1

MEDICAL ETHICS AND MEDICAL PRACTICE

1.01 This book is concerned with a vital debate that has captured the imagination of people throughout the world—that is, as to how we should deal with the remarkable advances in medicine and human biology that bid fair to change the way in which we see ourselves as human beings. But the debate is also concerned with the more day-to-day issues of the role of law in medical practice, with the moral and legal contours of the doctor/patient relationship and with the obligations that we owe to each other in matters of (public) health. It has an academic side to it—bioethics and medical law are recognised components of the curricula of many universities and colleges—but it also involves legislators, policy makers, national bioethics committees and, increasingly, the public itself. It is, of course, inevitable that such an issue should give rise to a burgeoning literature consisting of both general and specialised material.[1]

1.02 The importance and intensity of the public moral conversation about bioethics and medical law are explained in part by the very nature of their subject matter. This is an area of concern which touches upon people's most intimate interests. It deals with matters of human reproduction and human mortality—or sex and death—both of which have traditionally involved our religious convictions and have provoked intense emotions. Increasingly, medical technological advances allow us to manipulate the state of human health from transplantation to genetic modification and on to (de)selection of traits such as deafness or even gender. In addressing these issues, the debate raises many fundamental questions. What is it to be a person? What is the value of human life? How, if at all, should we attempt to influence the future biology of the species through the use of new knowledge?

1.03 There is no shortage of conviction on any of these issues. Most major cultural or religious traditions have firm views on such matters and are frequently prepared to assert them as being valid for all; indeed, much of bioethics is informed by such traditions. Those who approach the subject from the viewpoint of individual freedom, or of human rights, will argue just as vigorously that issues of this sort lie clearly within the confines of individual moral action. The antagonism between these two positions is sometimes intense and it

[1] The literature on bioethics is now greater than its counterpart in any other area of applied ethics. Constraints of space prevent more than a few examples of the genre but, of the general works available, T L Beauchamp and J F Childress, *Principles of Biomedical Ethics* (7th edn, 2012) has established itself as a classic. A useful starting point for many readers will be the various compilations which have been made, including J Harris (ed) *Bioethics* (2001) and P Singer and A M Viens (eds) *The Cambridge Textbook of Bioethics* (2008). A complementary companion to our own text is T Hope, J Savulescu and J Hendrick, *Medical Ethics and Law* (2nd edn, 2008).

often seems as if there is little prospect of common ground.[2] Yet, insofar as we have to live in a community, we are obliged to identify what is permissible and what is not—and this implies the involvement of the law. So we do need, for example, a law concerning artificial reproduction because, unless the law pronounces on the issue, society can be seen to be endorsing a non-interventionist approach which allows for unrestricted freedom of choice. In some cases, this may be what society actually wants but, in others, it will not represent the communal position, which also deserves protection. To take another example, the possibility of embryo stem cell research requires a legal response unless the human embryo is to be considered as a mere laboratory artefact. In fact, there are very few people who would argue for no regulation of such a form of research; the majority of supporters of a liberal attitude to this issue would accept that *some* level of regulation is vital in this area even if it is only in respect of the type of research permitted and the period during which it can be carried out. In other respects the law has steadfastly resisted pressure to facilitate or endorse individual choice about the most critical of life events. Euthanasia and physician assisted suicide, for example, remain prohibited in the vast majority of jurisdictions despite numerous challenges before the courts and attempts to introduce enabling legislation. But the fact that a growing number of jurisdictions now do permit assisted dying illustrates the complexities with which this book is concerned; shifting social and moral attitudes make medical law a constantly developing discipline.

1.04 Inevitably, then, the law is drawn repeatedly into the debates and this is especially so when there is a conflict of individual interests or a clash of individual and community interests. In a liberal society, however, the legislature and courts may seek to limit legal intervention in medically-related matters. Such a society may take a positivist stance and view the function of the law as being that of the neutral adjudicator—a role in which the moral content of legal decisions is kept to a minimum. This concept of the legal role has proved largely unrealistic in the area with which we are concerned. Medical law is catalysed by moral issues. The debate on embryonic stem cell research, for example, is essentially an exposition of different moral views; yet, in practice, it becomes one concerning what the law should be. It is pointless to attempt to disengage the moral from the legal dispute—when we talk about legal rules, we are inevitably drawn into a discussion of moral preferences seeking the legitimacy and sanction of law and legal institutions.

1.05 Thus, we often find ourselves engaged in debating not what the law is but what it should be. This requires us to engage in moral evaluation and this, in turn, raises the question of how we are to identify what is at stake, in individual and societal terms, and how we should proceed. This is no easy task, living, as we do, in a pluralist, secular age. And despite a burgeoning number of international legal instruments purporting to embody universal ethical values,[3] their success in providing us with answers to the dilemmas thrown up by modern medicine remains open to question. We are forced, therefore, to turn to the identification of the ethical basis for the practice of medicine itself.

A BASIS FOR MEDICAL ETHICS

1.06 It should not be thought that ethics is necessarily about discovering what is 'right'. Rather, ethics is a system of principles or values that assist in decision making. Ethics allows us to

[2] R Ashcroft, 'The troubled relationship between bioethics and human rights' in M Freeman (ed) *Law and Bioethics* (2008), ch 3.

[3] Most notably see UNESCO, Universal Declaration on Bioethics and Human Rights (2005) and also the Council of Europe, Convention on Human Rights and Biomedicine (1997).

justify a particular course of action by reference to wider, socially-accepted norms or values. Bioethics, then, is the branch of moral philosophy concerned with the ethical issues that arise out of medical practice, life sciences and a range of other interventions involving humans and animals. Morality, by contrast, refers to a personal, intuitive sense of what is right or wrong. Ethics comes into play when we are faced with a dilemma: that is, when we can see two or more possible and justifiable paths to take over any difficult decision. Arguing by reference to ethical principles or concepts helps us to decide which path is the better one; note, however, this also means that we may legitimately disagree over which path to take. In this sense, then, there may be more than one 'right' answer. A 'wrong' answer would be to take a path when we cannot justify doing so—it would be unethical to do so. But what, then, is at hand to assist in ethical decision making in medicine?

THE HIPPOCRATIC INFLUENCE

1.07 For the origins of our current medical practice—with its emphasis on the one-to-one relationship between doctor and patient within the confines of the home, surgery or hospital—we must look to Greece where, even by 500 BC, the acceptance of disease as 'an act of God' was being questioned and, consequently, the originally strong influence of the priest/physician had waned; a predominantly religious discipline had been taken over by the philosophers who, through the processes of logical thought, observation and deduction, transformed the concepts of medicine. Inevitably, this led to the formation of schools involving the close association of practitioners, paternalism and the elements of a 'closed shop'; a code of intra-professional conduct evolved, heralding the dawn of what has become known as medical etiquette. In addition, the new concepts dictated that the physician went to the patient rather than the patient to the temple. A standard of practice relevant to the new ideals was required and has survived as the Hippocratic Oath.[4]

1.08 While Hippocrates remains the most famous figure in Greek philosophical medicine, he was not alone and it is probable that the Oath predates his own school. It therefore indicates a prevailing ethos rather than a professorial edict and it is still regarded as the fundamental governance of the medical profession. Much of the preamble relates to medical etiquette and is clearly outmoded—very few ageing medical professors now anticipate social security by way of the generosity of their students! This, however, is not our concern here—and it is to be distinguished clearly from medical ethics. As to the latter, the Oath lays down a number of guidelines. First, it implies the need for coordinated instruction and registration of doctors—the public is to be protected, so far as is possible, from the dabbler or the charlatan. Secondly, it is clearly stated that a doctor is there for the benefit of his patients—to the best of his ability he must do them good and he must do nothing which he knows will cause harm. This is reflected in modern times in the principles of beneficence and non-maleficence, which we discuss in more detail later. Thirdly, euthanasia and abortion are proscribed; the reference to lithotomy probably prohibits mutilating operations (castration) but has been taken by many to imply the limitation of one's practice to that in which one has expertise. Fourthly, the nature of the doctor-patient relationship is outlined and an undertaking is given not to take advantage of that relationship. Finally, the Oath expresses the doctrine of medical confidentiality.

1.09 In fact, the Hippocratic Oath did not become an integral part of ethical teaching until well into the Christian era; it lapsed with the decline of Greek civilisation and was restored with

[4] See text available on Online Resource Centre (ORC).

the evolution of university medical schools. It is doubtful if any British medical school now requires a reiteration of the Oath at graduation but, avowed or not, all doctors would admit to its persuasive influence. The language of the Oath is, however, archaic and a modernised version was introduced by the World Medical Association as the Declaration of Geneva. This was last amended at Divonne-les-Bains, France in 2006[5] and provides the basis for several national and international codes.[6]

1.10 We have seen that Greek medicine was essentially a private matter and, indeed, its mode of practice was scarcely attuned to the needs of public health. For the origins of this, we must turn to the Judaeo-Christian influence which, certainly in the Jewish tradition, expressed itself most powerfully in accepting that the rights of the individual must sometimes be sacrificed for the good of the community—there was strong emphasis, for example, on the isolation of infectious cases, including those of venereal disease, the regulation of sewage disposal and the like—and the principles of public health medicine were born. As we have already noted, the fact that medicine was dominated by religion turned out to be mutually advantageous. Much of this attitude passed to the Christians, who were also forced into the group lifestyle, and were fortified by the concepts of equality, charity and devotion to the less fortunate—concepts which should still underlie the ethical practice of medicine in Christian countries. It is unsurprising that, during the Dark Ages, medicine was virtually kept alive in the monasteries, which provided the template for the voluntary hospitals of later years.

RELIGIOUS THEORIES

1.11 Today, there is a plethora of theories on hand that are designed to help us to justify difficult decisions. Many modern accounts of medical ethics are, however, strangely silent as to the importance of religious theories of medical ethics—the element of surprise stemming from the fact that medicine and religion have been intertwined from the earliest times when, as we have seen, priests were also recognised as physicians. As a direct result, religious theories historically constitute a major element of thinking in medical ethics and their influence continues to be felt in all corners of the subject, even if only tacitly. The common feature of such theories is a vision of man as involved in a dialogue with a divine creator, or possibly a spiritual force, as to the way in which the human body should be treated. The vision may manifest itself in an insistence on ritualistic practices, for example, in relation to burial. Such examples should not, however, be dismissed as an exercise of power based on superstitious reverence—many religious practices, especially those of orthodox Judaism, are, in fact, based on sound principles of public health. It may, on the other hand, be expressed at a higher level of abstraction, fashioning a view of the sanctity of human life which is capable of resolving a whole raft of practical issues. The Judaeo-Christian religious tradition has had the greatest impact in the Western world and is one which continues to influence much of the contemporary debate.[7]

1.12 Religiously-based medical ethics have a clear sense of fundamental values. In the Christian tradition, these include not only a belief that human life is a divine gift which cannot be

[5] See text available on Online Resource Centre.

[6] Including the International Code of Medical Ethics which was first amended at Venice in 1983 and most recently updated in 2006.

[7] For informative insights see P Morgan and C Lawton (eds) *Ethical Issues in Six Religious Traditions* (2nd edn, 2007)

disposed of by mortals but also a strong attachment to the importance of monogamous, enduring marriage. These values are translated into practical rules in the shape of an antipathy to euthanasia and abortion—an antipathy that amounts to prohibition in orthodox Roman Catholic thinking—and of a belief that various forms of intervention in human reproduction are morally wrong. Inherent in many of these traditions is a strong sense of the *natural,* which proposes a teleology for man. In the light of this, it is often seen as wrong to interfere with the manifest destiny which has been prepared for humanity. This may result in the rejection of an everyday medical issue such as sterilisation just as much as it might lead to a blanket refusal to contemplate interference in the genetic endowment of mankind.

