BENCHMARK

Queue-Jumping?: Do Mental Health Courts Privilege Criminal Behavior?

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Abstract

Mental health courts, premised on the notion of therapeutic justice, have become an increasingly appealing way of dealing with what is widely, although not uniformly, seen as the inappropriate incarceration of people who engage in criminal behavior caused by mental illness. Nevertheless, mental health courts are not without their critics and a number of objections have been raised against the implementation of these courts. Among these criticisms is that mental health courts may inappropriately privilege criminal behavior by the provision of expedited comprehensive services to persons with mental illness who commit criminal offenses and, in doing so, reduce or delay the provision of services to persons with mental illness who do not engage in criminal behavior. This article explores the mechanisms that may result in "queue-jumping" and analyzes whether a priority to offenders, when it does occur, is justifiable.

Key Words: mental health courts, queue-jumping, resource allocation, mental health services, mental health ethics.

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"The squeaky wheel gets the grease."

Traditional folk saying

Introduction

Rooted in the notion of therapeutic justice, mental health courts (MHCs) were created with the goal of diverting persons with mental illness who commit criminal offences to much needed mental health services rather than incarceration (Schneider, 2007; Stefan and Winick, 2005). Born partly out of recognition that an inordinate percentage of the prison population had some form of mental illness, this effort to "decriminalize" mental illness also sought to find a more appropriate and constructive way to deal with persons with mental illness who commit minor offenses (Griffin et al., 2002). However laudable the intention, the criticism arose that MHCs may inadvertently function as a short cut to access scarce treatment resources (Wolff, 2002; Seltzer, 2005, Hoskins, 2007). It has further been asserted that the expedited route to mental health services via MHCs may also result in an incentive to criminal behavior (Wolff, 2002; Schneider et al., 2007). This paper explores the notion of "queue-jumping" in the context of MHCs and examines conceptually whether MHCs "reward" criminal behavior by a "priority" provision of mental health services to persons who violate the law (offenders) over those who do not (non-offenders) (see e.g., Schneider et al., 2007; Steadman et al., 2001).

By viewing MHCs in the broader context of availability of services for people with mental illness, generally, this article aims to add to the discussion a dedicated conceptual examination of the criticism that the provision of expedited comprehensive mental health services to offenders via MHCs constitutes an unfair allocation of resources. Given the diversity in practices and procedures of MHCs across Canada and the U.S., this article addresses mechanisms that may be a factor in the existence or absence of the phenomenon of queue-jumping or unfair allocation of resources rather than on specific MHCs. Moreover, given the paucity of empirical data being collected and maintained on MHCs (Schneider, 2007; Sinaiko and McGuire, 2006; Redlich, et al., 2006), and the limitations on generalizability from data derived from a single court or court system, this conceptual analysis does not attempt to examine the question empirically, but rather ultimately seeks to contribute to a discussion about the fairness of mental health resource allocation.

Background

Mental health courts, premised on the notion of therapeutic justice, have become an increasingly appealing way of dealing with what is widely, although not uniformly, seen as the inappropriate incarceration of people who engage in criminal behavior caused by mental illness. As a result, the number of mental health courts in North America has increased substantially in the past decade (Redlich et al., 2006). Canada's newest MHC will be instituted in Nova Scotia (General Assembly, Nova Scotia, Bill No. 21, section 4(1); 2007) in 2009, following Ontario and New Brunswick (and pilot programs in Newfoundland and Labrador). Although there are several different models for MHCs, some features are considered essential. Most MHCs courts still limit the availability of therapeutic diversion to minor or moderately serious offenses, with a few exceptions that offer diversion to felony offenders

 (ISSN: 1916-2405)

who meet specific criteria (see e.g., Griffin et al., 2002; Stefan and Winick, 2005). Additionally, all MHCs typically involve prompt assessment of mental health status and a finding that the mental illness was the cause of the offense. If appropriate, the option to engage in therapeutic diversion rather than the traditional criminal justice is extended to eligible defendants. MHCs then impose a requirement that the offender undergo treatment for the mental illness, accompanied by monitoring of treatment compliance and graduated sanctions for non-compliance (Thompson et al., 2007; Hoskins, 2007). In this way, MHCs offer an alternative to offenders with mental illness by affording them the opportunity to treat the underlying illness, arguably benefiting both the offender and society by reducing recidivism and avoiding inappropriate (and potentially harmful) detention (see Schizophrenia Society of Canada (SSC), 2005).

