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Who's In Charge? The Relationship Between Medical Law, Medical Ethics and Medical Morality?

Introduction

Medicine and morality are inextricably linked. Procedures performed by medical practitioners such as abortion, the removal of nutrition and hydration from comatose patients and questions such as whether to provide medical treatment to an intelligent teenager who is refusing to consent to it can require as much, if not more, ethical reflection than technical medical skill. Yet these headline issues betray a more humdrum, lower order of ethical sensitivity required by all health professionals: the ethical principles practiced by staff at hospitals, both on a personal and professional level. In other words, there is a moral as well as ethical aspect to medicine. Sadly, because medical staff are as fallible as the rest of us, sometimes the high standards that they set themselves are not met, and there are moral or ethical failings. This was undoubtedly the case at the Mid Staffordshire NHS Foundation Trust, where staff were found to have routinely neglected patients and were guilty of, according to a public inquiry, "conditions of appalling care".[1] Moreover the Inquiry, chaired by Robert Francis QC, highlighted the fact that:

> "if all professional staff complied at all times with the ethics of their professions, there would have been no need for the plethora of organisations with commissioning and performance management responsibilities. It is because of the fact that not all boards are capable of maintaining acceptable standards or improving services at the required pace, or applying effective stewardship to the resources entrusted to them that healthcare systems regulators and performance managers exist. It is because not all professionals do live up to the high standards expected of them that we have professional regulators. … It does not need a public inquiry to recognise that this elaborate system failed dramatically in the case of Stafford. As a result, it is clear that not just the Trust's Board but the system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm and from unacceptable, and in some cases inhumane, treatment that should never be tolerated in any hospital."[2]

In other words, there was a *failure of ethics* – both professional ethics (and thus also a systemic failure by regulators to identify and address the issues) but also a failure on a personal level on the part of some staff. While the focus of our paper is not the events

[1] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (HC 947, 2013) Executive Summary page 7.

[2] *Ibid* at page 8.

covered by Francis' report, we feel that the failure of ethics identified therein highlights a fundamental question that does inform our paper. That is: what might the role of the law be in overseeing and intervening in issues of ethical significance? In order to address this, we must first begin by categorising what we see as distinct legal, ethical and moral decisions.

A Typology of Medical Law, Medical Ethics and Medical Morality

To begin with, we need to recognise that decision-making will take many forms, and that if there is to be consistency then it must be categorised. Thus, in this section we offer a generalised typology of medico-ethico-legal decisions, and an explanation of what we consider to be the distinctions between them. Essentially, we can divide the types of decisions to be made by doctors into three: legal, ethical and moral.

Briefly, 'Legal' decisions are decisions where the doctor has no choice at all. Rather, the law has intervened and mandates or proscribes a course of action. These most frequently occur when the law determines that the choice should belong to the patient rather than the medical profession or individual practitioner.

'Ethical' decisions are those that the law leaves to the medical profession to regulate. An 'ethical' decision is therefore one that reflects the corporate morality of the profession. In other words, the profession requires that certain decisions are made in certain ways: if a doctor does not conform, some action will be taken against her. Therefore, an 'ethical' decision is one that is made by the medical profession as a whole, rather than by medical professionals as individuals. As we argue below, when decisions are defined as 'ethical' in nature certain presumptions are made. The most pertinent is that there is a coherent set of governing principles and a mechanism within the medical profession that enforces adherence to them.

A 'moral' decision is one which is entirely uninhibited by anything other than the conscience of the individual doctor. It may or it may not accord with the view taken by the medical profession as a whole. The law sometimes expresses respect for moral decisions: its acknowledgment of the right to conscientious objection to abortion is a good example. These categories are best demonstrated by way of example.

'Legal' Decisions

As mentioned above, a 'legal' decision is one where the law takes charge and claims for itself the role of the body that defines acceptable conduct. It most frequently does this when it perceives the issue to relate to the right of the patient, and thus allows this to be used as a justification for regulating medical conduct. This is most clearly exemplified in the law

relating to informed consent. The courts have effected a process of change over the past 30 years which has fundamentally altered the focus of the law from being based on the duties of the doctor (as defined by doctors themselves) to emphasis on and prioritisation of the right to autonomy of the patient. Moreover, they have been transparent in acknowledging that the principal driver behind this change has been an enhanced recognition and prioritisation of both the ethical aspects of informed consent (in contrast to previous courts that saw it as a matter of technical medical skill), and patient autonomy.[3] In the case of *Chester* v *Afshar*, this even led the House of Lords to declare that if the law does not protect autonomy, the law must be changed.[4]

