1 Introduction

The approach that we take in this book is one that considers medical law and ethics. The book seeks to make clear distinctions when speaking of 'law', 'morals' and 'ethics', but what do we mean when we use these terms? It seems self-evident that these words do not mean the same things and it is vital to be certain of their meaning before embarking on working with medico-legal and medical ethics literature (and with this book for that matter). We will outline our use of these terms in the context of this book in this chapter in a way which, hopefully, will give the reader an appreciation of the delineation and overlap of these concepts. We do, of course, realise that these terms, and their exact relationship, are the subject of much debate. At the end of this chapter – as with all chapters – we have provided references for further reading that will illuminate the scope of that debate and allow the reader to delve deeper if he or she wishes to do so. For the purposes of this textbook, however, it is prudent to identify and define how *we* use these terms so that our discussion of their relationship can make sense to the reader.

On a very fundamental level, by 'law' we mean a framework of rules developed, codified and enforced by society in some way. 'Morals' refers to a more diffuse set of shared values and norms which inform our ability to decide between what is right and wrong in certain contexts. These values and norms might be cultural or religious. 'Ethics' is a systematic method for reflecting, arguing and justifying what a wrong or a right decision might be. In this book, we are concerned with medical ethics, which is a subset of applied ethics, and which follows slightly different rules from, for example, conventional moral philosophy. By and large, medical ethics looks at distinct case constellations from biomedical practice and seeks to make a normative statement about how one should behave in such cases. We are not suggesting that these three concepts of law, morals and ethics are the same types of categories. The law often enshrines moral notions (respect for the autonomy of a patient by way of requiring consent, for example), but not all laws are necessarily based on a moral notion. Ethics systematically uses moral notions to develop an argument for or

against a certain course of action, so ethics would not function without morals. Morals, on the other hand, are initially independent of law and ethics.

While it seems clear that there is a conceptual hierarchy at work here, the three terms we refer to do have something in common: they create a web of duties, obligations, rights and recommendations. A legal duty, for example, is clearly one that is prescribed by law – in some way, shape or form. This might mean a statutory duty, or one that is established through precedent or by way of guidelines that have been given binding character (by a legislator, a court or in some cases even a professional body). A moral obligation is one that an individual is thought to have towards others in a society,[1] based on shared sets of values, but which does not, necessarily, amount to a legal duty. In the area of medicine, we regularly touch upon issues that raise both types of obligations – a legal obligation as well as a moral obligation. This is why law and ethics (as the arbiter of morals) in medicine interact to a much greater extent than you might see in other areas of law – this is particularly visible when you try to get an appreciation of the formidable spectrum of different types of regulation you find in this specialised area: from primary law all the way down to standard operating procedures (SOPs) in laboratories and operating theatres. All of these instruments form part of the body of *regulation* that is medical law and medical ethics.

Most of the time, the foremost question that we are dealing with in this book is how an individual (for example a doctor) is supposed to act in certain (mostly very difficult, or life-and-death) circumstances. Consider the following case:

> Patient X is diagnosed as HIV positive by his GP. During the course of the post-diagnostic discussion, it becomes obvious that X intends to keep this diagnosis secret and will continue to have unprotected sex with his partner, who is currently not HIV positive.

Cases such as this one raise issues that can be looked at through the lens of law and that of morals. There may be a legal duty for the GP to act in such circumstances (for example, to prevent harm to X's partner) in the same way as there might be a legal duty for the GP not to act (for example, to protect X's privacy and to maintain confidentiality). At the same time, there might be a moral duty for the GP to act (in order to prevent harm to one or more others) or not to act (in order to respect X's autonomous decision-making, even if it seems poorly justified) in such circumstances. It is clear that it is not the law's job to enshrine all moral obligations we might care to think of – the law will merely try to encompass those moral obligations that are considered most weighty, although this assessment can clearly be contentious. A legal duty does not always correspond to a moral duty, and vice versa. In

[1] Contemplate how moral aspects might actually come into play in a fictitious situation where there is only one person and no others. Might we need more than one person in order to give rise to moral contemplations, or is there such a thing as being moral towards yourself?

fact, sometimes the moral and the legal duties conflict – for example where a doctor knows that an individual does not wish to be resuscitated, but the lack of appropriate documentation compels her to do just that in order to avoid liability. Law and morals, therefore, are not the same thing, but – to some extent – they overlap.