1.13 It would be wrong to assume that those who approach medical ethics from a religious viewpoint are uncritical and authoritarian in their moral thinking. Indeed, many of the more sensitive contributions to the literature of medical ethics have been made by those who approach the subject from this background. And sometimes it is only such a voice which will raise awkward, and yet very important, questions. The debate on euthanasia provides an instance of this in the form of the serious and persistent questioning provided by John Keown.[8] An historic example is the Protestant theologian, Paul Ramsey, whose work anticipated many of the questions which have since become the staple of contemporary debate in medical ethics.[9]

THE CURRENTS OF MEDICAL ETHICS

1.14 As we have seen, ethical discourse is concerned with the search for justification for our actions. An ethical dilemma arises when two or more courses of conduct may be justifiable in any given set of circumstances, possibly resulting in diametrically opposed outcomes. How, then, do we know what is the 'right' thing to do? Various means may be employed to argue for an ethical resolution to a dilemma and morality is but one such means. Morality may be individual or communal, in that it reflects a core set of values by which individuals or communities abide. As we discuss later, morality may even be a simple question of intuition and, on this criterion alone, it is difficult to argue that an individual's personal value system is 'wrong'. Ethics, on the other hand—while informed by moral debate and argument—usually operate within an established framework of values which serves as a reference from which to conduct the debate about the basis on which an action can or cannot be justified. Thus, for example, Beauchamp and Childress have long championed the utility of 'principlism' as a way to this end.[10] In brief, they hold that ethically appropriate conduct is determined by reference to four key principles which must be taken into account when reflecting on one's behaviour towards others. These are:

(i) the principle of respect for individual autonomy (i.e.—individuals must be respected as independent moral agents with the 'right' to choose how to live their own lives),

(ii) the principle of beneficence (i.e.—one should strive to do good where possible);

(iii) the principle of non-maleficence (i.e.—one should avoid doing harm to others); and

(iv) the principle of justice (i.e.—people should be treated fairly, although this does not necessarily equate with treating everyone equally).

[8] In particular by way of *Euthanasia Examined* (revised 1997), *Euthanasia, Ethics and Public Policy* (2002) and *Debating Euthanasia* (2011 with Emily Jackson). See the discussion of euthanasia at Chapter 18.

[9] See e.g. P Ramsey *The Patient as Person* (1970).

[10] N 1.

While principlism is by no means universally accepted as the lingua franca of ethics[11]—and indeed has been criticised as embodying too much of a North American perspective[12]—it does, nonetheless, provide a very good example of how ethical discourse requires reflection and justification of our actions by reference to accepted values and mores.[13] More 'European' perspectives are offered by authors who concentrate on notions such as 'dignity' and 'solidarity', thus elevating the ethical concerns above the purely personal.[14]

1.15 At a broader level of abstraction, contemporary medical ethics can be seen as a tapestry in which an array of philosophical theories interweave with one another. The two strands of deontological and consequentialist thought are, however, particularly evident. Deontological theories focus on the rightness or wrongness of an act in itself. They are not so much concerned with the consequences which that act will have; rather, they are concerned with identifying those features of the act which mark it as morally acceptable or otherwise. The classical exposition of such a theory is that by Kant, who stressed that every person must be treated as an end in him- or herself, rather than as a means to an end. Thus, the essential message of Kantian moral teaching is that we should not use others but should respect their integrity as individuals. Many modern theories of autonomy find their roots in this background and, as we shall see later, autonomy has come to be associated closely with the liberal individualism which has exerted a massive influence on the philosophical climate surrounding medico-legal debate in the last few decades. An irony, however, is that many Kantians emphasise that the core message of their philosophy concerns the *obligations* that we owe to others while, at the same time, many contemporary conceptions of autonomy insist on the atomistic *rights* of individuals to decide for themselves, all the while ignoring the impact of those decisions on the broader community.

1.16 Critics of deontological theories of morality, particularly of those in the Kantian mould, often stress what is seen as a rigidity of approach. The 'strict' Kantian does not give sufficient weight, it is said, either to human intuitions as to what is right at the time or to the virtues such as wisdom, compassion and fairness, which contribute to living a life of 'human flourishing' (*eudaimonia*).[15] An alternative, and more flexible, approach might be one which was more sensitive to the human feelings involved in any moral dilemma and one which also paid more attention to the consequences which flow from our actions. One such approach is that adopted by utilitarianism, a philosophy which has played a major role in the medical debate and which is regarded by many as underpinning modern ethical medicine.

1.17 Utilitarians are accustomed to being misrepresented by those who believe that utilitarianism is a philosophical theory that started, and ended, with the work of Jeremy Bentham. Classic utilitarianism of the Benthamite school held that the test of the morality of an action was the extent to which it promoted good consequences (pleasure) or bad (pain). The

[11] For an excellent collection of papers on the 'virtues' and 'vices' of principlism, see J Savulescu et al. 'Festschrift edition of the Journal of Medical Ethics in honour of Raanan Gillon' (2003) 29(5) J Med Ethics. Most recently, see also T Walker 'What principlism misses' (2009) 35 J Med Ethics 229.

[12] S Holm, 'Not just autonomy – The principles of American biomedical ethics' (1995) 21 J Med Ethics 332 and T Takala 'What is wrong with global bioethics? On the limitations of the four principles approach' (2001) 10 Cambridge Quarterly of Healthcare Ethics 72.

[13] See, J S Gordon, O Rauprich and J Vollmann, 'Applying the four-principle approach' (2011) 25 Bioethics 293.

[14] R Houtepen and R ter Meulen R (eds.) 'Solidarity in Health Care' (2000) 8 Health Care Analysis, Special Issue and H Ten Have and B Gordijn (eds) *Bioethics in a European Perspective* (2002).

[15] A Campbell 'The virtues (and vices) of the four principles' (2003) 29 J Med Ethics 292.

utilitarian measure of good is, therefore, the maximisation of happiness, although modern utilitarians, in particular, would stress that this does not necessarily lead to unrestricted hedonism. Modern utilitarianism acknowledges the importance of rules in identifying moral goals and, in this way, prevents the happiness of the many from overshadowing the rights of the few. Preference utilitarianism, a further modification of the classical theory, allows for the judging of the good of individuals according to their own values, a position perhaps best expressed in modern bioethics through the work of Peter Singer.[16]

1.18 Liberal individualism leans towards a utilitarian or consequentialist approach, in that it measures the effect of a decision on individuals. To the liberal individualist, the good which society should pursue is the fulfilment of the individual. The ideal society is, then, one in which each person makes his own decisions as far as is possible and 'creates himself'. In this way, the individual exercises and enhances his autonomy—how autonomy is used is not a major concern to the liberal individualist, so long as it is not used in a way that unduly restricts others from exercising their own autonomy.

1.19 This is the near antithesis of the last variation on ethical theory that we propose to mention—that is the communtarian ethos which is gaining ground as something of a counterweight to the almost relentlessly increasing reliance on personal autonomy as the cornerstone of both medical ethics and medical law.[17] Communitarianism visualises the community as the integral unit in which autonomy is expressed not so much on an egocentric base but, rather, as a state that is modified by a sharing of values with those of the group in which the individual operates; such values include but are not restricted to solidarity, social justice and a focus on the obligations we owe to others (as opposed to the rights we can claim for ourselves). Put in practical terms, the acceptability of an action is to be judged by the goodness or badness of its effect not on an individual per se but on persons as interdependent units of society—in short, it recognises John Donne's aphorism that no man is an island.[18] The critic will, immediately, ask what is a community?—and the simple answer is that group of persons who are significantly affected by an action or a decision. The application of community ethics to medicine is illustrated in Glover's consideration of abortion.[19] Accepting that there should be as few unwanted children as is possible, he points out that there are large and relevant moral differences between prevention of conception and abortion. These include the side effects not only on the doctors and nurses concerned but also potentially on society as a whole by way, for example, of 'undermining the general reluctance to kill'. In some senses, a well-tuned concept of communitarian ethics can draw on elements of deontological *and* utilitarian thinking whereby the emphasis is both on the obligations that we owe to those around us as well as on the consequences of our individual decisions.[20] This is no truer than in the context of public health, as we explore in Chapter 2. While principlism and rights-based arguments might work well in the confines of the doctor/patient relationship, arguably different values are at stake, and,

[16] Singer's contribution to contemporary applied ethics has been considerable. In the field of bioethics, he is associated with challenges to the traditional sanctity of human life view; on which, see his *Rethinking Life and Death* (1994) and more generally *How Are We To Live?* (1997).

[17] '… it would seem to me a matter of deep regret if the law has developed to a point in this area where the rights of a patient count for everything and other ethical values and institutional integrity count for nothing': *R* v *Collins, ex p Brady* (2001) 58 BMLR 173 per Kay J.

[18] For a wide-ranging exposition, see M Daly (ed) *Communitarianism: A New Public Ethics* (1994).

[19] J Glover, *Causing Death and Saving Lives* (reprinted 1986), p 142.

[20] For an interesting defence of communitarianism against principlism see D Callahan, 'Principlism and Communitarianism' (2003) 29 J Med Ethics 287.

so, different ethical paradigms are required when we are talking about the health of the community, and this potentially includes the global community.[21]

1.20 We have to admit to our, at least, partial adherence to community ethics. Nevertheless, a book such as this must recognise the undoubted fact that autonomy is by far the most significant value to have influenced the evolution of contemporary medical law, at least in the context of the therapeutic relationship. The concept which has dominated the control of medical practice more than any other in the last half-century is the insistence that individuals should have control over their own bodies, should make their own decisions relating to their medical treatment and should not be hindered in their search for self-fulfilment. The acknowledgment of autonomy has served to discredit medical paternalism in almost all its forms and has led to the promotion of the patient from the recipient of treatment to being a partner, or even client, in a therapeutic project—and this change has been reflected in the rapid development of the legal and political regimes by which medical treatment is now regulated in the United Kingdom.

1.21 In one sense, the philosophical apotheosis of autonomy has brought liberation. It has enhanced the freedom of those whose vulnerability, physical or mental, may have exposed them to insensitive treatment or even to exploitation; it has imparted dignity to the lives of those who might, otherwise, have felt themselves to be powerless in the face of the articulate and the professional. Yet, from another view, the acceptance of a particularly-individualistic sense of autonomy as the benchmark of the good has led us to ignore other values, and this may have negative effects.[22] The communitarian approach tells us that, even if self-fulfilment does shine through the development and the exercise of autonomy, there is a social dimension to life which is potentially equally enriching. Autonomy must be qualified by the legitimate interests and expectations of others, as well as by economic constraints. Autonomy is not an absolute.[23] In the medical context, the claims of autonomy must be moderated so as to accommodate the sensitivities of others, including those of the doctor—who is, after all, also an autonomous agent.[24] It may be that respect for individual autonomy points in the direction of allowing voluntary euthanasia—but another moral agent has to administer the drug that ends life, and that person may be affected by the task. There are also the interests of others in being protected against involuntary euthanasia; it is possible that, in providing such protection, we may have to deny self-determination to those who are fully capable of exercising it.[25] Personal autonomy must also be measured against the needs of society as a whole. In an ideal world, a sick person should be able to demand the treatment of his or her choice. A moment's reflection, however, is enough to show us that this is an impossible goal. Society itself demands

[21] B Bennett (ed) *Health, Rights and Globalisation* (2006).

[22] The conflict between individual autonomy and, say, society's interest in the preservation of life is illustrated in the Israeli Patient's Rights Act 1996 which allows for non-consensual treatment in certain circumstances. See M L Gross, 'Treating competent patients by force: The limits and lessons of Israel's Patient's Rights Act' (2005) 31 J Med Ethics 29—'there are no grounds for respecting a patient's less-than-informed refusal of treatment'.