This is not limited to informed consent, and indeed another excellent example of this can be found in the case of *Ms B* v *An NHS Trust*.[5] Ms B was maintained on a ventilator. She felt that her quality of life was so poor that she wanted to die, and asked her treating clinicians to stop the ventilation. They refused to do so, arguing that this would amount to killing her, and that this was 'unethical'. She went to court to force them to stop the ventilation. The court applied the well established and very simple legal principles: Ms B was a competent adult, and thus no medical treatment could take place without her informed consent; she not only did not provide this, but actively refused to do so, and therefore to continue with medical treatment would constitute a battery. Thus:

> "[I]t is established that the principle of self-determination requires that respect must be given to the wishes of the patient … To this extent, the principle of the sanctity of human life must yield to the principle of self-determination … and for present purposes perhaps most important, the doctor's duty to act in the best interests of his patient must likewise be qualified. On this basis, it has been held that a patient of sound mind may, if properly informed, require that life support should be discontinued … It is simply that the patient has, as he is entitled to do, declined to consent to treatment … and the doctor has, in accordance with his duty, complied with his patient's wishes."[6]

The ventilation ceased and Ms B died. What is of interest to us here is the fact that the medical profession tried to claim the issue of the desirability of Ms. B's survival as its own,

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[3] See J. Miola, "On the Materiality of Risk - Paper Tigers and Panaceas" (2009) 17(1) *Med L Rev* 76 for an account of the law's development in this area.

[4] *Chester* v *Afshar* [2004] UKHL 41. The importance given to autonomy in that case is reflected in the title of the most significant commentary on it: S. Devaney, "Autonomy Rules OK" (2005) 13(1) *Med L Rev* 102.

[5] *Ms B* v *An NHS Hospital Trust* [2002] EWCH 429

[6] *Ibid* at para 23, quoting Lord Goff in *Airedale NHS Trust* v *Bland* [1993] 1 All ER 821.

by defining it as 'ethical' in nature. However the court, by recognising what it saw as the patient's right of autonomy, gave effect to that right by forcing the doctors to cease treatment. In this case, then, we can see that the law took control of a matter with ethical content and defined it as legal – an approach that we shall return to later.

'Ethical' Decisions

In this paper we define 'ethical' decisions as those that the law decides are best resolved by the medical profession itself. Thus, it abrogates responsibility, and instead grants decision-making power to 'medical ethics'. This is a dangerous notion, given that medical ethics is itself an amorphous concept. We cannot exclude the possibility that judges act in this way when they simply do not wish to become involved – in other words, the invocation of 'ethics' is little more than a policy decision that, as we argue below, occurs on an inconsistent basis in the sense that sometimes ethics are evoked, while at others they are conspicuous by their absence.[7] There are many examples of the law abdicating responsibility for ethical issues to medical ethics, particularly in the context of *Bolam*isation, and it must be acknowledged that in some cases this is now being reversed. Nevertheless several examples remain, and we would not wish to overstate the extent or significance of de-*Bolam*isation. One example is the operation of the law relating to the consent of minors. In the case of *Gillick*, the House of Lords determined that minors under the age of 16 could, in certain circumstances, make their own medical decisions. This was entirely undermined by the Court of Appeal in the case of *Re R*, where Lord Donaldson MR held that *Gillick* could be distinguished, and that where a minor up to the age of 18 refused consent to medical treatment, the refusal could be trumped by either parent or by the court.[8] The case was criticised on several bases. One was that it would allow major surgical procedures to be forced upon mature minors despite their refusal of consent for valid reasons. In the subsequent case of *Re W*, Lord Donaldson confronted these criticisms directly, and trusted in medical ethics to prevent this legal loophole being exploited:

> "Hair-raising possibilities were canvassed of abortions being carried out by doctors in reliance upon the consent of the parents and despite the refusal of consent by 16 or 17

[7] See, for example, the case of *Re G (Persistent Vegetative State)* [1995] 2 FCR 46, where the ethical guidance relating to removal of artificial ventilation was consciously adopted as the legal standard by judges. In contrast, there have been times where the courts have equally consciously denied even the ethical nature of the decision taken by doctors – a good example being the cases of *Blyth v Bloomsbury Health Authority* [1993] 4 Med LR 151 and *Gold* v *Haringey HA* [1988] QB 481 relating to risk disclosure. See J. Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship* (Oxford, Hart, 2007) at chapters 4 and 7.

