1 Introduction

Medicine evolves. The human life cycle – birth, reproduction, death – is unremitting, but technological and social advances mean that not only do personal and societal patterns of disease change continuously, but also does our ability to cure or ameliorate disease. Indeed, the definition of 'disease' still remains a controversial concept.

The most notable feature of medical progress over the last 30 years is that its rate of evolution has markedly increased. There may be any number of reasons for this, including (but not limited to) improvements in information technology, the demand-led ethos of Western consumerism, the medicalisation of certain human conditions and behaviours, refinements and developments in scientific methods, and various political agendas relating to healthcare.

For decades, centuries even, the moral principles of Western medicine were informed primarily by the teachings of the classical philosopher-scientists, namely Thales, Hippocrates and Galen. These ideas were modified by the prevailing philosophical doctrines of subsequent historical periods: mainly religion before the Renaissance, humanism in the Age of Reason, and theories of Human Rights that have developed since the Age of Enlightenment. However, in our post-modern, secular society, there is growing concern that the recent accelerated rate of medical advance has outstripped the rate at which consequent ethical dilemmas can be discussed, or resolved. In particular, rapid advances in certain fields (e.g. in genetic engineering) mean that new moral dilemmas arise where there has previously been minimal, or no, ethical debate.

The simple question that arises is: why not just let medical progress advance unchecked by ethical scrutiny? Surely the ultimate goal of medicine is the alleviation of all disease and illness, and therefore medical progress is justification in itself? Indeed, many people might agree with this observation, and it may be difficult to see any other point of view when, for example, one is dying of a disease for which researchers are close to finding a cure. The simple answer is that there must be a right and moral thing to do. But can such a position really be maintained

when one allies the subjective notion of 'doing the right thing' to research methods such as those used, for example, by some doctors under the Nazi regime? Or if one's chance of a cure necessarily entailed the death or disablement of another person? These dilemmas are the fundamental questions in medical ethics, namely that there are certain moral boundaries that cannot and (arguably) should not be crossed by individuals or society, that just because a treatment can be administered does not mean that it should be, and that the practice of medicine is so very much more than the application of a rationally scientific solution to a pathophysiological problem.

The failure of the medical profession to convincingly resolve ethical issues that have arisen has resulted in a diminution of trust in the medical profession by both the public and politicians, and a correspondingly rapid evolution of medical law, in order to circumscribe what society is currently willing to accept as 'ethical medical practice'. Of course, other factors have been influential in the development of medical law: medical consumerism emphasises patients' rights (further reinforced by statutory provision in the form of the Human Rights Act, 1998), the burgeoning body of case law progressively delineates acceptable medical practice in a self-propagating fashion, and politically-motivated anti-professionalism seeks to regulate medicine as a profession. Furthermore, there is a general expectation (through improved education via the media) that patients will not only receive healthcare as part of the welfare state, but that the standard of that care will be of an acceptable or highest attainable level; medical law regulates the reality gap between such demand and its supply. In addition to these factors, the acute, interdisciplinary nature of critical care and perioperative medicine, with their reliance on multiple, high technology interventions mean that these areas of clinical expertise are amongst the most litigation-prone in medical practice. The increased threat of litigation has, it appears, led to a concurrent rise in defensive medical practice; this has been beneficial in improving quality assurance in medicine, but has inevitably led to increased financial costs, distorted clinical decision-making and over-treatment of patients.

Uncertainty is an inherent component of evolution. Medical law and ethics are not immune to this. For example, we just don't know what the consequences of cloning humans, human stem cells or animals are going to be; we cannot foresee how the possible legalisation of physician-assisted suicide might alter society's attitudes towards the medical profession. However, by applying ethical principles to the moral predicaments, we might at least be able to decide what is and is not acceptable. Even then, this may not be the case: issues surrounding the practice of abortion,

for example, are notorious for polarising peoples' attitudes. The effect of medical law is to resolve these issues one way or another (whether 'rightly' or 'wrongly'), so that at least decisions are made and boundaries set, and clinicians are informed in their day-to-day practice.