[23] G Laurie, 'The autonomy of others: Reflections on the rise and rise of patient choice in contemporary medical law', in S McLean (ed) *First Do No Harm: Law, Ethics and Healthcare* (2006), ch 9.

[24] Discussed in G M Stirrat and R Gill, 'Autonomy in medical ethics after O'Neill' (2005) 31 J Med Ethics 127. See also M Brazier, 'Do no harm – Do patients have responsibilities too?' (2006) 65 CLJ 397.

[25] This was the basis of the decision of the European Court of Human Rights in *Pretty* v *UK* (2346/02) [2002] 2 FLR 45; (2002) 35 EHRR 1; (2002) 66 BMLR 147 (see paras 18.54–18.58) that the United Kingdom's refusal to support assisted suicide for patients who voluntarily requested it was justified on the grounds of the broader concern to protect the vulnerable.

a just distribution of resources and this cannot be achieved in an ambience of unrestricted 'rights'—put another way, we can only realise our autonomy within the framework provided by society.[26]

1.22 Even so, the concept of rights has many proponents and, like autonomy, rights theory plays an important part in contemporary ethical debate. Yet the language of rights may also become unduly assertive and combative and may hinder, rather than promote, moral consensus.[27] This is not to decry the importance of rights. Many of the central ethical positions defended in this book can be couched in terms of rights. Once again, however, rights-talk is peculiarly suited to an individualistic moral tradition and conflicts of rights tend to lead to moral impasse. Most discussion centres on the rights of the patient—but has the doctor no rights when choosing treatment in accordance with his Hippocratic principles and his training? At one time the former Master of the Rolls, Lord Donaldson, expressed this unequivocally when he said:

> [I cannot, at present, conceive of any circumstances] in which the court should ever require a medical practitioner to adopt a course of treatment which in the bona fide clinical judgment of that practitioner is contraindicated as not being in the best interests of the patient.[28]

This position may no longer hold as strongly as it once did with the advent of increasing judicial intervention in medical decision making, especially in the context of disabled neonates, as we discuss further in Chapter 15. By the same token, we should not lose sight of the fundamental duty of the doctor described by Lord Donaldson as being to treat the patient in accordance with his own clinical judgement[29]—which opens the way to an alternative dialogue through the language of *obligations*. The way to a satisfactory doctor/patient relationship is not through the confrontational procession of rights but, rather, through a realisation of the obligations incumbent upon each side to work towards the ideal.

AUTONOMY AND PATERNALISM

1.23 The paternalist acts for the benefit of another, or in the other's best interests, without the specific consent of the person for whom he acts. Until a few decades ago, the practice of medicine was unquestionably paternalist—at least in parts—and many of those involved might have been surprised to discover that their practices could be considered morally objectionable. Thus, patients were often treated without adequate explanation of what was involved or significant facts about their illness were kept from them. It was, for example, common not to pass on information if it was thought that the knowledge would cause distress, and psychiatric patients could be subjected to treatments without any concern as to their views or preferences. Such practices are now largely regarded as unethical in modern Western medicine,[30] and are consequently rare. Yet examples still occur and surfaced, for

[26] See A V Campbell, 'Dependency: the foundational value in medical ethics' in K V M Fulford and G J M Gillett (eds) *Medicine and Moral Reasoning* (1994).

[27] In the view of some philosophers, rights can be reduced to principles which form the real content of morality. For a sceptical view, see R Frey, *Rights, Killing and Suffering* (1983); to be contrasted with L W Sumner, *The Moral Foundation of Rights* (1987) and with the outstanding contribution of K Cronin in *Rights and Christian Ethics* (1992). More recently, see Ashcroft, at n 2, for a sceptical view of rights where he describes them as…derivate rather than fundamental moral concepts.

[28] *Re J (a minor) (wardship: medical treatment)* [1992] 2 FLR 165 at 172; (1992) 9 BMLR 10 at 17.

[29] *Re J (a minor) (wardship: medical treatment)* [1992] 2 FLR 165 at 172; (1992) 9 BMLR 10 at 17.

[30] Compare a Western view: R J Sullivan, L W Menapace and R M White, 'Truth-telling and patient diagnoses' (2001) 27 J Med Ethics 192 with: D F-C Tsai, 'Ancient Chinese medical ethics and the Four Principles of

instance, at the turn of the century in disclosures of the unauthorised retention of tissues from paediatric post-mortem examinations. Certainly, a proportion of the pathologists involved in these practices did not ask for the permission of the parents, but at least some of these failed to do so because they wished to protect the parents from distressing facts. To quote from the President of the Royal College of Pathologists:

> No one ever had enthusiasm for discussing the detailed autopsy process with recently bereaved relatives, and it was always more comfortable to draw a veil over it. But that veil meant that relatives did not know what was going on … Strip away [the extraneous factors] and there remains the inescapable and uncomfortable fact that in the past post-mortem organ retention has been a prime example of professional paternalism.[31]

1.24 Even so, while an unqualified rejection of paternalism in medicine might satisfy some proponents of autonomy, it would undoubtedly, at the same time, cause avoidable harm. Paternalism is acceptable in principle—and, indeed, necessary in practice—where the person who is the object of such action is incapable of making his or her own decision.[32] An intervention in such a case will be justifiable if the disabling condition is either permanent or cannot be expected to lift in time for the person in question to decide for him or herself. The advantages of any intervention must, however, significantly outweigh the disadvantages which would otherwise accrue and the intervention itself must carry a reasonable prospect of success. This is essentially a test of reasonableness, which involves a careful assessment of motives for action and a balancing of interests. To achieve this balance, it may be necessary to take into account not only the patient's past views—when these are knowable—but also to consider what are likely to be his or her future views.

1.25 The principal subjects of medical paternalism are likely to be children, the psychiatrically ill, and the unconscious.[33] The medical treatment of children who are too young to make up their own minds provides a common and clear case of justified medical paternalism. Indeed, at times, the medical professional is called upon to protect the interests of a child against the wishes of his or her parents as to the appropriateness, or otherwise, of medical treatment.[34] Notwithstanding, the paternalist must take into account in this context the fact that capacity increases with growing maturity; caution must, therefore, be exercised in acting paternalistically towards teenagers. Paternalism in relation to the psychiatrically ill may be justified on the grounds that there is a mental disability which incapacitates the patient to the extent that he or she cannot understand that treatment may be required; it is, then, reasonable to assume that the patient will endorse what has been done once recovery has occurred. This latter justification—the appeal to subsequent approbation—may also be invoked in the treatment of the unconscious. The anticipated agreement may well be forthcoming in the majority of cases, but the treatment of those who are unconscious after an attempt at suicide may be more difficult to justify. The doctor who treats such a person is clearly acting paternalistically and might argue either that the attempt at suicide could have resulted from a mental illness (and could, therefore, be treatable without consent), or that the patient will later endorse the treatment. But what about the case where the patient

biomedical ethics' (1999) 25 J Med Ethics 315. Generally, see S Bok, *Lying: Moral Choice in Public and Private Life* (1999).

[31] J Lilleyman, 'From the President' (2001) Bull R Coll Path No 114, p 2.

[32] For a detailed account of paternalism in all its forms, see E Buchanan and D W Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (1990).

[33] For a suggestion of its unwarranted extension to pregnant women see C Gavaghan, '"You can't handle the truth": Medical paternalism and prenatal alcohol abuse' (2009) 35 J Med Ethics 300.

[34] Consider, for example, the treatment of children of Jehovah's Witnesses.

has made it clear in advance that suicide is what he or she wants and is the result of rational consideration?[35] In practice, such patients are often treated, although it is difficult to fit that into the category of justified paternalism.

1.26 As in all areas of medical practice, room must remain for clinical discretion to be exercised by the doctor. There will be cases where minor acts of paternalism aimed at preventing distress to those who are anxious will be an ethically justifiable thing to do. The law might be expected to recognise this at the same time that it recognises and protects the right of individual autonomy. In short, paternalism and autonomy are not mutually exclusive: the task of medical ethics and of medical law is to balance the two in a way which enhances individual dignity and autonomy but which does not inhibit the exercise of discretion in the marginal case. The task for the health care professional is to apprise him or herself of the full armoury of ethical tools for appropriate decision making with respect to the interests and needs of the immediate patient.

INTUITIONS, EXPERIENCE AND MORALITY

1.27 There are grounds, then, for doubting the practicality or effectiveness of applying a broad deontological brush to medical ethics. Each case is unique, and its individual features may change with each consultation. In supporting this approach, some moral philosophers have stressed the importance of imagination as a means of navigating our way through the moral landscape.[36] This moral imagination may, to an extent, rely on metaphors rather than on rules—which, in turn, points to a role, even if a circumscribed one, for moral intuitions. Intuition may have a limited appeal as a basis for moral philosophy but it should not be wholly discounted and this, for the reasons already given, is especially so in the field of health care.[37] Intuitions may point in the direction of a value which may not always be articulated formally but which may nonetheless be very important.

1.28 Our own view is that medical ethics are perhaps not best served by a rigid attachment to an undiluted vision of patient autonomy—but neither were they well served by the paternalistic philosophy of the past. What is required is an openness to the complexity of moral decisions, and an awareness of the sensitive contexts in which such decisions must be taken. Different contexts might require different ethical approaches; compare, for example, the doctor/patient relationship with concerns about public health. An understanding of the tensions is not necessarily something that philosophers can teach or lawyers prescribe. The insights of cognitive science, and of psychology in general, increasingly recommend a model of moral reasoning which gives a large role to learned moral responses. These moral abilities—if one may call them that—are acquired through education within a particular ethos and through hands-on experience in dealing with people and their suffering. There is all the difference in the world between, say, the experienced nurse who has spent years working in a hospice setting and the lay person who approaches the issue of end-of-life decisions from an entirely theoretical perspective. A moral response which discounts the validity of the insights of the former would be unlikely to be helpful. Those involved in caring for patients are moral beings who must be encouraged to develop and express their

[35] We will see later that there is also a hazard that the patient's life may be reprieved but only in a disabled state.

[36] See M Johnson, *Moral Imagination: Implications of Cognitive Science for Ethics* (1993); L May, M Friedman and A Clark (eds), *Mind and Morals: Essays on Ethics and Cognitive Science* (1996).

[37] For expression of this view, see T B Brewin, 'How much ethics is needed to make a good doctor?' (1993) 341 Lancet 161.

sense of the moral demands of a particular situation. There is not necessarily one right answer to the dilemmas which they encounter, and this should perhaps be recognised more extensively than it is today. There may be two, or even more, right answers depending on the people involved and the circumstances. In the end, it is as much the virtues of the decision maker, as someone who displays qualities such as wisdom, compassion, truth-telling, fairness, and justice, as the existence of philosophical theory that creates the appropriate environment in which ethical decision making should take place.[38]

1.29 The way in which we make sense of an ethical or legal problem is often the first step to its resolution. Consider this advice from the Nuffield Council on Bioethics:

> There is no set method for addressing an ethical issue. However, there are some generally accepted guidelines which can be applied to an issue. As a starting point for any discussion, it is essential that information is accurate and from an objective and reliable source. It is also important to be able to distinguish between facts and opinions. Clarity of terms and expressions is crucial…
>
> An important part of any ethical inquiry is to examine the implications of holding a particular view. Drawing up a list of the arguments on both sides, both for and against an idea, can help to focus discussion. A further step is to analyse the basis for these arguments. The conclusions of an argument must be defensible, so it is important to look for gaps, inadequacies, fallacies or unexpected outcomes. Having assessed the validity and persuasiveness of all the arguments, a decision may be reached or it may be apparent that more information is needed.[39]

1.30 From this, and what has been said previously, we can offer the following toolkit:

Your checklist to difficult decision making:

(1) **Get the facts straight**: separate the relevant from the irrelevant and facts from opinions
(2) **Identify your approach to the problem**: schools of thought come in handy here
(3) **Identify the pros & cons of your approach**
(4) **Consider the counter-arguments and the possible challenges to your position**
(5) **What conclusions do you reach: are these defensible?**

The crucial point is that the particular 'answer' that is eventually pursued can be justified within a recognised and accepted ethical and moral framework. A moral straitjacket is hardly helpful. Having said which, we should perhaps go on to examine the practical environment in which health carers set about their work.