The next question is how law and ethics interact. Georg Jellinek, an important German legal positivist from the early twentieth century,[2] very eloquently defined the scope of the law as the 'ethical minimum', and even if we do not agree with all of his views, Jellinek's way of describing the relationship between law and ethics is compelling:

> Law is nothing other than the *ethical minimum*. Objectively speaking, these are the maintaining conditions of society, to the extent that they are dependent on man's free will, i.e. the existential minimum of ethical norms. Subjectively speaking, it is the minimum of equitable activity and disposition demanded from members of this society.[3]

So it is clear that, in the sense that Jellinek is using the term, the scope of ethics goes over and beyond the law. The law merely covers the minimum that is required to 'keep going' in terms of societal cohesion. We have discussed law and morals, but what is meant here when the term 'ethics' is used? 'Ethics' is the reflective process that asks the question of what a moral norm really intends to achieve, what is 'right' and what is 'wrong' in certain circumstances. While both the law and morals, therefore, are frameworks of norms of differing binding quality and pedigree, 'ethics' can be the process which is used to reflect what course of action is appropriate in terms of moral obligations (much in the same way as we use certain methods to work out how to apply abstract law in individual circumstances). This means that the tools of medical ethics help us go over and beyond the interpretation of mere legal or technical norms in order to try and work out 'how to get it right'. After this first look at our three terms, we will now look at these three concepts – 'law', 'morals' and 'ethics' – in more detail to see how we use them in this book.

The special quality of human interaction in the field of biomedicine means that the scope of medical law already covers far more than mere matters of technical medical skill. Indeed, one of the peculiarities of the subject, which grew out of something of a tort and criminal law hybrid, is the fact that areas of ethical controversy (i.e. 'how to get a morally difficult decision-making process right') are ubiquitous. Abortion, euthanasia, the sterilisation of adults with serious mental disabilities: all of these are topics where moral questions are intrinsic and feelings

[2] Legal positivism is a school of thought that, by and large, propagates the idea that whatever is stipulated as law by a recognised source of law at any given time ought to be followed – even where moral norms, or natural law, suggest that this law might be unjust. Legal positivists, such as H. L. A. Hart, have suggested that some of the crimes perpetrated during the Nazi regime in Germany were legally (not morally) justifiable as long as they were in accordance with the law at the time. Law is therefore seen as a purely social construction by positivists.

[3] G. Jellinek, *Die sozialethische Bedeutung von Recht, Unrecht und Strafe* [The socio-ethical significance of justice, injustice and punishment], 2nd edn (Berlin: O. Häring, 1908), p. 45. (emphasis in original, our translation).

run deep. Even the fundamentals of medical law in the shape of capacity, consent and confidentiality are based on significant moral issues, so it is no surprise that medical law cannot avoid ethical discussion – and in some cases (such as in *Re. W*, which we also discuss later in this chapter), we can see that deliberate moral wriggle room is left by the law to acknowledge the difficult ethical dimension of legal decision-making in medicine. In this book, we recognise this fact by giving full consideration to both the legal and ethical issues behind each topic that we consider.

LAW AND LEGAL DECISION-MAKING

We begin by looking at how the law is shaping up in the areas that we cover. When a decision is legal in nature, this means that certain behaviour by a medical practitioner is either demanded or prohibited by the law. For example, a doctor who has begun an operation will be under a legal duty to complete it (in the absence of, for example, finding a replacement to do so); equally, doctors owe their patients a duty of confidence and may not in normal circumstances disclose information to others about them. These are rules that are prescribed by the law, and they are obligatory. A failure to follow them will result in civil or criminal sanctions being imposed on the transgressor independent of any professional sanction or authorisation of the act. This gives legal stipulations a certain – 'hard' – quality.