Medical law and ethics are currently 'hot topics' in the field of medical education. As discussed above, the plethora of ethical issues that have arisen from rapid scientific progress require extensive investigation and discussion. Whilst a considerable number of philosophers and allied professionals build their careers on so doing, there is an increased realisation that other interested parties, including doctors themselves, nurses and other health care providers, as well as patients and the general public would like to become – and should become – involved in the debate. Furthermore, the General Medical Council (GMC) has emphasised that all medical students should receive education in medical law and ethics as part of the core curriculum. In 1998, a consensus statement by teachers of medical ethics and law in UK medical schools reiterated the need for education in medical law and ethics in order to facilitate 'the creation of good doctors who will enhance and promote the health and medical welfare of the people they serve in ways which fairly and justly respect their dignity, autonomy and rights', and identified that these goals could be achieved through:

- ensuring that students understand the ethical principles and values which underpin the practice of good medicine;
- enabling students to think critically about ethical issues in medicine, to reflect upon their own beliefs about ethics, to understand and appreciate alternative and sometimes competing approaches and to be able to argue and counter-argue in order to contribute to informed discussion and debate;
- ensuring that students know the main professional obligations of doctors in the UK as endorsed by the institutions which regulate or influence medical practice particularly those specified by the GMC;
- giving students a knowledge and understanding of the legal process and the legal obligations of medical practitioners sufficient to enable them to practise medicine effectively and with minimal risk;
- enabling students not only to enjoy the intellectual satisfaction of debates within medical ethics and law but also to appreciate that ethical and legal reasoning and critical reflection are natural and integral components in their clinical decision-making and practice;
- enabling students to understand that ethical and legal issues arise not only in extra ordinary situations in medicine but also occur in everyday practice.

Aspects of the core curriculum include consent, confidentiality, research, abortion, death and the dying patient, rights, professional regulation and resource allocation, and these are the core chapters of this book.

Medical education traditionally dictates an allegiance to professional orthodoxy, such that 'doctors do this because that is how doctors do it, and have always done it'. The often abstract nature of medical ethics, with its emphasis on thought experiments and philosophical reasoning, can come as somewhat of a shock to the student. It is frustrating to the scientifically trained mind to conclude that there may not be a right answer (or even *any* answer!) to a problem. This book makes no apologies for not always stating what the current orthodoxy is. Instead, both by highlighting differing ethical viewpoints, and by providing the reader with the philosophical instruments on which to find an argument, it hopes to act as a springboard through which the reader might arrive at their own conclusions. The reader should not be surprised to note that there may be considerable dichotomy between their personal and professional ethics.

In terms of medical law, this book is more descriptive. Although there is considerable scope for the interpretation of legal decisions, it is usually of more value to those who are not legally trained to avoid conjecture and abstruse discussion, in favour of stating exactly what the law is. The dynamic nature of the subject, however, inevitably means that the law may have changed between the writing and publication of this book, and for this the authors apologise in advance. Recent decisions and reinterpretations of the law may be found in the *Medical Law Review* (http://www3.oup.co.uk/medlaw/).

FURTHER READING

Journals

Consensus Group of Teachers of Medical Ethics and Law in UK Medical Schools. Teaching medical ethics and law within medical education: a model for the UK core curriculum. *J Med Ethics* 1998; **24**: 188–192

Doyal L and Gillon R. Medical ethics and law as a core subject in medical education. *Br Med J* 1998; **316**: 1623–1624

Book

General Medical Council. *Tomorrow's Doctors.* GMC, London, 1993

2 An introduction to the UK legal system

Similarly to the other professions, the legal profession has established its own hierarchy, language and code of practice, in order to manage the large number of people professing general and specialist legal knowledge. As a result, the workings of the legal profession can appear arcane to the outsider, even despite recent attempts to improve public accessibility to the law.

This chapter provides a short introduction to legal system in the UK, as well as listing a number of sources of information by which the lay person may further access legal information.