THE ORGANISATION OF MODERN MEDICINE

1.31 Probably the single most important feature which distinguishes the 'modern' in modern medicine is the importance attached to experimentation and research,[40] and it was this change in emphasis which dictated most urgently that medical practice should be subject to central control.

[38] R Crisp and M Slote (eds), *Virtue Ethics* (1997) is a good introduction.
[39] See the Nuffield Council on Bioethics at http://www.nuffieldbioethics.org/ under Further Information.
[40] For a monograph which eloquently analyses this, see R Tallis, *Hippocratic Oaths: Medicine and its Discontents* (2004).

1.32 The age of medical research can be said to have begun with the Renaissance and, since that time, the practice of medicine has become increasingly scientifically based. New dimensions are, thus, introduced and new dilemmas posed. It is obvious that scientific medicine cannot improve without extensive research while, on the other hand, that process tends to turn medical practice into a series of problem-solving exercises—a diversion which, even now, stimulates, at the same time, some of medicine's severest critics and its admirers.

1.33 Perhaps the first practical effect of the scientific approach was to convince doctors that they have an expertise worth preserving and, as early as the sixteenth century, we find the establishment of the Royal College of Physicians of London, together with a general tightening of the rules governing the practice of surgery. The early Royal Colleges had considerable powers of examination and registration. The latter function has now gone and the major purpose of the colleges—which now represent some ten specialities with additional faculties—is to demonstrate a continuing standard of excellence among doctors seeking to obtain a Certificate of Completion of Specialist Training (CCST). (See para 1.58.)

1.34 As organisation proceeded, fortune began increasingly to depend upon fame, and fame, in its turn, upon academic superiority over one's colleagues; from all accounts, British medicine in the eighteenth and early nineteenth centuries was not the happiest of professions. Even so, it was not so much medical ethics, as they are understood today, that were found wanting but, rather, medical etiquette or intra-professional relationships. Something had to be done to ensure the status of the profession and this need was first met by the formation of the British Medical Association (BMA) in 1832. Insofar as the BMA is, today, a non-affiliated registered trade union,[41] its primary function has traditionally been the protection of doctors' interests. Clearly, such an interested party could not satisfy the public need for control of a profession with such power and it was largely due to the lobby of the BMA itself that the General Medical Council (GMC) was established by the Medical Act 1858. The current statutory regulation of the medical profession is found in the Medical Act 1983 which has, in turn, been substantially amended.[42]

1.35 We make no attempt here to overview the administrative law concerning medical practice in detail.[43] What follows is no more than a précis of what we consider to be the main aspects which fall under the rubric of 'law and medical ethics'. With this in mind, it is appropriate to begin with an overview of the GMC, which is the basic regulatory authority of the medical profession.[44]

THE GENERAL MEDICAL COUNCIL

1.36 The GMC at present consists of a governing body (the Council) and three Boards (the Undergraduate, the Postgraduate, and the Continued Practice, Revalidation and Registration Boards), the function of which is to advise the Council as to matters affecting

[41] Trade Union and Labour Relations (Consolidation) Act 1992. The distinction between a trade organisation and a regulatory body such as the GMC was emphasised in *General Medical Council* v *Cox* (2002) *The Times*, 16 April, in which it was held that the GMC was not a trade organisation for the purposes of the Disability Discrimination Act 1995, s 13.

[42] Medical Act 1983 (Amendment) Order 2002 (SI 2002/3135) and Health and Social Care Act 2008.

[43] For that, the reader is referred to the seminal work by J Montgomery, *Health Care Law* (4th edn, 2009).

[44] We appreciate that it could be more appropriate to speak in terms of 'health care ethics' but that would be to extend the scope of this chapter to unreasonable length. The reader should understand that we are concentrating on the medical profession as being typical of the health care professions as a whole. The others have their own Councils but, by and large, their governance is similar to that of the GMC.

the profession at its relevant career stages. The Council consists of 24 members of which 12 are registrant (i.e. registered medical practitioners) and 12 are lay members.[45] All members are appointed by the Appointments Commission.[46] The Chair is elected by the members. The Council is responsible for the strategic management of the delivery of its statutory functions but its practical work is accomplished by statutory committees of which, currently, there are seven.[47] The power to co-opt committee members is a prominent feature of the regulations. Some or all of the members of Committees may be persons who are not members of the Council[48]—which suggests that there will be increasing lay-person control at all levels. There are, of course, a large number of persons working with or on behalf of the Council and its Committees who are recruited through open selection or appointment.

1.37 The functions and the day-to-day operations of the GMC have been subject to criticism, and adjustment, almost since its inception and there is no doubt that the number of high profile, individual instances of alleged misconduct that were exposed at the end of the twentieth century caused sufficient public disquiet to provide solid grounds for extensive review—and revision—of the existing system for control of the medical profession.[49] Given that the preservation of the National Health Service (NHS) is now a major topic in the mind of the electorate, it is unsurprising that the ruling political parties have exerted relentless pressure on the profession's leaders to bend to the prevailing mood. The consequence has been that, while the GMC remains the governing body of the medical profession,[50] its overriding public function is, now, to protect, promote and maintain the health and safety of the public;[51] ensuring proper standards for medical practitioners is simply one of four main ways of achieving that goal. There is no doubt that many of the

[45] General Medical Council (Constitution) Order 2008 (S I 2008/2554).

[46] Shortly to be by way of recommendation to the Privy Council by the Professional Standards Authority for Health and Social Care (see n 69).

[47] Medical Act 1983, s 5 as amended by Health and Social Care Act 2008, sch 7. This essentially leaves the Council with three major specific functions additional to its generally fostering good medical practice—to investigate allegations of impaired fitness to practise, to supervise medical education and to maintain the medical register.

[48] Medical Act 1983, Sch 1, r 25(1A) inserted by 2002 Order, art 5(1)(b).

[49] Aside from regular reports of individual errors, a number of major incidents were disclosed which resulted in public investigations. Among these are included the standards of paediatric cardiac surgery at Bristol: *Report of the Public Inquiry into Children's Heart Surgery at Bristol Royal Infirmary 1984—1995* (Cm 5207, 2001); the retention of organs at Alder Hey Hospital: *The Royal Liverpool Children's Inquiry Report* (HC 12, 2001; the retention of organs in Scotland: *Final Report of the Independent Review Group on Retention of Organs at Post-mortem* (Scottish Exec, 2001). The GMC, despite its urgent restyling, itself came under savage attack in what was, essentially, an investigation into a mass murder: Dame Janet Smith, *The Shipman Inquiry 5th Report*, *Safeguarding Patients: Lessons from the Past—Proposals for the Future* (2004) (Cm 6394).

[50] It is to be noted that the conduct of the GMC is open to judicial review both as to its 'advice' *(Colman* v *General Medical Council* [1989] 1 Med LR 23, QBD; sub nom *R* v *General Medical Council, ex p Colman* (1989) 4 BMLR 33, CA) and as to the actions of its Committees: *R (on the application of Mahfouz)* v *Professional Conduct Committee of the General Medical Council* [2004] Lloyd's Rep Med 377, (2004) 80 BMLR 113. These, whether under the old or revised procedures, are now also subject to scrutiny under the Human Rights Act 1998. Access to judicial review is still available if referral to the CHRE (see para 1.42) is impractical: *R (on the application of Campbell)* v *General Medical Council* [2005] 1 WLR 3488; (2005) 83 BMLR 30. While exercising a judicial power, the GMC is not part of the judicial system of the state: *General Medical Council* v *BBC* [1998] 3 All ER 426; (1998) 43 BMLR 143. The increasing status now being afforded to truly 'alternative medicine' is to be noted. A practitioner of any form of alternative medicine will be judged by the standards of that particular art but must recognise that he or she is practising alongside orthodox medicine: *Shakoor* v *Situ* [2000] 4 All ER 181; (2001) 57 BMLR 178.

[51] Medical Act 1983, s 1(1A) inserted by Medical Act (Amendment) Order 2002 (S I 2002/3135), art 3.

changes that have been effected are essential to the delivery of high quality health care; the concomitant result, however, has been to increase political control at the expense of the profession's self-regulatory powers.[52]

The Investigative Function

1.38 We start with the investigative—or 'disciplinary'—function of the GMC because, based on the now discarded concept of 'serious professional misconduct', this has, perhaps, always been its activity which has occasioned the most interest. It is also an area where a major sea change in attitude has occurred[53]—misconduct is now regarded as but one possible cause of unfitness to practise.[54] The change of emphasis is exemplified by the relevant title in the Medical Act 1983 being altered from 'Professional Conduct and Fitness to Practise' to 'Fitness to Practise and Medical Ethics'. However, even taking into consideration the changes in structure and function of the GMC introduced by the 2002 Order, the committee system as it presently stands, which includes an interim orders panel,[55] an Investigation Committee, and a Fitness to Practise Panel, results in the Council being both investigator and adjudicator—and this has been a source of concern ever since the publication of the Shipman Inquiry.[56]

1.39 The original response was to dissociate the investigation of a case from its adjudication which it was proposed should be taken over by the Office of the Health Professions Adjudicator (OHPA).[57] Considerable opposition to the inevitable transfer of power —and to the supposed imposition of 'double jeopardy' on medical practitioners —fitted in well with a new government's intention to reduce the number of quasi-autonomous authorities and the plans were abandoned in December 2010. More recently, the GMC itself proposed the formation of a Medical Practitioners Tribunal Service[58] which was launched in June 2012. The service is headed by a judge and will be responsible for the improved training and function of Fitness to Practise Panels (see 1.40); it is part of, but operates independently of, the GMC.[59] No results of the initiative are available at the time of writing.

[52] See a critical leading article in the BMJ: D P Gray, 'Deprofessionalising doctors?' (2002) 324 BMJ 627. It is fair to say, however, that some of the more draconian proposals have been modified or abandoned in the last decade.

[53] Predominantly by way of a combination of the Amendment Order 2002 (n 52) and the Health and Social Care Act 2008. Note that any modification of the Medical Act by way of an Order in Council is empowered by the Health Act 1999, s 60.

[54] A doctor's fitness to practise can be questioned on the grounds of misconduct, deficient professional performance, a conviction for, or caution following, a criminal offence, his or her mental or physical health and, finally, a determination by any body responsible for the regulation of the health or social care professions in the United Kingdom that his or her fitness to practise is impaired: Medical Act 1983, s 35C(2).

[55] The function of which is not to investigate complaints against doctors but, rather, to take action for the protection of the public in advance of the complaint being proved. The effect of a suspension order, which can be imposed for 18 months and is renewable with the agreement of the High Court, can be devastating and the potential power of the interim order panel is, in our view, little short of horrifying. Its authority lies in the Medical Act 1983, s 41A. See the wide-ranging article: P Case, 'Putting public confidence first: Doctors, precautionary suspension, and the General Medical Council' (2011) 19 Med L Rev 339. Note, however, that the summary case will already have navigated the internal investigation: Department of Health, *Directions on Disciplinary Procedures* (2005) for which see para 1.47.