What we shall see is that in most cases where the law takes control and classifies the decision as legal in nature, it does so to protect patient autonomy (which is a moral concept underpinning much of the corresponding medical ethics discussion, as we shall see). Indeed, a fundamental aspect of this category is that the law identifies and protects what it sees as a fundamental right, almost always pertaining to the patient.

A good example of this is the case of *Ms B*.[4] The case concerned a paralysed woman who could not live without artificial ventilation. She made a decision that she no longer wished to live, and thus asked for the ventilator to be disconnected so that she could die. The doctors treating her refused to do so, despite the fact that she was legally able to make her own decisions. This, they said, was because they viewed their purpose as being to maintain rather than end life, and therefore that to disconnect the ventilator would be unethical. The court disagreed, and said that Ms B had a fundamental right to self-determination that must trump the doctors' views. It therefore ordered that the ventilator be disconnected in accordance with Ms B's wishes, thus bringing the force of the law to support her rights.

[4] *Ms B* v. *An NHS Hospital Trust* [2002] EWHC 429.

MORALS, DECISION-MAKING AND COMMONLY HELD VIEWS

'Moral' concepts initially seem far easier to define in the context of clinical decision-making. A decision might be classed as moral if it may be decided by the conscience of the individual medical practitioner. This is effectively the opposite of a legal decision, in that the normative weight of the decision-making process rests not at a macro level (i.e. legislation), or at the professional level (i.e. conduct mandated by a professional body with a sanction for non-compliance), but instead at a micro-level (i.e. with individual decision-makers, such as a doctor). This also means that there is usually no sanction in the same way that a legally relevant decision or activity might trigger a sanction, which in turn results in a situation where the ultimate choice often belongs to the medical practitioner, rather than the patient. Often, moral decisions pertain to controversial individual issues and the categorisation allows the doctor to opt out of involvement in a given practice. Notably, this is normally only possible where the patient will not be harmed by the doctor's choice. A classic example of this is the conscience clause in the Abortion Act 1967, which allows medical practitioners to choose not to participate in abortions if they have a conscientious objection to it.[5] This therefore prioritises the doctor's conscience over the patient's desire for the procedure. In much the same way, a medical practitioner (be this a doctor or other care staff) cannot be compelled to end life-supporting treatment for an individual, even where this is the clear wish of the individual. The limit of that individual's ability to give effect to her autonomy therefore lies somewhere where the autonomy of others is touched upon. This is a point worth remembering when looking at how different protagonists' interests are assessed by the law throughout this book.

The notable deviation from this concept of an exception based upon the doctor's conscience is that it does not apply where the life of the patient is at risk, or where not to perform the termination may lead to serious, permanent harm to the patient. Rather, in such emergency situations the welfare of the patient must come before the moral views of the doctor. The framework which underpins these types of decisions is one of shared sets of values and principles, at societal level ('first, do no harm'), at community level ('always help those who present at A&E') or at individual level ('always counsel against an abortion'). This framework might come from religious values, from traditional convention or from other strongly held beliefs – the distinguishing factor is that they are not prescribed by society in a 'hard' way, but expected or desired in a 'soft' way and left up to the individual to make her mind up about them. The process for making up the mind in such circumstances, then, is that of 'medical ethics' as used in this book.

[5] Abortion Act 1967 s. 4.