[8] *Re R (A Minor) (Wardship: Consent to Treatment)* [1991] 4 All ER 177.

> year olds. *Whilst this may be possible as a matter of law, I do not see any likelihood, taking account of medical ethics [that it should be allowed to occur]*".[9]

This is quite a bold course of action to take. Lord Donaldson is recognising that the law does not fulfil what he implies is its desired function, but at the same time he expresses such confidence in medical ethics as a regulatory tool that he is happy to delegate the issue to it. The fact that the court in this case appears to think of medical ethics as the medical profession's internal legal system is itself interesting, but for now it is sufficient to note that there are occasions where the courts, while recognising the ethical content of a case, nevertheless use this as a pretext for allowing the medical profession to make the requisite decisions, even if it presumes that it will do so in a certain way.

At this point we should clarify an important distinction: the fact that we can identify an ethical element to a case does not mean that it is appropriate to consider the decision to be best made by medical ethics. Quite the opposite, in fact: the more 'ethical' the issues in a case are, the more reason there is for the law to take control because an 'ethical' issue contains, by definition, elements other than issues turning on the appropriate exercise of technical medical skill. Doctors have no unique competence in the resolution of ethical issues. Thus, to use Lord Donaldson's example, any decision regarding *how* to perform an abortion on a minor who objects would be mostly medical in nature (and therefore appropriately governed by the medical profession). But a decision regarding *whether* to do so is ethical in nature, and doctors are no better able than non-doctors to make the 'correct' decision. There is therefore a strong practical justification for making the judges the final arbiters over 'ethical' issues which find their way to the courtroom.

'Moral' Decisions

Where it is open to the individual to make her own decision, the decision is correctly referred to as being 'moral' in nature. Neither the law nor the medical profession will (or should) impose any sanction on the medical practitioner for failing to make the 'correct' decision: the choice is for the doctor to make as an individual. Most moral decisions, then, will not involve harm to the patient *per se*, or the patient will be protected by alternative means. The rights protected, then, relate not to the patient but the doctor and her conscience. The most obvious example of this is the conscientious objection clause that exists within the Abortion Act 1967. Section 4(1) provides that:

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[9] *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1992] 4 All ER 627 at 635.

> "[s]ubject to subsection (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection"

The purpose is to ensure that those who have a conscientious objection to abortion are not forced to participate in abortions. However, as s.4(1) makes clear, it is subject to the proviso (detailed in subsection 2) that this right to not participate does not apply where the life of the pregnant woman is at risk, or where there is a risk of grave, permanent physical or mental injury. Therefore, the 'right' of the doctor to follow the dictates of her own conscience is protected so long as the patient is not to be sacrificed by her doing so. There is a balancing act: a 'moral' decision occurs where the patient can expect a certain treatment, but the law (and, for that matter, the medical profession) recognises that the issue is one where some might legitimately object to providing it and therefore so long as the patient does not suffer as a result the decision regarding whether to provide it should belong to the individual doctor, and that compulsion would be inappropriate. This might be distinguished from a case where compulsion would be appropriate as the underlying philosophy is considered unreasonable, such as where a racist doctor would refuse to treat other races.[10] Here, the decision is more correctly termed legal or ethical, and sanctions can appropriately be applied to those who do not comply.

The Law's Floundering Attempts to Use Ethics: Making Decisions, Making Distinctions

If we are to regulate medical behaviour adequately, it is critical that the law is able to recognise which problems are best resolved by each of the categories. Needless to say, the most problematic of the boundaries between these categories is that between the law and ethics. This is our focus here.[11] To be clear: by 'ethics' we mean the ethics of the profession, not individual doctors. Too often medical lawyers have upbraided the law for leaving decisions to 'doctors', when in reality what is meant is that decisions are left to the profession and its ethics.[12] For many academic medical lawyers, the allegation has been that

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[10] To give another example, in 2000 the Chief Executive of the UK Transplant Services Authority took early retirement following a furore over accepting organs from a man in Sheffield who added the condition that it could only go to a white person (see S. Boseley, "Transplant Chief Loses Job Over Racism Row" *The Guardian,* 23rd February, 2000, available at http://www.theguardian.com/uk/2000/feb/23/race.world1 (last accessed 15th October 2013). See T. Wilkinson, "What's Not Wrong With Conditional Organ Donation?" (2003) 29(3) *Journal of Medical Ethics* 163.