[56] N 49. See, for example, Department of Health, *Trust, Assurance ad Safety – the Regulation of Health Professionals in the 21st Century* (2007).

[57] Health and Social Care Act 2008, s 98. Plans to repeal the legislation are to be found in the Health and Social Care Act 2012, s 231.

[58] General Medical Council, *Reform of the fitness to practise procedures at the GMC: A paper for consultation* (2011).

[59] C Dyer, 'GMC launches new tribunal service to decide fitness to practise of UK doctors' (2012) 344 BMJ 3.

1.40 As things stand, the doctor whose fitness to practise is investigated may be discharged, issued with a warning, allowed to continue practising subject to agreed undertakings or referred to a public hearing by a Fitness to Practise Panel (FPP). Should the FPP find that his or her fitness is impaired, he or she may be subject to erasure from the register (except in a 'health case'),[60] to suspension for up to 12 months,[61] to conditional registration in accordance with the Panel's directions for up to three years or, in the case of misconduct, criminal conviction or of a determination by another body, to reprimand. Any of these restrictions can be imposed when an original suspension order is reviewed and, in the case of indefinite suspension, the doctor may request a review not more often than every two years. The standard of proof required before the panel is now the civil standard.[62] An appeal against a decision of the FP P is now available to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland.[63] Finally, it is to be noted that the name of a doctor that has been erased can be restored to the Register but not within five years of erasure;[64] subsequently, applications for restoration can be made yearly.

1.41 The effect of the transfer of the appellate function of the Privy Council to the High Court and its equivalents in Scotland and Northern Ireland has been instructive. Traditionally, the Council had been reluctant to alter the view of the facts taken by the, previously, disciplinary committee. The advent of the Human Rights Act 1998 has, however, tilted the balance—indeed, it was only the availability of an appeal to an independent tribunal that saved the disciplinary function of the health care professions Councils from being judged as incompatible with the 1998 Act.[65] As a result, there has been something of a steady flow of cases in which the findings of the committees of the GMC have been modified on appeal[66] and there is some evidence that the courts are anxious to rein in the punitive role

[60] As result, a case cannot be dealt with on health grounds if erasure is a real possibility: *Crabbie* v *General Medical Council* (2002) 71 BMLR 9, PC.

[61] Suspension in a 'health case' can only become indefinite if the original suspension has been in force for at least two years (s 35D(6) inserted by 2002 Order). For limitations of application, see *Raji* v *General Medical Council* [2003] 1 WLR 1052; [2003] Lloyd's Rep Med 280.

[62] Health Care Act 1999, s 60A inserted by Health and Social Care Act 2008, s 112.

[63] National Health Service Reform and Health Care Professions Act 2002, s 29. Previously, appeal was to the Privy Council. Judgments on appeal from decisions related to health and performance are no longer limited to points of law (a limitation that the Privy Council found frustrating: *Hall* v *General Medical Council* [2001] UKPC 46; (2001) 65 BMLR 53).

[64] Ironically, this may lead the court to a more lenient conclusion—see *Giele* v *GMC*, n 66.

[65] *Preiss* v *General Dental Council* [2001] 1 WLR 1926; [2001] Lloyd's Rep Med 491. For a similar Scottish decision, see *Tehrani* v *United Kingdom Central Council for Nursing, Midwifery and Health Visiting* 2001 SC 581; 2001 SLT 879.

[66] *Krippendorf* v *General Medical Council* [2001] 1 WLR 1054; (2001) 59 BMLR 81 (wrong assessment tests—Professional Performance); *Bijl* v *General Medical Council* (2001) 65 BMLR 10 (unnecessarily draconian penalty—PCC); *Manzur* v *General Medical Council* (2001) 64 BMLR 68 (disproportionate penalty for fraud—PCC); *Srirangalingham* v *General Medical Council* (2002) 65 BMLR 65; [2002] Lloyd's Rep Med 77 (inappropriate suspension—PCC); *Hossain* v *General Medical Council* (2001) 65 BMLR 1; [2002] Lloyd's Rep Med 64 (unreasonable erasure—PCC); *Giele* v *General Medical Council* (2005) 87 BMLR 34 (suspension sufficient to ensure public confidence in the profession). Other reported cases in which the GMC's findings were quashed include: *Silver* v *GMC* [2003] Lloyd's Rep Med 333; *Misra* v *GMC* (2003) 72 BMLR 108; *Raji* v *GMC*, n 61; *Southall* v *GMC* [2010] 2 FLR 1550; (2010) 113 BMLR 178 (insufficient evidence) and, most recently, *Walker-Smith* v *GMC* (2012) 126 BMLR 1 (unfair trial). On the other hand, the Privy Council has decreed that the reputation of the whole profession can, at times, take precedence over the interests of an individual member: *Gosai* v *General Medical Council* (2004) 75 BMLR 52. See also *Sadler* v *GMC* [2003] 1 WLR 2259; [2004] Lloyd's Rep Med 44 (seriously deficient performance confirmed).

recently adopted by Fitness to Practise Panels.[67] In *Giele* v *GMC,*[68] Collins J put it: 'the panel had to approach the question of sanctions starting with the least severe'.

1.42 The future management of the doctor suspected of being unfit to practise must, however, remain uncertain as several relatively recently formed organisations are still establishing their role vis-à-vis that of the GMC. In particular, the increasing influence of the Council for Healthcare Regulatory Excellence (CHRE)[69] must now be fed into the equation. The main function of the CHRE is to promote the interests of patients and other members of the public by way of overseeing the performance of the individual professional 'regulatory bodies'.[70] A regulatory body must comply with any directions given by the new Council,[71] which has the power to investigate complaints as to the regulatory bodies' exercise of their functions. The Council has, however, a major proactive role in that it scrutinises the disciplinary decisions of the regulators, considers them, if necessary, in a Council case meeting and, finally, may appeal some decisions to the High Court if it is considered that their leniency was incompatible with adequate protection of the public or that they should not have been made.[72] It seems that regulatory processes have improved as, while the number of fitness to practise cases investigated increases each year,[73] the number of cases referred to the High Court is now only some four per annum. The GMC has expressed itself as being satisfied with this arrangement.[74] It is notable that the High Court hears appeals from either side—which means that the same standards should apply irrespective of the origins of dispute.[75]

1.43 It would be unfortunate if the current emphasis on performance should lead to neglect of one of the health care regulators' original concerns—that is to maintain the behaviour standards of honourable professions. It seems, however, that, while the protection of the public has now been repeatedly adjudged as the paramount determinant of the severity

[67] E.g. *Meadow* v *General Medical Council* (2006) 92 BMLR 51, CA; *Raschid* v *General Medical Council* [2007] 1 WLR 1460; *Azzam* v *General Medical Council* (2009) 105 BMLR 142. See also, C Dyer, 'David Southall: Anatomy of a wrecked career' (2012) 344 BMJ e3377.

[68] N 6 at [26].

[69] Originally established as the Council for the Regulation of Health Care Professionals but renamed very shortly after by way of National Health Service Reform and Health Care Professions Act 2002, s 25 and Health and Social Care Act 2008, s 13. The Council is likely to be renamed the Professional Standards Authority for Health and Social Care (Health and Social Care Act 2012, s 222). For proposals for the future, see Department of Health, *Enabling Excellence: Autonomy and accountability for healthcare workers and social care workers* (2011).

[70] Currently, the CHRE oversees the General Medical, Dental, Optical, Osteopathic, Chiropractic and Pharmaceutical Councils, the Nursing and Midwifery Council, the Health Professions Council and the Pharmaceutical Society of Northern Ireland.

[71] Although changes to the rules of the regulatory bodies can only be made with the agreement of both Houses of Parliament.

[72] National Health Service Reform and Healthcare Professions Act 2002, s 29. See, for example, *Council for Healthcare Regulatory Excellence* v *Nursing and Midwifery Council* (2011) 120 BMLR 94.

[73] 764 cases were considered in 2005/6 rising to 2192 in 2010/11: Council for Healthcare Regulatory Excellence *Annual Report and Accounts 2010* (June 2011). Council members were involved in eight cases in 2010/11. Three were referred to the High Court and all involved the NMC.

[74] We do, however, wonder if it is fair for the Chief Medical Officer to interpret the GMC's welcome to the original CRHP as an expression of uncertainty as to its own role: Report of the Chief Medical Officer, *Good Doctors, Safer Patients* (2006), ch 10, para 11.

[75] A somewhat fortuitous example is to be found in the very controversial saga of Dr Southall: *Council for the Regulation of Health Care Professionals* v *General Medical Council* (2008) 84 BMLR 7; [2008] Lloyd's Rep Med 365 (GMC's conditions for practice modified); *Southall* v *General Medical Council* [2009] 2 FLR 1246; (2009) 109 BMLR 27 (erasure by GMC upheld); (2010 113 BMLR 178, CA (appeal allowed for want of adequate reasons).

of sanction for reprehensible behaviour, the reputation of the health care professions is not to be ignored. The need for or the proportionality of the sanction should, however, be subject to careful consideration.[76] There may, yet, be a good case for uniform assessment of appropriate sanctions across the various Councils. *Brennan* (see n 77) is a remarkable case involving blatant cheating at a game of rugby. The name of the physiotherapist involved was removed from the register of the Health Professions Council (HPC); the team doctor, who deliberately injured a player in order to compound the deception, was warned by the GMC; this discrepancy was noted in the High Court and strongly influenced the trial judge as a reason for recommending review of the HPC's decision. Three very relevant cases that have been referred to the High Court—concerning sexual relationships with patients[77] and a paediatric nurse's interest in pornography[78]—eventually came together in the Court of Appeal[79] where, basically, the Court confirmed that any rights to self-regulation by the medical profession must give way to the paramount concern—that is, the protection of the public.[80]

1.44 In addition, the Court addressed the vexed question of double jeopardy for the healthcare professions which is inherent in a two-stage system of control, and it is clear that the law now accepts this as an acceptable reality.[81] Lord Phillips quoted Collins J in *Truscott*:

> There is an element of double jeopardy of which account must be taken. It is of less importance in the context of s 29 of the 2002 Act because the emphasis is on the protection of the public rather than of the individual concerned (n 78, at para 29).

and went on to say:

> Considerations of double jeopardy must take second place when a case has been referred as necessary for the protection of the public.[82]

All of which may well be good public policy—but which, nevertheless, gives rise to some doubts as to the accused doctor's position in respect of Article 6 of the European Convention on Human Rights.[83]

1.45 The introduction of Part 2 of the National Health Service Reform and Health Care Professions Act 2002 was described as 'facing the medical profession with its greatest assault in 150 years',[84] a statement which may carry a ring of hyperbole. Nevertheless,

[76] See Ouseley J in *Brennan* v *Health Professions Council* (2011) 119 BMLR 1 at [62].

[77] *Council for the Regulation of Health Care Professionals* v *General Medical Council and Ruscillo* [2004] 1 WLR 2068; [2004] Lloyd's Rep Med 365; same *and Solanke* [2004] 1 WLR 2432; [2004] Lloyd's Rep Med 377; same *and Leeper* (unreported).

[78] *Council for the Regulation of Health Care Professionals* v *Nursing and Midwifery Council and Truscott* [2004] EWHC 585; (2004) *The Times*, 8 April.

[79] *Ruscillo* v *Council for the Regulation of Health Care Professionals and the General Medical Council, CRHP* v *Nursing and Midwifery Council and Truscott* [2005] 1 WLR 717; [2005] Lloyd's Rep Med 65.

[80] A Samanta and J Samanta, 'Referring GMC Decisions to the High Court' (2005) 330 BMJ 103.