Nevertheless, mental health courts are not without their critics. A number of objections have been raised against the implementation of MHCs. Among these criticisms are 1) that there should not be a "separate justice" system for the mentally ill as it creates stigma and is inconsistent with fundamental principles of equal justice (Stefan and Winick, 2005; Wolff, 2002) 2) that it is questionable whether mentally ill offenders understand and appreciate the consequences of choosing diversion (e.g. some courts require a guilty plea) (Redlich, 2005; Stafford and Wygant, 2005) 3) that the "coerciveness" of mandatory treatment is unfair (Stefan and Winick, 2005) and 4) that MHCs may give priority to offenders over non-offenders (Sinaiko and McGuire, 2006; Wolff , 2002; see also Schneider, 2007, 64), such that rather than expanding the pie of services for mentally ill persons, MHCs preferentially divert scarce resources to persons who have committed criminal acts.

Analysis

As noted, a common feature of MHCs is the presence of an expedited process to assess and treat mental health involving a coordinated treatment team that provides ongoing assessment of treatment and monitoring of compliance. It has been observed that this expedited comprehensive treatment for offenders may disadvantage non-offenders who may remain completely outside the health care system, or experience delay in receiving any treatment. Thus, the question must be asked whether this system of expedited services and attention to the subpopulation of mentally ill persons who engage in criminal behavior is fair with respect to the non-offender population.

Do MHCs Lead to Queue Jumping?

This analysis begins with a recognition of the complexities involved in getting mental health services to persons with mental illness, not all of whom are readily identifiable, may present with fluctuating symptoms, or may not be interested in receiving services or treatment. Furthermore, the situation is made more difficult by the fact of limited resources for the provision of services, which is intensified in the current cost-cutting climate. Thus, it is imperative to note at the outset that any conclusion that can be drawn from this analysis is one that takes as its starting point an imperfect system with finite resources, resulting in an inevitable, but not necessarily unfair, shortage of services to some people who need them.

Is it Really Queue Jumping?

Queue-jumping or "line bumping" (Schneider et al., 2007) can be said to refer to a disruption in the order of a system in which resources are allocated based on sequential presentation of those who would receive those goods. And in order for there to be queue- jumping in the case of MHCs, it must first be established that there is a queue of some sort. (Queues can take many forms, e.g., scheduling of non-emergency hospital appointments or buying tickets to a movie.) It is important to note that this need not be a single file as very often demands on scarce resources come from multiple sources and entry points. Nevertheless, where there is some ordering of allocation of finite scarce resources, (as there must necessarily be), some will receive services and others will not. Any disruption in the ordering must be justified. In the case of MHCs, there generally is a system that orders the receipt of services among those who need them. However, depending on the practices and procedures of the MHCs, the order of that queue may not necessarily be affected by the provision of services to offenders.

Consider a scenario in which several people with mental illness have sought treatment but must wait their turn. Consider then that the commission of a criminal offense by one of them removes that person from the line. Following this, there are several occurrences that may affect the allocation of resources. First, there must be an assessment of the accused that determines that there is mental illness and that this mental illness caused the person to commit the offense (see e.g., General Assembly, Nova Scotia, Bill No. 21, section 4(1); 2007; Schneider et al., 2007). Treatment for the illness can begin in detention during this process. Next, if eligible, the accused may choose to proceed through the traditional criminal justice system or through a MHC, where a required treatment program will be outlined backed by graduated sanctions for non-compliance. The impact on the "queue" of this diversion and whether this diversion constitutes queue-jumping depends upon several factors, e.g. 1) whether there was a waiting list for those mental health services, as there often is 2) if the offender was in queue for services, i.e. waitlisted, where in the order he was (i.e., if at the front of the line, the offender may actually receive services later than he would have had he not committed the criminal act) and 3) what the ultimate disposition of the case turns out to be (e.g. non-compliance, in which case fewer community services are consumed, or incarceration in which case services are likely to be consumed from a different pool). If the offender has not sought mental health services, then the effect on queue-jumping or "line-bumping" (Schneider, 2007) of diversion through a MHC would be different in view of the fact that someone who was not waiting for services suddenly becomes among the first to receive them. The Schizophrenia Society of Canada has identified the need to gain assurances that the system can accept a new client before a judge makes a determination regarding referral to community based services as a characteristic typifying well-functioning MHCs (SSC, 2005). Given the concern about a reduction in community mental health services available to non-offenders vis-a-vis offenders, careful scrutiny of procedures that may operate to the detriment of non-offenders is warranted.

