheostomy in her best interest? What about a course of antibiotics to treat pneumonia? Polly is still unconscious and incapacitous, so surrogate decisions must be taken on her behalf. To the medical team the answers may seem obvious. Polly's best chances for survival and recovery require that she be weaned off the respirator, so the tracheostomy is a medical imperative. Without the antibiotics pneumonia could be fatal. It is only by helping Polly survive these immediate threats that the team will be able to assess her longer-term prospects for recovery. So an initial survey of best interests creates a prima facie obligation to make use of these medical interventions. On the other hand, the law explicitly requires that an assessment of Polly's best interests should take into account Polly's own past and current preferences, insofar as those are reasonably ascertainable. It also requires that Polly's family and others close to her be consulted and that reasonable efforts be taken to determine what Polly herself would have chosen under the circumstances. If this process is undertaken seriously, and the facts about Polly's character and values come to light, the medical team will certainly come to feel the pressure of the antithesis: if it becomes clear that Polly herself would have refused these treatments, then do we not have an obligation

[11] This priority of the principle of beneficence is far from absolute. Among other things, it finds a limit in cases where an incapacitous patient has a legally valid and applicable advance directive. For present purposes I abstract from this complication.

to desist? Once again it is those who are involved in the vocations of care who most directly find themselves confronted with the antinomy.

Before leaving Polly, there is one further aspect of her antinomy which merits our attention, for once again it pertains to a difference in the perspective or point of view which the law prescribes. In the case of a refusal of treatment, the critical question under the law is whether the patient has capacity *at the material time* – i.e., at the time a decision needs to be made.[12] In practice, this can lead to a narrow, "time-slice" perspective on the potential care-recipient. An assessment of capacity focuses on "capacity-now"; an individual who is found to have capacity-now will accordingly have the right to make their own decision based on their *current* preferences and values. An experienced care-giver may well have reason to believe that this decision is one that the patient will later regret, but the liberal commitments of the law preclude paternalistic intervention on the basis of that assessment; a poor decision is not of itself evidence of incapacity. When it comes to a judgment of best-interest, by contrast, the requisite temporal perspective is quite different. A judgment of best interest is not a judgment about the interests of the present time-slice of the person; it is a judgement about that person as a whole, where the relevant whole is extended across a significant expanse of time. So, while respect for a capacitous decision tends to focus on the present moment, a best-interest assessment must somehow take in a view of a temporally extended totality.

§ 5: The Eve Standard

The extravagant speculative thought that we encountered in Fichte also finds a place in Hegel, albeit with a rather different inflection. Like Fichte, Hegel envisions a speculative reconciliation of self-determination and determination-by-other in a circumstance where the other is no longer something alien. Here is one of his formulations: "*For freedom it is necessary that we should feel no presence of something else which is not ourselves*".[13] So formulated, Hegel's vision may well sound solipsistic – as if freedom requires that I be insulated from contact with anything or anyone else. But of course this is not at all Hegel's conclusion. The Hegelian variant on the Fichtean thought famously requires alterity (and indeed altercation!) in an intersubjective setting for freedom: self-determination is inextricably tied up with forms of determination by Others.

[12] MCA, 2005, § 2, p. 1.

[13] I take this formulation from Wallace's rather free translation of *Encyclopaedia* § 24, Zusatz 2 (Hegel, 1975, 8:39). Hegel's original reads as follows: "*Freiheit is nur da, wo kein Anderes für mich ist, das ich nicht selbst bin*" (Enz., p. 84).

The most famous intersubjective encounter in Hegel is of course the dialectic of master and slave, together with the struggle of life and death from which it originates. But both in his *Science of Logic* and in the *Philosophy of Right*, Hegel takes his initial orientation from a different intersubjective encounter: Adam's first encounter with Eve. Recall the story. God announces at Genesis 2:18 that Adam needs a "fitting partner" – or, as the King James has it, "a helper, meet for him". He proceeds to create all the wild beasts and birds, forming them out of the earth, and presenting them in turn to Adam. Adam gives names to each of them, but none are found to be a fitting partner. So far, all this is recounted; it is only when God creates Eve (out of Adam this time, rather than "out of the earth") that we finally hear Adam's first speech. "This at last is bone of my bone, flesh of my flesh. This one shall be called Woman, for from man was she taken" (Gen. 2:23).