[81] And one that is likely to persist should the GMC's proposal for the formation of a Medical Practitioners Tribunal Service be adopted (para 1.39). See H Jaques, 'Proposal for a fitness to practice tribunal risks double jeopardy for doctors' at http://careers.bmj.com/careers/advice/view-article.html?id=20003544, 28 June 2011. In view of the fact that both the GMC and the CHRE can appeal a Tribunal's decision, this might legitimately be regarded as treble jeopardy.

[82] N 79 at para 42.

[83] Though this would be unlikely to be engaged as 'what is sometimes called the double jeopardy rule has no application as such a strict rule': per Newman J in *R (on the application of Phillips)* v *General Medical Council* (2005) 82 BMLR 135 at 137.

[84] Chairman of the Academy of Medical Royal Colleges quoted in (2002) BMA News, 16 March, p 1.

while the CHRE is characterised as an independent body, three of the seven non-executive councillors are appointed by the Secretary of State and three by devolved governments;[85] no one may be a Chair or non-executive member of the Council who has at any time been a professional controlled by one of the regulatory councils now supervised.[86] One would surely need rosy spectacles not to see this as raising the spectre of overt political control of the health care professions.

1.46 Supervisory regulation of the 'regulators' is increasingly moving to combine the administrative and clinical aspects of health care[87]. The most significant re-organisation in this respect is the Care Quality Commission[88] which is the independent regulator of all health and adult social care services in England. The Commission appears to have had a difficult time since its inception and its relationship with other regulatory authorities in this field—e.g. the CHRE—is uncertain at the time of writing. The former has a very wide remit—indeed, the fear is that it may be too wide (see Chapter 13) and is, thus, failing in its objectives.[89] It seems, therefore, that further discussion would be out of place in the immediate context of this chapter.

1.47 Beyond all the foregoing, it has to be remembered that deficiencies in practice or in personal relationships within the NHS are also subject to administrative regulation. Incompetence and personal misconduct by NHS practitioners are now investigated under the terms of HSC 2003/012.[90] The guidelines are imprecise but, essentially, the process is under the control of a local case manager who has several options available. The case may be dealt with at local level with or without the involvement of a complex system of committees. It may, however, be referred to a higher authority such as the GMC or the National Clinical Assessment Service (NCAS)[91] whose stated mission is to help resolve concerns about a practitioner's performance. At the time of writing, then, it must be said that the future of the disciplinary control of the medical, dental and pharmaceutical professions is put still further in doubt. The cooperative relationship between the GMC and the NCAS has been agreed between the two bodies in a memorandum of understanding. [92] This, however, is couched in the broadest of terms. Even so, although it is not directly stated as such, it is clear from the Department of Health's guidelines that the NCAS is the preferred first port of call in the event of an NHS doctor's competence being questioned.[93] It is dangerous to forecast in a rapidly changing administrative ambience. The impression is, however, that

[85] National Health Service Reform and Healthcare Professions Act 2002, sch 7, para 4 as amended by Health and Social Care Act 2008, s 114.

[86] Council for Healthcare Regulatory Excellence (Appointment Procedure etc) Regulations 2008 (SI 2008/2927).

[87] K Walshe, 'The Rise of Regulation in the NHS' (2002) 324 BMJ 967.

[88] Established under the Health and Social Care Act 2008, s 1. It incorporates the former Commission for Healthcare Audit and Inspection, the Mental Health Act Commission and the Commission for Social Care Inspection.

[89] National Audit Office, *Report by the Comptroller and Auditor General, Session 2010-2012*, HC 1665, 2 December 2011.

[90] As amplified by the Department of Health Annual Report, 15 February 2005: *Maintaining High Professional Standards in the NHS: Doctors' and Dentists' Disciplinary Framework*.

[91] The National Clinical Assessment Authority is now abolished (Special Health Authorities Abolition Order 2005, SI 2005/502) The resultant National Clinical Assessment Service is now part of the National Patient Safety Agency (reinvented under SI 2005\504). Over 1,700 doctors were referred to the NCAS in the years 2001–05: Report of the Chief Medical Officer, *Good Doctors, Safer Patients* (2006). For the contractual nature of review by the NCAS, see *Palmer* v *East and North Hertfordshire NHS Trust* [2006] Lloyd's Rep Med 472.

[92] Dated December 2005.

[93] 90% of NHS Trusts have used the NCAS at least once: Report of the CMO, n 91, ch 5, para 75.

protection of the public from poor health care delivery will be increasingly devolved to individual NHS Trusts; the workload of the regulatory bodies' investigative panels and of the proposed Adjudicator may, as a result, be correspondingly reduced.[94]

Public involvement in medical regulation

1.48 On the other side of the coin one must also note the regulatory arrangements that are specifically directed to public participation in health care delivery; this is but one dimension of a growing phenomenon of public engagement in the development of medico-legal policies, about which we say more presently. The most important example in the regulatory sphere appeared to be the Commission for Patient and Public Involvement in Health but this was disbanded within six months of its inception.[95] Similarly Patients' Forums, which were established for each NHS Trust or Primary Care Trust[96] in England under s 15 of the same Act, have also been disbanded[97] and replaced by Local Involvement Networks (LINks).[98] In any event, Health Authorities, Primary Care Trusts and NHS Trusts are under a general duty to involve and to consult with the public on any aspect of the services they provide while, at the same time, the Secretary of State must now make arrangements for the provision of an independent Advocacy Service which will assist the public in making complaints under procedures operated by a health service body.[99]

The Educational Function

1.49 Medical education has not been neglected in the rush to revise the function of the GMC. Undergraduate education and examination and the supervision of those undertaking their year of provisional registration have been, and remain, within the ambit of the Education Committee. By contrast, however, there has been unremitting tampering with postgraduate education which, following the massive reorganisations of the early twenty-first century, was placed under the control of the Specialist Training Authority of the Royal Medical Colleges.[100] This, in turn, was replaced by a new Postgraduate Medical Education and Training Board in 2003,[101] but the life of this organisation was short by any standards as it was disbanded in 2010. [102] Responsibility for both postgraduate and undergraduate medical training is now the prerogative of the GMC. The effect on individual qualifications such

[94] A long-awaited review of the future of the NHS has recently been made public: Lord Darzi (leader), *High Quality Care for All* (2008, Department of Health, CM 7432). This, however, consists, in the main, of aspirations based on the premise that, in general, 'higher quality care works out better for patients and the taxpayer' (at p 31). It has surprisingly little significance in the present context.

[95] Local Government and Public Involvement in Health Act 2007, s 232.

[96] Primary Care Trusts were established by the Health Act 1999, s 2 and have continued in existence by way of National Health Service Act 2006, s 10.

[97] N 95, s 231. [98] N 92, s 221.

[99] Health and Social Care Act 2001, ss 11 and 12. Community Health Councils are now abolished (2002 Act, s 22) by reason of increased powers of scrutiny of the health services that is given to local authorities in the Health and Social Care Act 2001, ss 7–10.

[100] Postgraduate training for general practitioners is similarly controlled by the Joint Committee on Postgraduate Training for General Practice: General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 (SI 2003/1250, art 3).

[101] General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 (SI 2003/1250).

[102] General and Specialist Medical Practice (Education, Training and Qualifications) Order 2010 (SI 2010/234, art 3). This followed one of 47 recommendations made in *Aspiring to Excellence. Final Report of the Independent Inquiry into Modernising Medical Careers* (J Tooke, Chairman), January 2008.

as Membership or Fellowship of the Colleges is a matter for continuing negotiation.[103] What is clear, at least in a negative sense, is that Fellowship of a Royal College no longer provides a ticket to registration of specialist status (see para 1.59).

Maintaining the Medical Register

1.50 Maintaining the official register of medical practitioners remains a basic function of the GMC. The purpose of the register has traditionally been to protect the public from those who have not undergone recognised training; unlike the practise of dentistry, no specific offence lies in an unqualified person practising medicine in the United Kingdom—the offence has always been that of pretending to be a registered medical practitioner[104] or of usurping functions which are statutorily limited to registered practitioners—such as prescribing 'prescription only' medicines. This, however, is arguably the function of the GMC that has undergone the greatest metamorphosis in the upheaval of the last few years and registration will now no longer provide an indefinite entitlement to practise medicine—in future; an additional licence to practise will be required.[105]

1.51 This is to be granted on first registration but, thereafter, is subject to revalidation, a procedure whereby the practitioner's continuing fitness to practise is evaluated—and it is anticipated that it will be required every five years. The process of revalidation is still under review even as this latest edition goes to press;[106] significantly, the proposed dual streaming by way of relicensing—with the intention to ensure that the doctor is still capable of 'good medical practice'—and recertification, thus demonstrating continuing proficiency in one's stated specialty—has been abandoned in the interests of clarity. The conditions for recertification are a matter for agreement between the GMC and the Royal Colleges (see para 1.59). One technical result of these changes is that, although it will be possible to remain registered but unlicensed,[107] one must now read 'registered practitioner with a licence to practise' wherever the words 'registered practitioner' arise in the context of an actively practising doctor.

1.52 The situation was, however, at least temporarily clarified in the important report of the Chief Medical Officer for England and Wales which detailed the government's tactical plans for on-going revalidation of medical practitioners.[108] There is space here only to summarise what we regard as the essential elements of the proposals:

- The process is seen, perhaps through rose-tinted lenses, as one of improving the quality of care rather than of weeding out the incompetent;
- There is to be a strong element of patient and carer participation in evaluation;

[103] The resulting almost chaotic situation was considered in N Hawkes, 'The royal colleges must up their game – or die' (2007) 334 BMJ 724.

[104] Medical Act 1983, s 49. It is now, similarly, an offence to falsely claim to hold a licence to practise (Medical Act 1983, s 49A inserted by the 2002 Order).

[105] Expectation is that licensing will be enforced as from Autumn 2009.

[106] For the current position, see General Medical Council, *Revalidation: Information for Doctors* (June 2009).

[107] E.g. for use when 'social status' is, thereby, indicated. Such a doctor could, for example, sign identifying passport photographs.

[108] L Donaldson (Chairman), *Medical Revalidation—Principles and Next Steps* (2008, Department of Health) at http://www.dh.gov.uk/publications. This working group was set up following the Government White Paper *Trust, Assurance and Safety—The Regulation of Health Professionals in the 21st Century* (2007, Department of Health, Cm 7013).

- Practitioners will be revalidated every five years but the process will be on-going by way of continuing obligatory annual, locally based appraisal; [109]
- The appraisal process and the recommendations to the GMC will be in the hands of local Responsible Officers.

While it would clearly be premature to attempt to praise or criticise this policy at its present stage of development, it would, at the same time, be idle to deny that there are still some doubts which need airing. Certainly, it seems to us, a form of revalidation of those practising what is a continually developing healing art is essential. On the other hand, it is notable that large numbers of commentators—and administrators—attribute the new proposals, at least in part, to the activities of the late Dr Shipman (see 1.38); it would be unfortunate, to say the least, if this attitude, which is, essentially, based on suspicion of the medical profession, were to persist—to be acceptable, revalidation must be seen, as the report itself points out, as primarily supportive rather than disciplinary. More important, perhaps, is the role of the patient and other health carers in the assessment process. No one would deny that doctor/patient relationships do and will continue to evolve in a changing world and that the needs and aspirations of the public must be recognised—but the question raised by the report is 'how strong' is a strong element of patient participation in evaluation? A doctor may be a brilliant diagnostician but, yet, not the most tactful person in practice. Given a conflict, how is the Responsible Officer (see 1.53) to balance his or her clinical acumen against his or her conversational charm? And the knowledge that the patient is due to be asked for a report on the practitioner is bound to have a profound effect on their relationship. [110] We can only hope that government policy can be so implemented that any change will be for the better.