STRUCTURE OF THE UK LEGAL SYSTEM

The UK has three distinct legal jurisdictions: England and Wales, Scotland, and Northern Ireland. All of the jurisdictions are common law jurisdictions, but Scotland has a very distinct, separate and interesting legal system that incorporates aspects of the civilian system of law seen in continental Europe.

The legal profession in the UK is split into two branches, solicitors and barristers, whose training, practice and regulation are separate.

Solicitors are the legal equivalent of general practitioners, and are visited first by clients seeking legal advice. Solicitors instruct barristers to provide specialist legal advice and representation (if necessary) in court. Solicitors in England and Wales are regulated by The Law Society of England and Wales. In other countries of the UK they are regulated by the equivalent body.

Barristers play a similar role to that of hospital consultants, acting as a referral service for solicitors. They are the only members of the legal profession allowed to appear in the Appeal Courts and (in most cases) in the High Court. Most specialise in particular areas of the law, for example, clinical negligence. Barristers are not allowed to have direct access to lay clients, except in very limited circumstances, hence the requirement for

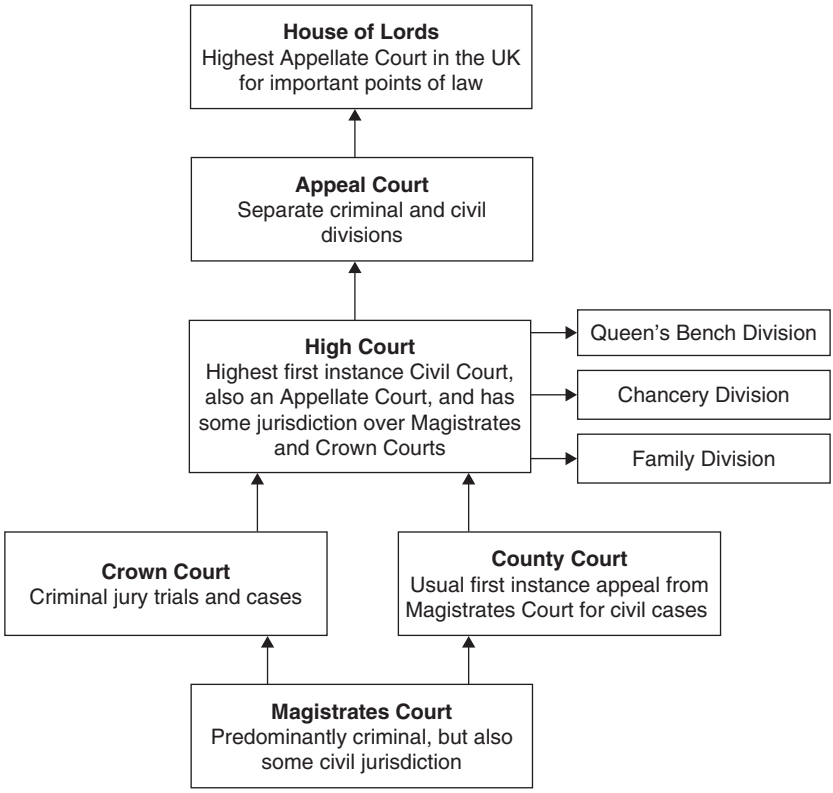

Figure 2.1 The Court structure in the UK.

their instruction via solicitors. The activities of Barristers are regulated by the Bar Council of England and Wales. In the other countries of the UK they are regulated by the equivalent body.

The courts are administered by the Court Service under the Department of Constitutional and Administrative Affairs.

The fundamental distinction in the English common law is between Criminal Law and Civil (i.e. Non-criminal) Law. The court structure reflects this (Figure 2.1).

At the time of writing, as part of its Constitutional Reform Bill, the UK government is considering abolishing the role of the law lords in the House of Lords, in favour of a US-style Supreme Court. The Supreme Court would act as a final Appellate Court in the UK. Although this move is designed to reinforce the independence of the judiciary from political interference, critics have suggested that the current system has worked well for centuries and is delivered at a tenth of the proposed cost of the new system.