For Hegel, the story of Eve inscribes a number of fundamental truths. It is, first, a story of *Anerkennung*. Adam *recognizes* Eve, and this recognition itself involves both a cognitive moment ("she is like me") and a normative moment ("she is *fitting*; she is appropriate for me"). In Adam's first speech the recognition is certainly not yet complete (among other things, Adam speaks *about* Eve, but he does not speak *to* her – nor she to him). Nonetheless we have from the outset the standard of recognition inscribed in the encounter with an Other. This in turn points to the second key concept Hegel extracts from the encounter in Eden: Adam's first speech expresses the basic logic of *Geist*. For Hegel, the concept of *Geist* essentially *is* the concept of an intersubjective collectivity which is constituted in relationships of recognition. Indeed in at least one place Hegel translates Adam's speech into his own preferred speculative idiom: "Just as Adam says to Eve: 'You are flesh of my flesh and bone of my bone', so does *Geist* say: 'This is *Geist* of my *Geist*, and its alien character has disappeared'" (PR § 4 Zusatz, p. 47). This "disappearance of an alien character" [*die Fremdheit ist verschwunden*] is crucial for the Hegelian strategy. The encounter with Eve involves an encounter not simply with a not-I, but with an Other that is not-other, a not-I that is both me and not-me.

These are riddling formulations, to be sure. But they reflect three underlying commitments of Hegel's project upon which I propose to draw. The first is what I shall call "the Eve Standard". Autonomous determination *can be* determination by another, as long as that other is an other whom I rightly recognize as appropriately not-other. So formulated, the Eve Standard is at best a schema. In particular, it calls for an elaboration of just what "rightly recognize" and "appropriately not-other" can mean, such that freedom is realized and preserved.

The second key point concerns contradiction. Hegel's articulation of the encounter with Eve is couched in forms that defy the principle of non-contradiction: Eve is both I and not-I, other and not-other; freedom requires alterity that has lost its alien character. We may well wonder whether and how these dialectical formulations might be tamed in a logic that honored consistency, but Hegel's stance is that the dialectic runs all the way down. And this itself, he

claims, is a defining feature of *geistig* reality. Hegel: "What belongs to Nature is destroyed by contradiction, [...] but *Geist* has the power to preserve itself in contradiction" (Enz. § 382 Zusatz, 10:26–27). This is another lead worth pursuing. If *Geist* has the resources to absorb contradiction, might it have resources for managing antinomy as well?

These first two points are couched in the high-level abstractions of Hegel's logic, but they come closer to the ground in Hegel's strategy for considering how the Eve Standard might be satisfied in our own world. What would be the lived experience of the sort of self-determination-through-Others that Hegel has in mind? Central to Hegel's answer is the idea of a kind of ownership of the world – not in the sense of treating the world as my property, but of finding the world to be *my own*, in finding myself to be *at home* in it. In the *Encyclopaedia* Hegel introduces the notion of spirit (*Geist*) by explicitly linking this distinctive form of ownership with Adam's speech about Eve: "Therefore it [*der freie Geist*] is possessed of the confidence that in the world it will find its own self, that the world must be befriended to it, that, just as Adam said of Eve that she was flesh of his flesh, *Geist* has to seek in the world Reason of its own Reason" (*Enz.* § 440 Zusatz, p. 230).[14] To apply these Hegelian promptings seriously to our antinomies would be to consider how Eve's Standard might be met where the vocations of care are regulated in a broadly liberal legal environment. In such a circumstance where I am cared for beneficently by others whom I rightly recognize as appropriately not-other, in a world which I can find to be my own, paternalism and autonomy would coincide. Allow me one more story in order to try to make this schema plausible.