1.53 The third area for concern lies in the role of the Responsible Officer and it is worth looking at the background to this. A major criticism of the GMC has been that it has always had very little power to institute disciplinary proceedings itself; effectively, the Council has been able to act only by way of information received—a little understood fact which has resulted in some, often unfair, criticism of its efficiency. Very often, the only likely informants will be fellow doctors—for example, in the important circumstances when treatment of doubtful validity is being provided. Most professional men and women—and, come to that, criminals—are, however, inherently unwilling to denounce their colleagues and this reticence was severely criticised in the Bristol inquiry.[111]

1.54 The government's remedy for this potential gap in the day–to-day monitoring of doctors' performance has been to legislate that every provider of health care will establish a Responsible Officer within their domain—responsible, that is, for evaluating the fitness to practise of medical practitioners having prescribed connections with that body.[112] It is difficult to understand how this office is to fit into the existing layers of surveillance of medical practitioners and the regulations[113] cannot, by their very nature, reflect the tensions that are likely to arise in what is likely to be a close personal relationship; the Act, however,

[109] Department of Health, *Appraisal* (last modified 6 September 2007).

[110] See N Edwards, M J Kornacki and J Silversin, 'Unhappy doctors: What Are the causes and what can be done?' (2002) 324 BMJ 835.

[111] N 49.

[112] Medical Act 1983, Part 5A, inserted by Health and Social Care Act 2008, s 119.

[113] Medical Profession (Responsible Officers) Regulations 2010 (SI 2010/ 2841). For more intimate guidance, see Department of Health, *The role of Responsible Officer; Closing the gap in Medical Regulation—Responsible Officer Guidance* (2010)—adherence to which is mandatory.

makes it clear that, subject to Parliamentary scrutiny, there is little or no limit to the extent of such regulations. Even so, the distinction between disparaging the skill of another doctor, which the GMC would regard adversely, and informing as to behaviour which raises a question of patients' well-being, which is rightly approved,[114] may be tenuous and it is the uncertainty of the dividing line that many would find disturbing. Responsible officers are likely to be drawn, in the main, from medical directors; it is possible, then, that the clinician's proficiency may be judged on his or her administrative rather than clinical record. Finally, the word 'responsible' raises a question mark—for whom and/or to whom is the office 'responsible'? Ideologically, he or she will be responsible for safeguarding the standards of the appointing authority; but this can most efficiently be done by ensuring the competence of the individual doctors in the authority's employ and the whole tenor of the guidance, combined with the intention that responsible medical officers should play a major role in the periodic revalidation of their charges, emphasises the importance attached to proactive assessment of the individual doctor's professional skills. If one person is 'responsible' for the protection of a health care provider, is it not likely that he or she will be concerned to estimate inadequacies of its staff with particular harshness? Overall, it is encouraging to note that, in making regulations as to the duties of the Responsible Officer, the appropriate Minister must have regard to the importance of avoiding unfair prejudice to health care workers against whom unsubstantiated allegations are made.[115]

1.55 It is easy to visualise the Responsible Medical Officer as Big Brother writ large. Nonetheless, those filling the posts will be specifically selected and trained for the position. It is, therefore, equally fair to regard the system as being preferable to the current catch-as-catch-can arrangement whereby any involved person, from consultant to student, can report a doctor and, thereby, initiate an inquiry and all that that entails.[116]

1.56 In practice, a large proportion of reports of dubious behaviour on the part of doctors stems from outraged nursing staff.[117] Many such protests are based on grounds of conscience, these being related especially to life or death decisions, and the probability is that the great majority are motivated by the genuine belief that they are protecting the public against undisclosed violations of the moral, professional and criminal codes. An employee who discloses in good faith, inter alia, that the health or safety of an individual has been, is being or is likely to be endangered is now protected from recrimination by the Employment Rights Act 1996, ss 43A—M[118]—protection of the individual is, of necessity, subject to a

[114] General Medical Council, *Good Medical Practice* (2006) para 43.

[115] Health and Social Care Act 2008, s 121(5). Moreover, it is anticipated that Responsible Officers will rarely take important decisions absent appropriate advice: *Responsible Officer Guidance*, n 113, para 4.11. See, also, Department of Health, *Maintaining High Professional Standards in the Modern NHS* (2005).

[116] The GMC has recently published *Raising and Acting on Concerns about Patient Safety* (2012). Despite its obvious sincerity, clearly good intentions and multiple caveats, we have to admit that it does little to assuage the misgivings as to potential malpractice that are apparent in the text. See also *GMC Leadership and Management for All Doctors* (2012). It is to be noted that any correspondence related to the doctor's fitness to practice attracts absolute privilege: *White* v *Southampton University Hospitals Trust* (2011) 120 BMLR 81.

[117] A survey of community nurses indicated that only some 61% would certainly have reported a general practitioner whose performance was thought to put patients at risk: J Burrows, 'Telling tales and saving lives: Whistleblowing—the role of professional colleagues in protecting patients from dangerous doctors' (2001) 9 Med L Rev 110. Interestingly, as many would have been more likely to report fellow nurses than report doctors. Very clear guidance is provided in the Nursing and Midwifery Council *Code of Professional Conduct* (2002), section 8 (http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/).

[118] Inserted by Public Interest Disclosure Act 1998, s 1, and amended by the Health and Social Care (Community Health and Standards) Act 2003, sch 11, para 65 and sch 14, part 4, National Health Service (Consequential Provisions) Act 2006, sch 1, para 178, and Primary Medical Services (Scotland) Act 2004 (Consequential Modifications) Order SI 2004/957, sch, para 8(a) and (b).

number of qualifying conditions which include following a prescribed procedure. Clearly, the practice of what is popularly known as 'whistleblowing' is open to abuse or misconception; nevertheless, the great majority would now approve the spirit of the regulations. Not only is frankness in the investigation of both ethical and clinical error to the advantage of the patient,[119] but it is also important that the spectre of 'closed ranks' does not undermine the public's faith in the health care professions. At the same time, the ill-effects of a potential rebound towards defensive practice cannot, or should not, be ignored.

PUBLIC RELATIONS

1.57 The importance of the overall relationship between the medical profession and the public cannot be overstated. The established primacy of the cult of patient autonomy and patient choice has carried with it a parallel claim to a right to personal assessment of one's doctor's expertise and quality—aided by a large number of 'league tables' and mortality records. This has added a new dimension to the GMC's traditional attitudes to advertising by the medical profession. There is little doubt that the original restrictions were based on a fear of competitive doctors 'touting' for patients; the advent of the NHS virtually eliminated any need for them and the antipathy of the GMC was steadily relaxed.

1.58 Resolution of the position was, however, catalysed by the reference of the GMC's ban to the Monopolies and Mergers Commission, who held that the rule forbidding advertising in the press by general practitioners was against the public interest[120] and the GMC's advice currently reads:

> If you publish or broadcast information about services you provide, the information must be factual and verifiable … You must not make unjustifiable claims about the quality or outcomes of your services in any information you provide to patients. It must not offer guarantees of cures, nor exploit patients' vulnerability or lack of medical knowledge. You must not put pressure on people to use a service, for example by arousing ill-founded fears for their future health.[121]

1.59 The GMC's general opposition to elitism on the part of 'specialists' has been overtaken and overruled by the need for uniformity throughout the European Union.[122] As a result, a Specialist Register, referring to 57 medical specialties, is now held and constitutes the benchmark for those claiming a particular expertise and who have qualified for a CCST,[123] and the traditional secrecy surrounding a doctor's specialism no longer exists—indeed, the

[119] This was the purpose behind the National Patient Safety Agency, the function of which was to set up a system for mandatory reporting and collation of incidents and 'near-misses' on a national scale. The Agency, however, has now been abolished: Health and Social Care Act 2012, s 281. its functions have been transferred to the NHS Commissioning Board: NHS Commissioning Board Authority (Functions of the Authority) (Amendment) Directions 2012. See also the reinvention of the Health and Social Care Information Centre (2012 Act, s 252).

[120] Interestingly, the Court of Appeal subsequently upheld that the recommendation did not render the GMC's position unreasonable *(Colman*, para 1: n 50).

[121] General Medical Council, *Good Medical Practice* (2006), paras 60–62.

[122] Directive 93/16/EEC (OJ No L 165, 7.7.1993), Title II and III. For incorporation into UK law, see European Specialist Medical Qualifications Order (SI 1995/3268) as amended by European Specialist Medical Qualifications Regulations 1997 (SI 1997/2928).

[123] See para 1.33. Note that, whereas Membership or Fellowship of a Royal College indicates completion of special study in a given field, registration as a specialist demands a Certificate of Completion of Specialist Training, without which it is now impossible to be a consultant in the NHS.

GMC must provide details of those registered if asked.[124] Recommendation for the grant of a CCST lies with the GMC which, in this connection, operates though its agency, the Joint Royal Colleges of Physicians Training Board which, in turn, is served by its Specialist Advisory Committees (SACs). Refusal of a CCST by the relevant SAC is subject to judicial review.[125]

LEGAL INTERVENTION IN MEDICINE

1.60 The early twenty-first century picture of medical practice is one of rapidly advancing technology which is effected in a strongly research-orientated environment and which exists within an increasingly hedonistic and materialistic society. Society, for its part, demands more and more esoteric methodology, and personal involvement in medical care is encouraged at all levels. The law, however, moves more slowly than either the medical or public mores. Thus, the general rules of doctoring are being developed within a moral framework which is constantly being restructured by contemporary society while, at the same time, doctors frequently find themselves operating in an atmosphere of legal uncertainty. All of this promotes confrontation within the triangular relationship of medicine, society and the law;[126] a major purpose of medical jurisprudence as it evolves is to break down any barriers of latent hostility.

1.61 Whether the law has a right to impose morality is a well-known and controversial issue in jurisprudence but, for present purposes, we argue that the public conscience, as embodied in the law, provides a useful guide to medical ethics. As Hoffmann LJ once put it persuasively:

> I would expect medical ethics to be formed by the law rather than the reverse.[127]

This, however, is not to say that the law should dictate to the profession and, particularly, not that it should dictate by means of restrictive statute. Effectively, we are merely pointing out that medicine must operate within broadly stated legal rules—such as those embodied in the common law—and, as Lord Scarman classically indicated,[128] the law must be flexible in the absence of parliamentary direction.

1.62 The crucial question, then, is that of determining the *extent* to which medical decisions should be the object of legal scrutiny and control. At one extreme there are those who hold that the medical profession should be left to regulate itself and that it alone should decide what is acceptable conduct. According to this view, intervention by the law is too blunt a way of tackling the delicate ethical dilemmas which doctors have to face: the individual must confront and resolve the day-to-day ethico-legal issues of medical practice—and it is a truism that no two patients present precisely the same problems in diagnosis and management.

1.63 The contrary view denies that there is any reason why doctors alone should regulate their relationship with their patients. In this view, reserving to the medical profession the right to decide on issues, say, of life and death is an improper derogation from an area of

[124] 1995 Order, art 9(5).

[125] E.g. *Malone* v *Specialist Training Authority of the Medical Royal Colleges* (2005) 87 BMLR 108.

[126] Lord Woolf identified five main areas of dissatisfaction involving all three parties in 'Clinical negligence: What is the solution? How can we provide justice for doctors and patients?' (2000) 4 Med Law Internat 133.

[127] In *Airedale NHS Trust* v *Bland* [1993] 1 All ER 821 at 858; (1993) 12 BMLR 64 at 103.