MEDICAL ETHICS, GUIDANCE AND DISCOURSE

'(Medical) ethics' can operate in more than one way. We outline two ways here, but do not make representations that these are the only (or even the most significant) ways. The unifying characteristic for both of these is the fact that 'ethics' means that a moral decision-making process is left to an individual, on the basis of guidance and shared values. The first of these ways in which ethics operates is regulatory in nature. The medical profession is a self-regulating one, and under the Medical Act 1983 the regulator is the General Medical Council (GMC). In order to be able to practise medicine, a doctor must be registered with the GMC, and this registration may be suspended or even permanently deleted from the register (hence doctors being referred to as having been 'struck off') in the event of misconduct. This misconduct can include both technical and ethical deficiencies in performance. Indeed, under section 35 of the Act, the GMC also has the power to give ethical advice to the profession. It provides that:

> The powers of the General Council shall include the power to provide, in such manner as the Council think fit, advice for members of the medical profession on –
> (a) standards of professional conduct;
> (b) standards of professional performance; or
> (c) medical ethics.

Thus, the GMC publishes documents relating to a range of issues, from consent to doctors' use of social media, which are available to all on its website.[6] As might be expected from guidance issued by a regulator, it is prescriptive. To give an example, at the beginning of the guidance on consent, readers are advised of the following:

> In this guidance the terms 'you must' and 'you should' are used in the following ways:
> 'you must' is used for an overriding duty or principle
> 'you should' is used when we are providing an explanation of how you will meet the overriding duty
> 'you should' is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can comply with the guidance.[7]

The sanctions for failure to comply are also clearly set out, as doctors are warned that '[s]erious or persistent failure to follow this guidance will put your registration at risk. You must, therefore, be prepared to explain and justify your actions.'[8]

[6] www.gmc-uk.org/guidance/index.asp.
[7] GMC, 'Consent: Patients and Doctors Making Decisions Together' (GMC, 2008), www.gmc-uk.org/Consent___English_0513.pdf_48903482.pdf.
[8] GMC, 'Consent'.

The ability to explain and justify actions, in the light of guidance that (a) is outside the spectrum of what 'law' encompasses, (b) is within what we consider to be 'moral' (such as issues of consent) and (c) has regulatory character is what we consider much of medical ethics to be about. It is also evident that the translational process of moral and ethical norms into delegated regulation changes the 'hardness' of the norm: from a relatively soft and broad moral sentiment to a codified and enshrined professional norm, armed with sanctions.

Therefore, the GMC guidance must be seen as having a regulatory function in a similar way to the law in that it provides standards that must be met and penalties for non-compliance. In this sense, the GMC's guidance is unique as it is the only body that has control over the medical register and therefore the only one that can discipline doctors and ultimately decides who can legitimately practise. Nevertheless, doctors are also provided with a plethora of advice on ethical matters from other medical bodies. Most notably the British Medical Association (BMA) – the doctors' trade union – and the Royal Colleges publish books, booklets and pamphlets on all of the issues covered by the GMC. In the case of the BMA, this is even more voluminous in nature. It is worth repeating that these professional bodies have influence over who may, and may not, practise this particular profession. A prohibition from this self-regulated body of professionals amounts to an occupational ban, which is a very strong (indeed, 'hard') sanction.

Given the prestigious nature of the organisations which provide this documentation, it is no surprise that this is also taken very seriously by the medical profession. It is also taken seriously by the law, and indeed there have not only been cases where such guidance has been cited by the courts, but also others where it has been used by judges as evidence of what the legal standard may be.[9] This is even the case when deciding such an intrinsically ethical matter as whether a medical practitioner should be allowed to remove life support from a patient in a coma despite the objection of the patient's relatives.[10] At other times, the courts will assume that regulatory medical ethics is an effective policeman of medical conduct. A good illustration of this is the case of *Re. W.*[11] The issue was the refusal of medical treatment by minors. Lord Donaldson MR had, in an earlier case, held that where a mature minor refuses consent to medical treatment, the doctor could still proceed legally where there was consent by one or both parents.[12] The decision was criticised by academics and others as potentially allowing for serious and contentious treatments to be allowed by law to be forced on older minors. His Lordship