[11] This is not least because it has long since stopped being seen as acceptable for decisions to be left to *individual* doctors in a systematic fashion, so the 'moral' category is, broadly speaking, defunct. Even in matters of technical skill the law judges conduct by referring to what others would do, which can be considered a collective standard.

[12] See, for example, I. Kennedy, *The Unmasking of Medicine* (London, George Allen and Unwin, 1981).

medical law has traditionally been overly deferential to the medical profession, and that this has led to a medicalisation of non-technical issues – a development that has failed to protect patients, or has even endangered them.[13] Sheila MacLean puts it well:

> "No matter the quality of medicine practised, and no matter the doubts of doctors themselves about the appropriateness of their involvement, human life is increasingly medicalised. In part, this is the result of the growing professionalism of medicine, in part our responsibility for asking too much of doctors. In part, however, it is also because the buffer which might be expected to stand between medicalisation and human rights - namely the law - has proved unwilling, unable or inefficient when asked to adjudicate on or control issues which are at best tangentially medical."[14]

We agree that the law was overly balanced in favour of medical professionals, often in issues not actually involving matters of medical expertise. However, we would also argue that the way that the law has utilised ethics in a haphazard way which does not constitute a deliberate policy of medicalisation. Ethics, if used at all, has been as often as not used as a tool to help the court come to which (perhaps on other grounds) it has already decided to come. [15] The temptation for the law may be to solve the problems created by its dysfunctional relationship with medical ethics by taking more control itself. This, as we argue below, is what it has done, albeit unwittingly.[16] However, we can identify two failings in how the law deals with ethical issues: the first can be termed structural: the second relates to the actual content of the law's analysis. Before that, however, it is necessary to provide an example of the dysfunctional relationship between law and medical ethics in practice.

To demonstrate this, we need only return to the example cited above regarding minors and consent. It will be remembered that Lord Donaldson stated that while he acknowledged that it would be legally possible to force an unwanted abortion on a 17 year old on the basis of a parent's consent, medical ethics would prevent this. He was content to leave a lacuna in the law because he was confident that medical ethics would act as a guardian and prevent it being exploited. Thus his Lordship assumed that 'medical ethics' would effectively police the

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[13] This is a prevalent theme in the work of Ian Kennedy, such as *The Unmasking of Medicine* and see also I. Kennedy, *Treat Me Right: Essays in Medical Law and Ethics* (Oxford, Clarendon Press, 1991).

[14] S. MacLean, *Old Law, New Medicine: Medical Ethics and Human Rights* (Pandora Publishing, 1999), at page 2.

[15] See J. Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship*, *op cit*.

[16] Indeed, we would also argue that as the law has yet to identify the fact that it does have a dysfunctional relationship with medical ethics, this is not a conscious decision. It is more likely that the reason for the increased judicial control is an often imperfectly executed attempt to prioritise autonomy. See C. Foster, *Choosing Life, Choosing Death: The Tyranny of Autonomy in Medical Ethics and Law* (Oxford, Hart, 2009).

medical profession's conduct. However, as one of this paper's authors has previously argued, not only do the GMC and BMA guidelines relating to this issue contain no specific prohibition of such a procedure, but that doctors are repeatedly encouraged to seek legal advice in order to decide what they should do.[17] Thus the BMA guidance regarding the medical treatment of minors provides, inter alia, that:

> "a person with parental responsibility can *legally* consent to her undergoing the termination. In all cases, the patient's views must be heard and considered. If an incompetent minor refuses to permit parental involvement, *expert legal advice should be sough*t. This should clarify whether the parents should be informed against her wishes".[18]

The result is that the law delegates responsibility to decision-making to medical ethics, while medical ethics in turn abrogates responsibility back to the law. This circular process results in a regulatory vacuum that is most likely to be filled by the conscience of the individual medical practitioner – the consequence being that a decision that should have been adjudicated by either law or ethics will be made by morality instead. Thus the outcome that post-war medical ethics sought to avoid (namely that the conscience of the individual practitioner should determine questions of ethical complexity) will be far more likely.: the doctor may well do what she would have done in any event – without engaging in any structured ethical reflection.