Consequently, it is not clear that diversion of a mentally ill offender to a MHC always necessarily results in queue-jumping. Nevertheless, the system is such that in some instances, an offender may gain

access to services in a manner that disadvantages a non-offender. For example, where there are waiting lists for community mental health services and the MHC does not or cannot require that the offender assume her place on the waiting list, this could clearly result in "queue-jumping" as the diverted or detained offender must consume mental health resources from some source in order to undergo the required treatment, and thus consumes resources ahead of non-offenders. However, to the extent that MHCs require that there be space available before allowing diversion or that the offender join an existing waiting list, the problem of queue-jumping with regard to community mental health resources may be minimized somewhat. This, of course, would result in extended detention for the offender (and additional consumption of forensic resources). Nevertheless, priority allocation to offenders may occur. Thus, in most instances the more appropriate question is whether this priority allocation can be justified.

Here, I briefly explore three arguments regarding whether priority allocation of mental health resources is unfair when viewed independently and within the broader context of availability of services to non-offenders. These arguments¬--1) whether the priority allocation helps the "worst off " 2) the acceptability of the counterfactual and 3) satisfying the goals of (therapeutic) justice, together suggest that some privilege favoring offenders may not be unfair.

Helping the Worst Off

MHCs offer an option that is tailored to the unique needs of the population that comes before it. Essentially, the criticism of unfair allocation of resources claims that of two identifiable populations—1) persons with mental illness who do not engage in criminal acts (non-offenders) and 2) persons with mental illness who do engage in criminal acts (offenders), that MHCs unfairly divert services to offenders. However, the values underlying this diversion could yield an explanation that renders a priority allocation to offenders both fair and desirable.

A theory that is sometimes applied to problems of resource allocation suggests that goods should be distributed equally, but where there is necessarily an unequal distribution of goods, that any inequality should benefit the least advantaged. (Although this simplified description of Rawls' "Difference Principle" was initially intended to direct benefit the least well off *economically*, this principle may still be useful in considering the dilemma at hand.) (Rawls, 2003) Indeed, the distribution of mental health services via MHCs may in some instances give priority access to offenders over non-offenders; however, in applying a loose construction of the *difference principle*, it may be that this priority distribution, when it does occur, benefits the "worst off". Thus, this analysis does not hinge on a single conception of "worst off" rather "worst off" may refer to characterization of predicament, health status, and economic or future prospects.

Michael Seto and colleagues conducted a study which, in 2004, constituted the largest empirical comparison of forensic and non-forensic psychiatric patients (Seto et al., 2004) This study measured these two patient populations on criminogenic, clinical, and social problems. Seto and colleagues found that forensic patients typically scored lower on all three variables, leading the researchers to conclude that forensic patients are actually less impaired than civil patients and this may be due to longer hospital detention of forensic patients leading to better outcomes (Seto et al., 2004) These findings are significant to many aspects of this analysis, as will be further discussed in the following section.

However, regarding whether the forensic population (of which those diverted through MHCs are a subset), how "worst off" is defined, figures prominently in analysis of this issue. Even if client profiles are similar as between offenders and non-offenders as the Seto study suggests, the fact of entry into the criminal justice system changes some aspects of their characterization. As between these two populations, an argument could be made that offenders are, in fact, more disadvantaged than non-offenders because, while both groups suffer from illness, one group also has the added disadvantage of a criminal prosecution, (the possibility of) a criminal record, and the loss of certain freedoms. Moreover, if MHC assessments of eligibility are accurate, one could also make the claim that the mental illness may be more troublesome because it was such that it caused the individual to engage in criminal behavior. Given that this "causation" element is a required finding for eligibility for MHCs, there may be some basis for this claim. Therefore, to the extent that there is a priority allocation of services to offenders, it may be justified because it arguably benefits the least well off, depending on how that characterization is made.