§ 6: "I made the decision on my own in the end"

John suffers from schizophrenia. He is in prison, awaiting trial on a criminal indictment.[15] In prison he refuses to accept treatment for his psychiatric condition. When he begins to develop de lusional symptoms, a MHA assessment is conducted. John is found to suffer from a mental disorder of a nature or degree

[14] I have adapted Wallace's translation of this passage. Hegel's German reads as follows: "*Er besitzt daher die Zuversicht, daß er in der Welt sich selber finden werden, daß diese ihm befreundet sein müsse, daß, wie Adam von Eva sagt, sie sei Fleisch von seinem Fleische, so er in der Welt Vernunft von seiner eigenen Vernunft zu suchen habe*". Wallace uses "*reconciled*" to translate "*befreundet*" (Hegel, 1971, p. 179), but it is worth marking the difference between the sort of "friendship with the world" that Hegel invokes here and the reconciliation (*Versöhnung*) that is meant to be one of the deliverances of Hegelian philosophy.

[15] I have discussed John in print elsewhere, in collaboration with Ryan Hickerson (Martin and Hickerson, forthcoming). For the case material regarding John, I am grateful to Beth Eastwood of the BBC.

to make hospital treatment appropriate; his condition is deemed to make him a danger to himself and to others. On the basis of this assessment he is sectioned for treatment under the MHA. He is transferred from prison to a secure ward in a National Health Service medical facility, where he receives involuntary treatment in the form of anti-psychotic medication. With treatment, John's schizophrenic symptoms are brought under control. But John also suffers from a physical ailment. He is a heavy smoker and in prison had begun to lose his speaking voice. In the hospital, tests show that he has advanced laryngeal cancer – cancer of the voice box. The indicated treatment is surgical removal of the voice box and the fitting of a speaking valve in John's throat.

Laryngeal cancer is not itself a mental disorder, so the proposed treatment is not covered by John's mental health section, nor indeed by the MHA. Surgical treatment for cancer would therefore require John's consent – if indeed John has the capacity to provide it. In consultation with his surgeon, John exhibits understanding of the diagnosis and the purpose of the treatment, and agrees to proceed with surgery. Back at the psychiatric ward, he discusses the situation with his care team and case worker. Plans are made for the surgery. But a few days later John's delusional symptoms return. He is now convinced that the proposed medical procedure is a conspiracy, and that the surgeon's specialty (commonly abbreviated as "ENT") is not "Ears, Nose and Throat", but "Electroneurotherapy", a fictional treatment that will kill him. He refuses to go ahead with the surgery.

By now we can recognize the tendency toward antinomy in such a circumstance. The care team's aim is to care for John, yet they are also committed to honoring John's rights as a patient. Should they treat John involuntarily in his own best interests? Should they desist in the face of his refusal? They know that in such circumstances the law requires a capacity assessment, but the outcome of such an assessment varies dramatically depending on the time they choose to conduct it. John's capacity fluctuates with his disorder, and perhaps also with his medication cycle, etc. In the end John decides to go ahead with the surgery. Reflecting back some time later, John sums up the episode in these words, spoken through his newly fitted valve: "The psychiatrist did say to me [that] someone else would have to make the decision because I was changing my mind. But I made the decision on my own in the end".[16]

Before considering the dialectical structure of John's case, it will be worth noting some of the events that unfolded *between* John's refusal and the final decision to proceed with the surgery. In the face of John's refusal, the care team undertook a number of steps. They consulted with John's family, and the family in turn with John. The surgeon, in consultation with the hospital's lawyers, drafted a letter, setting out John's condition and the medical options for treat-

[16] BBC Radio 4 (2010).

ment, together with a frank summary of the likely outcomes of both treatment and non-treatment. They reviewed the letter with John, his family, and a case worker. The psychiatric team reviewed John's medication regimen and adjusted his dosage. John's decision came about through the mediation of these interventions.

In analyzing John's case, it is instructive to begin from his own retrospective assessment. It might be tempting to conclude that John's report is simply mistaken. From what *we* know of the case, it seems plain that John did *not* in fact make the decision *on his own*; a veritable army of Others helped him make it, and those Others played a significant role in *determining* what that decision turned out to be. Some of that determination came in the form of presenting him with information. But it also involved framing that information in ways designed to shape John's response to it; and it involved some quite direct manipulation of the neurochemistry of John's brain. In the sparse language of our dialectic: John was determined by the not-I.