[9] See, e.g., *Airedale NHS Trust* v. *Bland* [1993] 1 All ER 821; [1993] AC 789; and *Re. G (Persistent Vegetative State)* [1995] 2 FCR 46.
[10] This was the issue in the case of *Re. G.*
[11] *Re. W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1992] 4 All ER 627.
[12] *Re. R (A Minor) (Wardship: Medical Treatment)* [1992] Fam 11; [1991] 4 All ER 177.

met this criticism directly in *Re. W*, and noted that he was happy to leave a legal lacuna due to his faith in medical ethics as a regulatory tool:

> Hair-raising possibilities were canvassed of abortions being carried out by doctors in reliance upon the consent of the parents and despite the refusal of consent by 16 or 17 year olds. *Whilst this may be possible as a matter of law, I do not see any likelihood, taking account of medical ethics [that it should be allowed to occur].*[13]

However, professional bodies are not the only source of medical ethics discourse. The second way in which ethical discourse works and influences the law is as a result of the overwhelming variety of opinion and debate contributed by philosophers, lawyers, sociologists and others – including, of course, this book – which seeks not to *regulate*, but rather to *discuss*. In short, these contributions do not claim to provide 'answers' and are thus more discursive than they are normative in nature.[14] Sometimes referred to as 'critical' or 'philosophical' medical ethics, this discourse has also been referred to by the courts, but has one obvious flaw: if it does not seek to provide answers, then it can only be used to guide rather than regulate, as it has no way of choosing between competing answers to questions. As Ranaan Gillon asked rhetorically,

> if Dr A's conscience tells him to transfuse a Jehovah's Witness regardless of her own views and Dr B's conscience tells him not to transfuse such a patient, where stands medical ethics? Which position is right and why? Are both right? Why? Is no resolution or even attempt at resolution possible or desirable?[15]

While this is in line with our principal understanding of the meaning of 'ethics' (i.e. it being the skillset required to adequately reflect competing moral theories in difficult individual circumstances), it is sometimes of little assistance when applied in a context where a normative statement is required. Therefore, this type of discoursive ethics is most likely to be used by judges to justify decisions that they have already come to – most notably if there is no settled law in the area or the judges wish to reshape the existing legal rules. This is not uncommon, and occurs on several occasions in cases referred to in this book.[16] In *Chester* v. *Afshar*, for example, the House of Lords wished to change the law so as to prioritise patient autonomy (and thus make the decision 'legal' in nature). It justified this, in part, by quoting the following piece of work by the legal philosopher Ronald Dworkin to demonstrate the principle that it wished to uphold:

[13] *Re. W*, at 635. Our emphasis.
[14] Of course, as these discoursive dealings with medical ethics usually end up suggesting that one course of action might be more justifiable than another, there is also a weak normative element to them.
[15] R. Gillon, *Philosophical Medical Ethics* (Chichester: John Wiley & Sons, 1986), p. 31.
[16] See, for the former, *Chester* v. *Afshar* [2004] UKHL 41; [2005] 1 AC 134; and, for the latter, *Airedale NHS Trust* v. *Bland* [1993] 1 All ER 821.

> The most plausible [account] emphasizes the integrity rather than the welfare of the choosing agent; the value of autonomy, on this view, derives from the capacity it protects: the capacity to express one's own character – values, commitments, convictions, and critical as well as experiential interests – in the life one leads. Recognizing an individual right of autonomy makes self-creation possible. It allows each of us to be responsible for shaping our lives according to our own coherent or incoherent-but, in any case, distinctive-personality. It allows us to lead our own lives rather than be led along them, so that each of us can be, to the extent a scheme of rights can make this possible, what we have made of ourselves. We allow someone to choose death over radical amputation or a blood transfusion, if that is his informed wish, because we acknowledge his right to a life structured by his own values.[17]