The Privy Council, one of the oldest parts of the government, maintains a judicial authority through a committee known as the Judicial

Committee of the Privy Council. This body is composed of Privy Councillors (life-appointments), for those who hold, or have held, high judicial office in the UK. The Committee hears appeals from those Commonwealth countries who have retained the right of appeal, from colonial territories and, importantly, from tribunals of the medical, dental and optician's professions.

Judges and tribunal lawyer members are appointed by the Lord Chancellor, who heads what used to be known as the Lord Chancellor's department, which has transformed itself into the Department of Constitutional Affairs (http://www.dca.gov.uk/index.htm).

In the Civil Courts the introduction of a completely new set of Civil Procedure Rules (April 1999), covering the procedure of the High Court and the County Court, is supposed to simplify court proceedings by giving judges more control over proceedings, and encouraging parties to settle their differences, preferably before litigation even starts. The rules also encourage the use of plain English in legal documentation.

The law of England and Wales is based on judge-made common law (or 'case law') based on court decisions ('precedents') made over a number of centuries, but is increasingly overlaid by a number of statutes (Acts of Parliament) and statutory instruments (secondary legislation that also has to be approved by Parliament). However, statute requires court interpretation, the decisions of House of Lords, the Court of Appeal and the High Court each being binding on the courts at lower levels. Decisions of the County Court are not normally reported and are only 'persuasive', (i.e. are not binding on other County Courts).

A further distinction that is made is between public law (pertaining to government and society) and private law (pertaining to disputes between individuals, also called civil law). Both public law and private law depend on statute and common law. The majority of public law relates to criminal law, compared to private law, which mainly concerns civil offences.

THE EUROPEAN COURT OF JUSTICE

Membership of the European Union (EU) has added another layer of jurisdiction to the legal process of the UK.

Set up in 1952, the European Court of Justice (ECJ) acts as a Supranational Court (based in Luxemburg) that is able to enforce European Community (EC) law against individual defaulting EU Member States.

The ECJ comprises 15 judges and 8 advocates general. The judges and advocates general are appointed by common accord of the governments of the Member States and hold office for a renewable term of 6 years.

One of their numbers is selected by the judges to be President of the Court for a renewable term of 3 years. The President directs the work of the Court and presides at hearings and deliberations.

Judges ensure that EC law is not interpreted and applied differently in each Member State. In order to fulfil that role, the ECJ has jurisdiction to hear disputes to which the Member States, the Community institutions, undertakings and individuals may be parties. If it is judged that a Member State has not fulfilled its obligations under the Treaty of Europe, the Commission can initiate proceedings that require the State concerned to submit a defence of its position. If this fails to satisfy the Commission, a reasoned opinion may be delivered which requires the matter to be resolved by a specific date.

More than 500 cases are heard a year. To cope with the turnover of cases efficiently, a Court of First Instance has been set up by the European Council, whose advocates general assist the ECJ in its task, by delivering impartial and independent opinions on cases brought before the Court.

With relevance to perioperative medicine the ECJ may be asked to rule, for example, on the free migration of doctors between member states, on the application of the European Working Time Directive, on the right of individuals to become 'health-tourists' in order to facilitate more rapid access to treatment, and on the regulation of medicines and medical devices.

THE EUROPEAN COURT OF HUMAN RIGHTS

The UK is bound by many international treaties which oblige it to respect human rights, in particular the European Convention on Human Rights (ECHR), a formulation of the Universal Declaration of Human Rights. This treaty allows those who believe their human rights infringed to appeal for redress to a higher court than that offered by the legal system of the UK.

The ECHR was drawn up under the auspices of the Council of Europe, an organisation of West European countries, based in Strasbourg, which is quite separate from the EC.