[128] In *Gillick* v *West Norfolk and Wisbech Area Health Authority* [1986] AC 112; [1985] 3 All ER 402, HL.

legitimate public concern and an encroachment by clinicians into what is, properly, social policy. According to the proponents of this opinion, the law, even if it is an imperfect and often inaccessible weapon, is at least one means of controlling the health care professions in the interests of the community as a whole. In the event, modern conditions are such that the courts cannot avoid involvement in decisions that are essentially matters of medical ethics rather than of law; as a result, they are increasingly prepared 'to adopt a more proactive approach to resolving conflicts as to more traditional medical issues'.[129] The reasons for this are several and, in many ways, indeterminate. We suggest, however, that it is in large part due to the rise of the culture of rights and the impact this has had on the non-acceptability of paternalistic practices. In essence, there have been fundamental adjustments in the doctor/patient relationship—and the relationship between law and medicine is also changing.

1.64 The relationship between the law and medicine had, over the years, effectively settled into a classical domestic state in which mutual trust had been, occasionally, interspersed with outbursts of disaffection. Certainly, the law has, traditionally, been content to allow doctors as free a hand in carrying out their duties as is possible. Nonetheless, as Lord Woolf cogently pointed out in a non-judicial capacity,[130] times change—including as to the distribution of domestic chores—and can change rapidly if the conditions are ripe. Thus, we have Lord Brandon holding, some 20 years ago:

> …[T]he lawfulness of a doctor operating on, or giving treatment to, an adult patient disabled from giving consent will depend not on any approval or sanction of a court but on the question whether the operation or other treatment is in the best interests of the patient concerned.[131]

Within 10 years, however, the Court of Appeal was unanimously limiting the powers of the doctor beyond matters of clinical judgment and, at the same time, delineating the relative powers and responsibilities of the doctors and the judges:

> [I]n determining the welfare of the patient, the *Bolam*[132] test [of the acceptability of a doctor's actions] is applied only at the outset to ensure that the treatment proposed is recognised as proper by a responsible medical opinion skilled in delivering that particular treatment…In deciding what is best for the disabled patient the judge must have regard for the patient's welfare as the paramount consideration. That embraces issues far wider than the medical…In my opinion *Bolam* has no contribution to make to this second and determinative stage of the judicial decision.[133]

In effect, this retreat from *Bolam* is but part of a steady shift of judicial and societal concern away from the duties of the medical profession and its relocation under the umbrella

[129] Lord Woolf, 'Are the Courts Excessively Deferential to the Medical Profession?' (2001) 9 Med L Rev 1.
[130] N 129.
[131] *Re F* [1990] 2 AC 1 at 56, sub nom *F* v *West Berkshire Health Authority* (1989) 4 BMLR 1 at 8, HL.
[132] *Bolam* v *Friern Hospital Management Committee* [1957] 2 All ER 118; (1957) 1 BMLR 1. We discuss the *Bolam* test, which judges the propriety of a doctor's action by way of the standards of the medical profession itself, in detail in Chapter 5. Both the Lord Chief Justice of England (nn 126 and 129) and the Lord Chancellor (Lord Irvine of Lairg, 'The Patient, the Doctor, their Lawyers and the Judge: Rights and Duties' (1999) 7 Med L Rev 255) see its modification as central to the development of a medical jurisprudence.
[133] *Re SL (adult patient) (medical treatment)* [2001] Fam 15, (2000) 55 BMLR 105 at 119 per Thorpe LJ.

of patients' rights[134]—though whether or not this serves to harmonise doctor/patient relationships is open to discussion. The advent of the Patient Rights (Scotland) Act 2011 is unusual in that it is the first attempt in the UK jurisdictions to give statutory expression to the growing phenomenon of autonomy in health care provision articulated overtly as patients' rights. The Act includes, for example, the right that health care be 'patient focused, have regard to the importance of providing the optimum benefit to the patient's health and wellbeing, and allow and encourage the patient to participate as fully as possible in decisions relating to the patient's health and wellbeing'.[135] While this might do no more than articulate entitlements that have been developing over the years in the courts, this sea change is emblematic of the shift of power that has occurred in the discipline of medical jurisprudence.

1.65 It has to be said, however, that the courts are also willing to recognise their position in relation to the legislature in face of the speed of evolution of modern technology—as Lord Browne-Wilkinson put it: 'Existing law may not provide an acceptable answer to the new legal questions [raised by the ability to sustain life artificially].'[136] He went on to question whether judges should seek to develop new law to meet a wholly new situation and to suggest that it was a matter which required society, through the democratic expression of its views in Parliament, to reach its decisions on the underlying moral and practical problems and then reflect those decisions in legislation—and, in this, he was strongly supported by Lord Mustill.[137] In other words, the House of Lords, at least, is anxious that society, as the third point in the triangle of policy decision makers, should take its full share of responsibility for the ethico-legal directions we are following.

1.66 Even so, as we have already noted, statute law is a cumbersome tool for control of an area of what is ostensibly public law but which is, in practice, heavily influenced by considerations of patients' private lives.[138] This has led to a pattern of legislation whereby the day-to-day implementation of policy has been left to regulatory authorities with, more recently, an increasing lay involvement.[139] Its overall impact remains difficult to measure. What we view with greater suspicion is the parallel politicisation of modern medicine—populism is a very doubtful formulator of morality.

[134] See, in particular, the seminal case of *Chester* v *Afshar* [2004] 4 All ER 587, HL (para 4.130). See also G Laurie, 'Personality, privacy and autonomy in medical law' in N Whitty and R Zimmermann (eds), *Rights of Personality in Scots law: A Comparative Perspective* (2009), ch 10.

[135] Patient Rights (Scotland) Act 2011, s 3.

[136] In *Airedale NHS Trust* v *Bland* [1993] 1 All ER 821 at 878; (1993) 12 BMLR 64 at 124.

[137] (1993) 12 BMLR 64 at 135.

[138] We discuss this paradox in more detail in J K Mason, 'Particularity and Medical Law' in Z Bańkowski and J MacLean (eds), *The Universal and the Particular in Legal Reasoning* (2007).

[139] Albeit that the recent review of health-related authorities (and the subsequent cull of many), suggests yet another political shift in the management of medicine and life science development: see Department of Health, *Liberating the NHS: Report of the Arms-Length Bodies Review* (2010). Inter alia, this has seen many authority functions moving to the Care Quality Commission (CQC) and has led to the abolition of entities such as the Health Protection Agency and National Information Governance Board (Health and Social Care Act 2012, Parts 2 and 10). A consultation on the proposal to transfer functions from the Human Fertilisation and Embryology Authority and the Human Tissue Authority to the CQC and the recently-established Health Research Authority resulted in a decision not to abolish HFEA and HTA but rather to conduct a fundamental review of functions, see Department of Health, Government response to the consultation on proposals to transfer functions from the HFEA and HTA, 25 January 2013, para 69.

THE DOCTOR'S POSITION

1.67 The fact that the courts are prepared to assist doctors in coming to their ethical decisions—and have shown this by the steadily extended use of their declaratory powers[140]—is laudable and helpful. But it does not compensate in toto for the fact that doctors often still have to work in a 'legal vacuum' in which, without such pre-emptive assistance, they may be uncertain as to whether or not they face the prospect of a civil action or, again in the words of Lord Mustill, they take the risk of having to validate their conduct after the event in the context of a trial for murder.[141]

1.68 One effect of this can be to distort people's behaviour through the fear of litigation or prosecution. One may then be concerned, not with doing what one feels to be right, but with what one feels to be the safest thing to do. Doctors in the United Kingdom may be particularly fortunate in this respect as, notwithstanding the changes of direction that we have discussed, the courts remain inherently reluctant to interfere in clinical matters. Although, with acceptance of the absolute right of a patient to refuse treatment,[142] and the rise and rise of self-determination, the fear could be that, if anything, the pendulum has swung too far in favour of autonomy, adherence to which may, in too many cases, be tantamount to abandonment of one's patients rather than respect for them as persons.

1.69 Moreover, one must question whether the adversarial system of apportioning justice (or blame) is the right route to follow if there is to be a decision in the event of disagreement between doctor and patient or, more often, between doctor and surrogate decision maker. The concept of winners and losers provides an uneasy foundation for the solution of sensitive and complex ethico-legal problems but one looks in vain for a suitable alternative. Certainly, the vision of a bed-side consultation, as evidenced in *Re B*,[143] has its attractions but it would be ingenuous in the extreme to suppose that it could take the place—or even partly take the place—of a full court hearing in every similar case.

1.70 Even so, try as one may to avoid the issue, there is no doubt that the intrusion of the law into the doctor/patient relationship, essential as it may be in some instances, leads to a subtle but important change in the nature of the relationship. Trust and respect are more likely to flourish in one which is governed by morality rather than by legal rules and the injection of formality and excessive caution between doctor and patient cannot be in the patient's interest if it means that each sees the other as a potential adversary—as Lord Woolf said, in a non-judicial capacity: 'My cure . . . involves a change of culture as to litigation resulting from medical care'.[144]

1.71 Where, then, does the doctor stand today in relation to society? To some extent, and perhaps increasingly, he is a servant of the public, a public which is, moreover, widely—though not always well—informed on medical matters. The competent patient's inalienable rights to understand his treatment and to accept or refuse it are now well established and society is encouraged to distrust professional paternalism. The talk today is of 'producers and

[140] See, for example, Practice Note (Family Division: Incapacitated Adults: Declaratory Proceedings) [2002] 1 All ER 794; [2002] 1 WLR 325.

[141] In *Airedale NHS Trust* v *Bland*, n 127, BMLR 133.

[142] *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649, (1992) 9 BMLR 46.

[143] *Re B (adult: refusal of medical treatment), sub nom Ms B* v *An NHS Hospital Trust* [2002] EWHC 429; (2002) 65 BMLR 149.

[144] Lord Woolf, 'Clinical negligence: What is the solution?' (2000) 4 Med Law Internat 133 at 134.

consumers' and the ambience of the supermarket is one that introduces its own stresses and strains.[145]

1.72 It is, moreover, in many ways extraordinary that the provision of a national health service, which one would have thought should, above all other services, be free of bias, has, in recent years, become perhaps the main political issue that determines the voters' intentions in the United Kingdom.[146] As a result, more and more extravagant claims—and, more significantly, promises—are made with little regard for the fallibility and limitations of those who must implement them. Like it or not, only one person can be the best thoracic surgeon in Startown; the rest can only carry on doing their personal best which no amount of 'hype' or sanction can improve.

1.73 Unless the humanity of both health carers and patients is appreciated by both sides and is not exploited in the political arena, the resulting disappointment, again on both sides, may well lead to a relationship of conflict—or of mutual suspicion—which is in the interests of neither doctor nor patient. What is needed is one of mutual understanding in which doctors acknowledge the interests of patients and patients, for their part, reciprocate this respect while appreciating the pressures, both physical and mental, under which a health carer must work. The public has also to understand the broader issues in medicine. The profession must experiment and research if it is to improve its art and many would hold that a slight loss of autonomy on the part of patients is a small price to pay for a useful advance in therapeutic skills. The profession must also teach, or there will be no doctors to serve future generations; some loss of confidentiality can be looked upon as a return for the best treatment and the best investigative facilities. Clearly, these opposing attitudes cannot be reconciled so long as they are polarised or the claims of one party are accepted to the exclusion of the other. A middle way, based on respect and trust,[147] must be found and this is the function of medical jurisprudence which we attempt to express in the chapters which follow.

[145] For discussion, see J K Mason, 'Medicine, doctors and patients: The changing face of society in the health care field' in M Jeeves (ed) *Human Nature* (2006), ch 5.4.

[146] The Chairman of the BMA is on record as stating that the NHS has become 'the Punch and Judy show of British politics': L Eaton, 'Politicians Must Stop Exploiting Patients' (2002) 325 BMJ 6.

[147] For the importance of trust, see O O'Neill, *Autonomy and Trust in Bioethics* (2002).