So was John's retrospective report simply an error, perhaps even a delusion? Such a conclusion would be far too hasty. For one thing, John is well aware that other people played a significant role in enabling his decision. He is not *denying* their role in claiming the decision as his own. Yet despite the decisive role of others, John *experiences* his decision as his own; he *recognizes* it as his own, and it in turn is recognized as his decision. For in taking John's consent as valid, John's care team are recognizing John's ownership of the decision. So John's decision is determined by the other, yet it is also recognized as one that he made for himself. This is not an antinomy, but it is the sort of contradiction that the idealists claimed to find in *Geist*, and through which *Geist* is said to be able to endure.

If this is right – if John's case could be an instance of sustaining contradiction – then we want to know *how* it manages to do so. Let's try to tackle this question with reference to what Hegel taught us about Eve. According to the Eve Standard, John's self-determination is compatible with – indeed is made possible by – determination by others *insofar as John can rightly recognize those others as appropriately other*. And this in turn is to be assessed by considering whether and how John can find himself "at home" in a world that has "befriended" him. Of course Eve in John's circumstance is not any one person. A whole community of Others (an Otherhood?) played a critical role in determining his decision. And that community is by no means symmetrical or homogenous. It includes surgeons and psychiatrists but also case-workers and legal experts, friends and family. It ultimately includes, if only mediately, judges and courts, the BBC, and even you and me. In Hegel's vocabulary, it comprises the family, civil society, and the state. To apply the Eve Standard to John's circumstance would be to ask: is this Otherhood so constituted that John can rightly recognize it as appropriately other?

That is a big question, and it is not one that I can responsibly undertake to answer here. But it is worth singling out one feature of John's community that bears on our answer. That community somehow manages to bring together a

number of quite different *perspectives* on John. Some in John's decision community are taking a view of John as a biochemical complex whose behaviour can be manipulated and indeed predicted with the tools of pharmaceutical medicine. Some are taking a view of John as a bearer of rights who must be respected; others view him primarily as a suffering individual in need of care. But there is also significant variation in the *temporal* perspective on John. The surgeon's perspective is focused on the growth of the cancer, which is increasingly threatening John's ability to breathe and could be fatal in a matter of days or weeks. Some members of the team are projecting ahead to the moment when John wakes up from the surgery. Will he complain at that point that he had been tricked or coerced into the surgery? The family is also projecting ahead, but with a longer view, trying to help John see that he still has much to live for, despite his current legal and medical troubles. But all this taking in of temporal complexity is not to the exclusion of the perspective where everything depends on the present moment. John's consent can only be legally taken if he possesses capacity *at the material time*. One could go on with this sort of analysis, but I hope the point is clear: John's Otherhood is a forum in which a whole array of divergent perspectives are held together in such a way that facilitates John's decision, and helps enable his retrospective ownership of it.

A final point to make about John's situation concerns not John himself, but the care-givers who played a role in John's world. The many practitioners of the vocations of care who came into contact with John at the material time of his decision encountered him with an orientation, we might even say an impulse, a habit (*hexis*) of beneficence. In their capacity as doctors, psychiatrists, social workers, even prison officers, an intrinsic aim of their vocation is to help John, to care for him, to act in such a way as to advance John's own interests. But this habit of beneficence does not hold sway unchecked. It is balanced and opposed by a duty, and presumably also a desire, to respect John's autonomy, his right of self-determination. That itself, we must hope, has become a habit of care too. In many circumstances of care, including John's, these two impulses/habits/reasons/motives pull in opposite directions. It is then all too easy to think of the tension between these two principles finitely, as a zero-sum game. Where the choice is vexed, one looks to the law for guidance. Which statute applies here? Which principle trumps the other? But in the logic of John's situation we find a possibility of holding the ensuing contradictions in such a way as to preserve both of these commitments.

§ 7: Applications

What remains is to consider whether and how this Hegelian schema might help us understand and navigate the antinomies from which we began. Before tackling this question directly, we must be careful to calibrate our expectations. No

philosophical analysis or theoretical framework will make cases like those of Kerrie and Polly easy or happy; these are tragic hard cases in which any decision will be fraught and any outcome tinged with regrets. Moreover, it would be a mistake to expect any philosophical investigation of these questions of itself to provide "answers" to questions that must in the end be decisively influenced by subtle factors that can only be gathered "on the ground" in the clinical encounter and by empirical considerations about the populations to which Kerrie and Polly belong. The most we should expect of a philosophical analysis is that it might provide a framework within which such particular considerations can be taken into account.