However, we must also be careful to ensure that we distinguish between a decision that is ethical in nature and one that is best left to medical ethics. In particular, it is important to remember that the latter does not automatically follow from the former. Thus, a decision regarding whether abortion should be legal – which is one that is almost universally considered to be ethical in nature – is not necessarily one that should be decided by the medical profession. Indeed, we would argue the opposite, which is that decisions that are ethical in nature provide the law with more rather than less legitimacy to make itself the final arbiter. This is because by their very nature ethical decisions are not matters of technical medical skill, and therefore doctors are not uniquely competent to make these decisions. In fact, it might be argued that the law rather than the medical profession is the proper forum for the resolution of ethical issues and conflicts. Certainly, the pattern of medical law in the recent past has been one of movement towards greater judicial activism, as we detail below, but medical ethics in both its regulatory and discoursive forms still remains of great significance both inside and outside of the courtroom.

When we consider medical ethics in this book, we refer to the second type of ethics described here. In other words, we discuss the theoretical elements rather than what the guidelines have to say. Morals have a much greater role to play, and we seek to examine what principles are at play rather than what conduct the profession demands.

THE LAW'S ROLE IN DECISION-MAKING

It is undeniable that the law has adopted a more interventionist stance over the past fifteen years. The old *Bolam* test from 1957, which we discuss in detail in Chapter 3 on errors and fault, used to provide that as long as the defendant doctor could provide some expert witnesses willing to testify that they might have acted in the same way as

[17] R. Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (New York: Vintage Books, 1993), cited in *Chester* v. *Afshar* at para. 18, *per* Lord Steyn.

she did, then it was not then open to the judge to find their conduct to fall below the legally required standard of care.[18] In such circumstances, the law would refuse to intervene to censure the doctor's conduct. It takes little imagination to see how this represented an almost insurmountable hurdle for plaintiffs to leap over. Almost unbelievably, this interpretation of doctors' legal duties was applied by judges until 1997. Even since then, courts are only to be allowed to find doctors liable if the expert evidence on their behalf was unable to withstand logical analysis – which makes it possible but still very hard for plaintiffs to succeed.[19] Even more worryingly, *Bolam*, which was principally intended to relate to medical negligence (which most often *does* involve the application of technical medical skill), grew to be almost ubiquitous in medical law. Thus, questions surrounding, for example, whether to remove life-sustaining treatment from patients in a persistent vegetative state and whether to sterilise adults with learning disabilities came to be governed by what was known as the *Bolam* test. In other words, *Bolam* also crept into the resolution of ethical matters – thus failing to distinguish between ethical issues and issues that should be governed by medical ethics. This was seen by many, such as Sheila McLean, as an abrogation of responsibility on the part of the law:

> No matter the quality of medicine practised, and no matter the doubts of doctors themselves about the appropriateness of their involvement, human life is increasingly medicalised. In part, this is the result of the growing professionalism of medicine, in part our responsibility for asking too much of doctors. In part, however, it is also because the buffer which might be expected to stand between medicalisation and human rights – namely the law – has proved unwilling, unable or inefficient when asked to adjudicate on or control issues which are at best tangentially medical.[20]

While *Bolam* has been reined back in and its reach outside of negligence may be seen as contracting (through, for example, the Mental Capacity Act 2005 as we discuss in Chapter 5), its influence remains and medical law retains many instances of decisions effectively being made by doctors through medical ethics rather than the law.

THEORIES OF ETHICS

While we have, in this book, put the focus of our ethical discussion on the pertinent issues identified in the corresponding legal discussion, a number of recurring themes will become apparent. These themes can, by and large, be

[18] *Bolam* v. *Friern Hospital Management Committee* [1957] 1 WLR 582. While it is unlikely that this is the way in which the judge in *Bolam* intended his judgment to be interpreted, this is how it was applied by future courts. See M. Brazier and J. Miola, 'Bye-Bye Bolam: A Medical Litigation Revolution?' (2000) 8(1) *Med. L. Rev.* 85–114.
[19] See *Bolitho (Deceased)* v. *City and Hackney HA* [1998] AC 232.
[20] S. MacLean, *Old Law, New Medicine: Medical Ethics and Human Rights* (London: Pandora Press, 1999), p. 2.