The rights guaranteed by the ECHR have recently been incorporated into UK statutory law as the Human Rights Act 1998 (see Chapter 4). In theory, this means that there will be fewer cases going to the European Court of Human Rights (ECtHR), as the UK courts should ensure adherence to the ECHR, although complainants may still be able to appeal to the ECtHR if, for example, they believe the law has been incorrectly applied.

There are two ways in which alleged breaches of the ECHR by the UK can be brought to the attention of the ECtHR:

- A complaint may be made by one of the other countries bound by the ECHR. In practice, countries are reluctant to bring cases against each other, doing so only in the most extreme cases or where their own interests are affected.
- More commonly, an individual may complain that his/her rights have been infringed. Any person claiming that their ECHR rights have been infringed may appeal directly to the ECtHR.

GENERAL COMMENTS ON THE EVOLUTION OF MEDICAL LAW

Medical law is a comparatively young subject. Nevertheless, the continuing advance of medical technology, which often has debatable ethical consequences, together with the ongoing social development towards an increasingly consumerist society, has led to a boon in medicolegal practice. To an extent this is reflected by the previous paucity of legal guidance in the area. However, it may also represent enthusiasm on the part of the legal profession to extend the provisions of existing common law into the field of medicine, driven as much by financial reward as a crusading and altruistic desire to protect patients from the excesses of the medical profession. Whatever, medical law is here to stay, and will become a significant consideration in the professional lives of future doctors.

As mentioned, much of medical law has been guided by the courts, and decided by judges. However, increasingly, statutory provisions have been put in place by Parliament (e.g. the Human Fertilisation and Embryology Act, 1990). Nevertheless, the ethical dilemmas posed by medical advances tend to be avoided by politicians keen not to alienate potential voters, so it is likely that the courts will continue to provide the main guidance in the developing body of law, albeit modified and guided themselves by non-statutory but official edicts and guidelines from such august bodies as the British Medical Association (BMA), General Medical Council (GMC), and Department of Health.

COURT TRANSCRIPTS AND HOW TO UNDERSTAND THEM

Consider the reference to the following judgement:

ReF (in utero) [1988] 2 All ER 193 (CA)

In this example, the case reference may be broken down into:

- *ReF*, which means 'in the case of *F*', *F* representing the first initial of the subject of the trial. *Re* usually precedes cases where a decision needs to be made about an individual, rather than more adversarial cases in which a decision needs to be made between parties (e.g. *Paton v Trustees of BPAS*). In the latter, the first name is the plaintiff or appellant (in the Court of Appeal) or claimant (in plain English). The second name is the defendant. *R v X* indicates a crown prosecution (i.e. *Rex (Regina) v X*), *A-G v X* indicates the involvement of the Attorney-General.
- *(in utero)*. Obviously, there are lots of people whose name begins with F. Bracketed terms in '*Re*' cases are an attempt to narrow the field of reference.
- [1988]. The year in which the case was reported, which is usually the same as the year in which the case was heard in court.
- 2. 2nd volume, etc.
- All ER. This describes the law report in which the case was reported. All ER: All England Reports; BMLR: Butterworth's Medical Law Reports; Med LR: Medical Law Review; Fam: Family Division Law Reports; EHRR: European Human Rights Reports; QB: Queen's Bench.
- 193. The first page of the report.
- (CA): the court before which the case was heard. CC: County Court; HCJ: High Court of Justice; Fam Div: Family Division; QBD: Queen's Bench Division; CA: Court of Appeal; HL: House of Lords; ECtHR: European Court of Human Rights, SC: Supreme Court (US, Canada and Australia).

Judges names are suffixed by the letters J (Justice); LJ (Lord or Lady Justice); MR (Master of the Rolls); P (President of the Family Court); LCJ (Lord or Lady Chief Justice); VC (Vice-Chancellor) and LC (Lord Chancellor). Judges in the lower courts are usually referred to as HHJ (His/Her Honour Judge).

SOURCES OF INFORMATION ABOUT MEDICAL LAW AND ETHICS

There are, of course, any number of books, journals and web sites containing information about medical law and ethics.

The following references are good starting points, being both readable and easily accessible.