But aside from these familiar general warnings, there is a further consideration that applies here. The main point that I have been trying to press is that antinomies like those of Kerrie and Polly are intrinsic to our current situation. No technical fix to the legislation – e.g., a better definition of "best interest" or an improved test for capacity – will make them go away. Indeed we can hypothesize that versions of Kerrie's and Polly's antinomies will arise in any jurisdiction which applies broadly liberal legal commitments in regulating the vocations of care. Accordingly, the last thing we should expect of our abstract Hegelian analysis is that it will show us that one side in the antinomial tension is the "right" one to endorse against the other. If the Hegelian analysis can nonetheless help orient our approach to the antinomies, it must be at a different level altogether, by providing a perspective from which we can acknowledge both thesis and antithesis, and by providing an orientation that can be put to work in navigating fields of practice that are characterized ineliminably by antinomial tension.

In approaching this task it is worth taking note of what we might think of as the *fractal* character of the antinomies that we have uncovered. Recall that in surveying the antinomial tensions we found a first instance in the tension between two competing statutes with overlapping jurisdictions: the MHA and the MCA. Looking more closely at the MCA, we found it to be organized around two leading concepts: the concept of capacity and the concept of best interests. Here again we found the ingredients for antinomy, insofar as the two leading concepts mapped onto different value structures and different perspectives on the patient. But then the antinomial tensions appeared again even within the narrower bounds of a best-interest assessment for a clearly incapacitous patient, as we found in the case of Polly's tracheostomy. Just as a fractal exhibits the same geometric pattern as one varies the scale, so in this domain of law and practice we find a systematic recurrence of a common antinomial structure at different layers within the overall body of mental health legislation. This suggests a strategy of analysis. Before tackling the individual antinomies by way of their legal and clinical particularities, we should consider first how we can manage the underlying tensions that are manifesting themselves in this fractal pattern where the law gets applied to hard cases.

If the antinomies that we have considered vary in their specifics, what they share is an underlying basic structure. This structure is best exhibited by focusing not so much on the *patients* involved but on the *care-givers* who find themselves confronted by those patients. For a care practitioner operating in a broadly liberal legal environment, the sphere of practice is fundamentally structured by two sets of impulses and two sets of duties. On the one hand there is an impulse of beneficence, and a corresponding duty to care for the patient in his or her best interest; on the other hand there is an impulse and a duty to respect the patient's autonomous decisions. While the legal and clinical particularities give different textures to the different cases, it is ultimately the potential for conflict between these two sets of impulses and duties that creates the potential for antinomy.

So what lessons can we apply from the Hegelian approach to these dialectical tensions? At one level, the lessons concern what we can broadly think of as *institutional design*. The antinomies we are considering do not manifest themselves in a vacuum, nor indeed can their significance be understood if we focus narrowly on the doctor-patient relationship as regulated by an abstract body of law. The circumstances of patients like Kerrie and Polly unfold within complex institutions populated by an array of diverse experts playing different roles in a common enterprise. Moreover, those institutions themselves exist in a broad social context in which families, civil society, and the State all play roles. The basic challenge for the Hegelian approach is to consider how this broader social (or *geistig*) context might be constituted so as to manage the contradictions that inevitably arise in particular cases. Is there some configuration of those institutions in which Kerrie and Polly found themselves that would be sufficiently robust as to allow their care-providers to do justice to *both* of their conflicting impulses and duties?

I cannot pretend to provide an adequate answer to this question here; my modest hope is that our articulation of what I have called Hegel's Eve Standard might provide a framework that can be used in tackling it. If our institutions of care can be designed in a way that meets the Eve Standard for particular patients, then there is an important sense in which both sides of the antinomial tension can be sustained. For where determination by an other takes the form of determination by a rightly recognized appropriate other, the opposed duties of care (for well-being) and respect (for autonomy) coincide.