We do not argue that all judicial interactions with medical ethics are similarly dysfunctional. Rather, we believe that the seemingly ad hoc, unpredictable nature medical law's use of medical ethics betrays a lack of thought on the part of the judiciary: Lord Donaldson, for instance, seems to have thought little about to what he was abrogating responsibility.[19] We can find some interactions that are structurally sound, such as the law relating to informed consent.[20] In that area, the law has consciously taken control, but has imposed a minimum standard of conduct that nevertheless finds itself below the ethical standard prescribed by the GMC. The law therefore requires only that the doctor explain to the patient the purpose of the procedure and lists the material risks inherent in the proposed procedure.[21] The GMC,

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[17] J. Miola, "Medical Law and Medical Ethics: Complementary or Corrosive?" (2004) 6(3) *Med L Int* 254.

[18] BMA, *Consent, Rights and Choices in Health Care for Children and Young People* (BMA Books, 2001), at page 172. Emphasis added.

[19] See J. Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship*, *op cit*.

[20] *Ibid*, chapter 5.

[21] See *Chatterton* v *Gerson* [1981] 1 ALL ER 257 and *Sidaway* v *Board of Governors of Bethlem Royal Hospital* [1985] 1 ALL ER 643.

however, mandates a bespoke interaction, requiring the doctor to find out the patient's individual requirements and desires and tailor the information to them.[22]

Thus, it is possible for a doctor to be acting unethically (and lay herself open to professional sanction) despite acting unlawfully – the conduct must fall far below the ethical standard to even come close to being legal. This is what we see as being a structurally sound interaction between medical law and ethics: there should be a progressively higher standard applied as the quality of the conduct works its way through from the legal minimum, past the ethical middle ground and up to the gold standard of moral behaviour. Indeed, it should be noted that the structure only works this way around. If it is inverted, so that the law demands a higher standard than the ethics, then it becomes possible for a doctor to be acting in accordance with her professional ethics yet still illegally. Needless to say, this constitutes an unsound structure. Lord Donaldson's example – which must assume that medical ethics contains a different standard to the law if he is confident that the law's lacuna will not be exploited – also makes two other assumptions about the relationship between medical law and medical ethics. Those assumptions are that medical ethics acts as an alternative system of regulation to the law, and then following that that both work together to achieve the right result. Neither can be counted upon.

Thus, even if the relationship between law and ethics is the appropriate one, the ethical principles must still be applied competently by the law for the law-ethics synergy to produce the right result. Here, and again, the law has proved itself to be less than successful. The example we use of structural competence – informed consent – illustrates the problem of inadequate ethical content. It is perhaps ironic that the more that the law relating to informed consent has recognised the ethical component to the provision of information the less it has trusted medical ethics to adjudicate on the reasonableness of medical conduct.[23] Furthermore, the principal driver behind the significant changes in the law has been an explicit judicial recognition of the ethical content of the issue and a corresponding desire to prioritise the principle of autonomy. This culminated in the decision of the House of Lords in the case of *Chester* v *Afshar* that we mentioned at the beginning of this paper, where the court went so far as to state that if the law did not adequately protect autonomy, then even the law must be changed.[24] Their Lordships even engaged with the question of what autonomy might mean, with Lord Steyn providing a long quote from Ronald Dworkin to demonstrate what autonomy should look like:

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[22] See GMC, *Consent Guidance: Patients and Doctors Making Decisions Together* (GMC, 2008)

[23] See J. Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship*, *op cit* at chapter 4.

[24] *Op cit*.

> "The most plausible [account] emphasizes the integrity rather than the welfare of the choosing agent; the value of autonomy, on this view, derives from the capacity it protects: the capacity to express one's own character-values, commitments, convictions, and critical as well as experiential interests-in the life one leads. Recognizing an individual right of autonomy makes self-creation possible. It allows each of us to be responsible for shaping our lives according to our own coherent or incoherent-but, in any case, distinctive-personality. It allows us to lead our own lives rather than be led along them, so that each of us can be, to the extent a scheme of rights can make this possible, what we have made of ourselves. We allow someone to choose death over radical amputation or a blood transfusion, if that is his informed wish, because we acknowledge his right to a life structured by his own values."[25]

The problem – no matter whether one agrees with Dworkin's definition – is that the House of Lords failed to create legal rules that put this vision into effect. Rather, it assumed that simply requiring the doctor to provide information as a 'list of risks' to the patient would automatically result in the latter making an autonomous decision.[26] Of course, this is not the case at all. The account of autonomy apparently assumed is embarrassingly simplistic. Indeed, it is arguably not an account of autonomy at all, but rather a description of liberty.[27] It might be argued that this is necessary if the law is to maintain the correct structural model in relation to medical ethics, in which case it can be said that the failings in content occur as a direct result of the structural soundness. Nevertheless, what this does demonstrate is that the judiciary are increasingly willing to take responsibility for regulating medical decision-making.[28] Moreover, even in the case of medical negligence – where doctors' conduct was traditionally all but rubber stamped by the law – judges have begun to second-guess medical decisions.