Considering the Counterfactual: Allocation of MHS Without MHCs

In the absence of MHCs mental health services are available to offenders through the criminal justice/prison system and various interim and long term detention arrangements (Schneider, 2007). Since health care (including mental health care) is mandatory for inmates, offenders will still have access to services even without the existence of MHCs, but from a different pool. However, the nature, quality, and consistency of services provided to incarcerated individuals varies considerably. Furthermore, the delivery of mental health services in an unsafe environment (like many jails or prison) is likely to undermine any benefit gained from treatment. Thus, neither the individual offender nor society gains by the incarceration of non-dangerous persons with mental illness. Moreover, given that the comprehensive treatment of offenders may reduce recidivism and facilitate the offender's ability to become a contributing member of society, MHCs may ultimately serve to expand the pool of resources available to non-offenders. (See also Calgary Diversion Project, Final Evaluation Report, as cited by SSC, 2005 showing a decrease in the number of police complaints and "a significant reduction of costs to the health system" due to less utilization of emergency rooms and reduction of inpatient hospital days (SSC, 2005).

Furthermore, Seto and colleagues point out that because forensic patients are less impaired than civil patients typically, that many forensic patients "could be appropriately diverted into general mental health services", thus freeing up demand on forensic resources (Seto et al., 2004). This is, in fact, what MHCs do in identifying a subset of the forensic population for re-entry into the community and uptake of community resources.

Goals of (Therapeutic) Justice

Some critics of MHCs have called these courts "misguided" (see

e.g., Seltzer, 2005). They insist that there should not be separate justice for specific populations, and that everyone should be subject to the same laws, with any special considerations to come at the point of sentencing (see e.g. Wolff, 2002). This analysis takes the position that therapeutic justice is not, in fact, separate justice. Rather therapeutic justice is considered here to be one of many avenues that can be used to achieve justice. Nevertheless, therapeutic justice should not "trump" other legal principles (Casey, 2000).

The goal of therapeutic justice as one of bridging rights and care perspectives (Casey, 2000), has resulted in "specialty courts", e.g., drug and mental health courts (see e.g., Winick and Wexler, 2002). These represent institutional recognition of the different considerations necessary to administer justice with particular populations or types of offenses. However, these institutions should also be viewed contextually. Creating a luxury facility for young people who use cocaine, while doing nothing about substandard services for persons who use other illegal substances, could seem irresponsible. Even if admirable when viewed on its own merits, viewed contextually, this initiative may seem misguided and possibly creates incentives to undesirable behavior. MHCs do not present so clear a picture, but concerns about preferential treatment of offenders has been raised. While MHCs may be a positive move toward justice when viewed narrowly, they must also meet the requirements of contextual fairness.

Thus, whether therapeutic justice is at odds with fair allocation of mental health services seems to depend largely on the procedures of the MHC regarding access to community treatment services. On the one hand, it would appear that diversion of mentally ill offenders avoids treating them in ways that serve neither them nor society would constitute a benefit. Yet, on the other hand, consuming resources at the expense of non-offenders would seem to contradict another sense of fairness. Furthermore, processing offenders through the traditional criminal justice system arguably does not satisfy its objectives given that the goals of incarceration are generally punishment, deterrence, and public safety (however also see General Assembly, Nova Scotia, Bill No. 21, section 4(2)(c) acknowledging the goal of MHC to protect the rights of the public, the accused and the integrity of the criminal justice system, 2007). For a person who has committed a crime because of mental illness, neither punishment nor deterrence is achieved. Moreover, since MHCs typically limit participants to misdemeanants, public safety is generally not a major issue. Instead, continued involvement in the community, along with appropriate treatment and supports are more likely to serve the goals of therapeutic justice and be consistent with traditional justice, particularly given graduated sanctions involving community service by offenders (see Griffin et al., 2002 noting an aversion to community service).

Inadvertent Incentive and the "Squeaky Wheel"

A remaining question is whether MHCs provide inappropriate incentives to criminal behavior (see e.g., Wolff, 2002, SSC, 2005) because they promptly provide services to persons who come to the "negative" attention of the authorities. The fact is that if a group of individuals are gathered in a park, it will be the one who urinates on private property or harasses a passerby because of a disordered mental state who will be taken away and given treatment, support, and ongoing assessment (see Schneider et al., 2007, 17). However, because of the eligibility criteria for most MHCs, i.e. that mental illness caused the person to commit the offense; it seems highly improbable that priority treatment operates as an incentive to criminal behavior for one who commits a crime because of mental illness. The requisite level of deliberation is inconsistent with the MHC eligibility criteria.