This is a framework that we can apply more or less directly to the antinomy over Polly's tracheostomy. Here the care team has to make a best interest assessment on behalf of a plainly incapacitous patient, where authorization of the surgery creates the best available hope for Polly's survival and route to possible recovery, but would seem to involve acting contrary to what Polly herself would likely have chosen, and indeed in contravention of what the evidence suggests to be Polly's considered values and preferences. So what should the care team do? The Hegelian answer, if we can put the point rather paradoxi-

cally, is that they should take pause in order to *think about themselves*. How might *we*, as the decision-making body in this instance, so organize ourselves that we could be rightly recognized by Polly herself as an appropriate other, and hence could be experienced – if Polly herself were able to experience – as an Other whose determination is not an alien imposition? To some ears this may sound utopian, but it seems clear that this is an ideal that can be approximated to a greater or to a lesser extent. Consider the latter possibility first. Suppose that the medical team, in making their decision, considered only or primarily the statistical information about survival rates of patients in Polly's condition with or without a tracheostomy. Suppose that they reached their decision without meaningful consultation with Polly's family and without undertaking any serious inquiry to find out who Polly is and what she values. Suppose that Polly's family, when raising queries and objections about the propriety of Polly's treatment, were treated as "problem family members" and viewed as an obstruction to be managed rather than a source to be incorporated into the decision procedure. Suppose, finally, that the presiding consultant effectively takes the stance that there is no point in consultation with emotionally distraught people who know nothing of the medical factors that are decisive in the circumstances. Just to be clear: I do not mean here to allege that any of this actually happened in Polly's case. But if it had happened, then the Eve Standard would clearly not be met. Polly herself could never have recognized *this* community of decision as an appropriate other; she would rightly experience it as an alien other whose paternalistic intervention stripped her of all autonomy with respect to this critical medical intervention.

This may seem itself an odd way of expressing the point. After all, if Polly is already in a coma then has she not already lost all vestige of personal autonomy? My answer – if I may once again be allowed to court paradox – is "no". Polly may be unconscious but a pathway for respecting her autonomy remains open. For, suppose now that we replay the scene we have just rehearsed, but now play it out differently. Those who find themselves tasked with this decision now undertake to learn about Polly's values and preferences, and to consult with her family and friends. Suppose they now explicitly set out to constitute their Otherhood in such a way that Polly herself could have recognized it as her fitting Other, and *will* so recognize it retrospectively if indeed she emerges from her ordeal. Under such circumstances, I submit, Polly retains a significant form of autonomy even in her coma.

Here I must pause to consider a legal objection. It is common among jurists to distinguish between two opposed frameworks for best-interest decision-making. According to what is known as the "substituted standard", a best-interest decision is in effect an attempt to model the decision that the patient herself would have taken if she had been possessed of capacity at the material time when a decision has to be made. This is contrasted to an "objective" construal of the best-interest standard, which allows that patients are sometimes

in error as to their own best interest.[17] It is easy to see that the two standards can diverge. A heroin addict who is lacking in capacity might well have opted for more heroin if he had been possessed of the capacity to make his own decision, but such a decision would not be in his best interest, objectively construed. Now in Polly's case, the governing legal authority is the MCA, which is commonly described as adopting an objective standard of best interests, rather than a substituted standard.[18] So it might be objected that the pathway I have just recommended contravenes the governing statute, to the extent that it allows itself to be decisively guided by what Polly herself *would* have decided, rather than by what is in fact in her best interest. To the extent that Polly's autonomy is respected, it is respected in contravention of law.

But the objection is based on a double mistake. There is a mistake, first, in adopting too stark an opposition between a substituted standard and an objective standard of best interests. For while it is true that current English law and judicial practice generally rejects a strictly substituted standard (which is often dismissed as "the American approach"), the "objective" standard of the MCA nonetheless incorporates a very strong degree of substituted reasoning in its prescribed procedure for determining objective best interest. Indeed the very first step in determining best interest is to undertake to discover what one can about the patient's own "values and preferences". The second mistake is to suppose that applying the Eve Standard will simply reproduce the outcome of the substituted standard. Polly's Others might end up making the decision that Polly herself would have made in the circumstances, but they will not always do so. An appropriate other will sometimes intervene in my life in order to override my current preferences in the service my own best interests. Such an intervention meets the Eve Standard insofar as I nonetheless can rightly recognize the intervening other as an appropriate other whose imposition is not in the end an imposition by an alien force.

Let's return, finally, to the hard case of Kerrie Wooltorton. Kerrie's Antinomy is not like Polly's in a number of important respects. Kerry's decision-making capacity is at least open to question, where Polly is obviously incapacitous. Kerrie is committing suicide, where Polly has been in an accident. Kerrie has a long and well-documented history of mental illness; Polly does not. But perhaps the most important difference is legal: Kerrie arguably falls under the jurisdiction of the MHA, a statute that places no particular value on the patient's autonomy, but is guided instead by the value of public health and public order. Can the approach we have taken with Polly's Antinomy also provide guidance in Kerrie's fundamentally different situation? I think that it can, at least to an extent. The reason for this comes back once again to the

[17] See e.g., *Airedale NHS Trust v Bland* [1993] AC 789.
[18] See e.g., *Re P* [2009] EWHC 163.

fundamental commonality that comes into view when we consider the basic structure *from the care-giver's perspective*. Despite the differences in the governing legal provisions, and despite the many important differences in the particular circumstances of the patients, the circumstance of the care-giver once again is structured by the now-familiar antinomial tensions: an impulse and duty to protect a vulnerable individual as against an impulse and duty to respect an autonomous person.

It is striking the extent to which the very considerable attention that has been paid to Kerrie's case has tended to focus on one of two sets of questions: questions about the details of Kerrie's medical history and condition, or questions about the provisions of the legal statute. In one way this may seem obvious: surely the problem here is to understand how the formal and abstract provisions of law apply to the concrete particularities of an individual patient. But if the analysis that I have offered here is correct, this focus has missed a crucial factor. If we are members of Kerrie's care team then we must not simply think about Kerrie and about the law; we must also think about ourselves. We should ask ourselves whether and how we can constitute ourselves as the sort of collective Other that meets the Eve Standard, such that when it comes to the point that we determine what happens with Kerrie's life, it is possible for Kerrie to recognize us as an other whose alien character has been overcome.

In applying this schema to Kerrie's Antinomy, however, we have to think differently about the scope and scale of the relevant Otherhood. In Polly's case it seems clear that family members form a core part of the relevant community of others. But if Kerrie's relationships with her family are fraught, or if indeed she is profoundly alienated from them, then their inclusion in the community of decision might well increase Kerrie's alienation from those who find themselves with the task of determining her fate. On the other hand, Kerrie's social worker, who can help the accident and emergency team understand the context and history of Kerrie's self-harming behaviour, might well play a critical role in coming closer to an arrangement that could satisfy the Eve Standard.

But all this might well seem to leave the main question unaddressed. After all, we began by providing an analysis of Kerrie's situation in terms of an antinomy of conflicting legal obligations. It is hard to see how restructuring the community of others at the hospital is of itself going to eliminate that antinomy, or tell us which of the two obligations to privilege. Make the Otherhood as Eve-ish as you want. At the end of the day Kerrie either receives the dialysis or she does not. In order to meet this objection, I suspect that we may have to undertake a massive shift in the scale of our account. Certainly this would be Hegel's own strategy. The community of others who are determining Kerrie's fate does not just comprise the hospital workers, or the hospital workers and their families, or the workers and the family and the social worker and the hospital's legal counsel. Ultimately it comes to comprise the whole relevant apparatus of civil society and the State as well. It implicates the legislators who

adopted the relevant statutes and the judges who apply them and the Research Councils that provide funds for workshops to reflect about the dilemmas that ensue. The task Hegel sets himself in the *Philosophy of Right* is to describe a whole society that satisfies the Eve Standard.

I shall not here try to describe Hegel's solution to this large-scale problem. But it does seem to me that, for us, one element of the solution might be for such a society to adopt a range of overlapping and partly competing statutory arrangements that are applicable to a case like Kerrie's and are available to care-workers to deploy in the exercise of their vocation. If Kerrie finds herself in such a society, and if her local of decision community is constituted such that a choice among those statutory provisions is undertaken in a way that is itself guided by the Eve Standard, then Kerrie's Antinomy can be navigated – not in a way that avoids tragedy, but in way that satisfies both of the impulses and duties from which it ultimately arose.[19]

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