Opponents of MHCs may point to the careful attention and treatment that is given to offenders who are diverted through MHCs. While it would be desirable to provide this level of comprehensive treatment to all persons needing mental health services, the reason that this level of service can be provided to offenders is because they are now within the jurisdiction of the courts. This jurisdictional authority gives the coordinated diversion team the leverage to get treatment to persons who need it but may not seek it or will not voluntarily adhere to a treatment program otherwise. So while offenders are provided with a comprehensive treatment program, it is within a coercive framework by virtue of the leverage of the threat of jail, a criminal record, and/or community service.

Coercive Nature of MHCs as the Mechanism of Unequal Allocation

If comprehensive mental health services (often including housing and occupational training) taken up by offenders with mental illness is due to the fact that MHCs have the leverage to compel receipt of these services, then this should be noted. Nevertheless, there is disagreement about the impact of this leverage (see Redlich et al., 2006 finding no association between leverage and compliance; but also see Poythross et al., 2002 for discussion of findings of impact on compliance).

However, if the actual priority benefit to offenders is the compulsory comprehensive treatment program, then perhaps the antidote is to make similarly coercive treatment programs available to non-offenders. Different forms of this exist in programs with community treatment orders (CTOs) and preventive outpatient commitment (see Schneider et al., 2007; Stefan and Winick, 2005). While these programs may present in many different forms, they typically seek agreement from the prospective patient (see Schneider et al., 2007 for discussion of Toronto program) However, such programs have met with questions about effectiveness (Winick, 2003), not to mention controversy (see Stefan and Winick, 2005). However, if it is compulsory comprehensive treatment that is the unequally distributed "good", then the charge would be to identify a satisfactory mechanism that makes this "good" equally available to non-offenders. Such a mechanism could involve allowing non-offenders to enter into "Ulysses contracts" whereby they voluntarily bind themselves to a course of treatment backed by sanctions that might include, for example, community service (see Griffin et al., 2002 for anecdotal reference to aversion to community service). Of course, the true leverage of these agreed-to sanctions may be questionable.

Conclusion

The impact of MHCs on the provision of services to persons with mental illness is complex and seems to depend on several factors, foremost of which are MHC practices and procedures in ensuring that community services are, in fact available, before referring offenders and careful assessment of eligibility for MHC diversion in

the finding that the mental illness caused the criminal behavior. Nevertheless, diversions by MHC may still result in queue-jumping or other priority allocation of resources to offenders. This analysis concludes that even if MHCs result in some advantage to offenders in the distribution of resources, this inequality may be justifiable on the grounds that 1) this distribution works to the benefit of the "worst off" 2) it best achieves the goals of therapeutic justice and 3) is consistent with principles of traditional and therapeutic justice. As many have observed, further empirical work and evaluations of the effectiveness of MHCs is needed. This analysis does highlight the implications of a possible variation in the uptake of comprehensive treatment programs that may result in better outcomes for MHC clients. Whether this uptake, albeit driven by compulsion, serves as an incentive to criminal behavior seems unlikely given that eligibility criteria for MHCs would seem to negate this possibility. But this, too, is subject to empirical challenge. Furthermore, because these services are generally available to non-offenders through community treatment programs, it seems difficult to substantiate a claim that MHCs inherently privilege criminal behavior. Indeed, it may only be the "compulsion" or leverage that is generally not available to non-offenders. If it is not access, but rather "compulsion" that leads to better outcomes then, absent a wide embrace of compulsory psychiatric intervention for non-dangerous non-offenders, this dilemma may persist unless a program is devised that allows non-offenders to voluntarily enter into a form of "Ulysses contracts" whereby they can bind themselves to future sanctions for non-compliance with treatment programs. Yet, issues of competency and liberty make this a complex option.

That a mentally ill offender takes a space in community treatment is not necessarily unfair to non-offenders. It is important to remember that the offender is a member of the population for whom the services were designed and that to process this individual through the traditional court system does not serve the ends of justice nor improve the condition of the person with mental illness. In the end, MHCs can benefit criminally accused persons with mental illness, the community by way of reduced recidivism and, arguably, the non-offender population as well, if the lack of recidivism and productivity of the "well offender" results in more resources available for the general pool. Nevertheless, questions of unfair allocation of resources and inappropriate incentive are important ones that warrant ongoing close scrutiny.

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Competing Interests: *None.*

Acknowledgements: *The author extends sincere thanks to Jocelyn Downie and Tim Krahn for stimulating and informative discussions. Thanks also to the two anonymous reviewers. This work was supported by a grant from the Canadian Institutes of Health Research (CIHR).*

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