However, a glance at the cases where this has happened shows that judges are not involving themselves only in questions of technical medical skill, but are ready to do so also when dealing with broader questions in respect of which doctors do not enjoy a unique competence.[29] Certainly the examples cited in textbooks of cases where courts have rejected defendants' evidence on this basis all involve such broader questions. In *Penney*, the

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[25] *Ibid* at para 18, quoting R. Dworkin, *Life's Dominion: An Argument About Abortion and Euthanasia* (New York, Knopf, 1993).

[26] See J. Coggon and J. Miola, "Autonomy, Liberty and Medical Decision-Making" (2011) 70(3) *Cambridge Law Journal* 523.

[27] *Ibid*.

[28] Lord Woolf, "Are the Courts Excessively Deferential to the Medical Profession?" (2001) 9 *Medical Law Review* 1

[29] For a full discussion see R. Mulheron, "Trumping *Bolam*: A Critical Analysis of *Bolitho*'s 'Gloss'" (2010) *C.L.J.* 609

decision not to retest cervical smear slides that were inconclusive (and labelling the results negative) resulted in some women not being diagnosed with cervical cancer early and was found to be unreasonable by the court.[30] *AB* v *Leeds* involved the decision by the hospital to remove organs from dead patients without the knowledge or consent of relatives – a common practice at the time, but found to be unreasonable.[31] Finally, in *Richards* the court found for the claimant following the hospital's multi-site layout, which meant that a consultant took an hour to travel to attend a patient, denying that patient the benefit of timely treatment.[32] These are not issues of technical medical skill – they are instead questions relating to whether to do something, or how to organise the performance of tasks. They are areas in which, we would argue, the court is more than entitled to make up its own mind rather than deferring to medical opinion or common practice.

The problem is, though, that if the law is to accept or even demand responsibility for making such decisions, then it must ensure that both the structure and the content of its ethical reasoning is sound. As we have argued above, so far the law has not demonstrated that it has adequately, if at all, thought about these issues and sought coherence. Given that this is the case, we must ask ourselves whether the law is equipped to mediate in such matters. Indeed, we have spent so long being sure that the medical profession shouldn't be making such decisions without oversight that we have neglected to examine the credentials of the overseers. We rectify this below.

Breaking out of the circularity

So, then, for the sake of transparency and coherence, we must break out of the circularity whereby law defers to ethics and ethics defers to law. How is that to be done? We are in no doubt that law needs to be the senior partner. We make the case for that contention below. And since that is our view, it is tempting to adopt the easiest route to establishing law's supremacy – the overruling of the *Bolam* test. But the easiest routes are not always the best. The topography of medical law is complex. Or at least it should be, since it should reflect the complexity of its astonishing subjects, human beings.

There are some areas of medical practice where some degree of deference to medical opinion is appropriate. These are areas where technical clinical competence is in issue. There will always be such areas, but they will decrease in importance as the evidence-based medical

[30] *Penney v East Kent Health Authority [2000] Lloyds Rep Med 41*

[31] *AB* v *Leeds Teaching Hospital NHS Trust* [2004] EWHC 644

[32] *Richards v Swansea NHS Trust [2007] EWHC 487*

revolution continues. If the literature conclusively demonstrates that treatment X is preferable to treatment Y, and X and Y are economically comparable and equally available, then there is no responsible body of medical opinion that would endorse Y. But the revolution will never be complete. Medicine will never be completely a science rather than an art. The law can and should acknowledge that since human beings cannot be perfectly pigeonholed, nor can their pathologies, and accordingly that the exercise of medical judgment and discretion must be protected if patients are to have the benefit of bespoke rather than off-the-peg medicine.

The *Bolam* test has often been abused in clinical negligence cases, leading to culpable defendants escaping liability. That abuse was squarely and effectively addressed in *Bolitho v City and Hackney Health Authority* – a case which simply put in italics the word 'responsible' in the *Bolam* test. 'Responsible' had lain low, unexamined and undemanding since 1957. It emerged in *Bolitho*, promising to end the culture of immunity that a sloppy reading of the *Bolam* test had engendered. That promise, we think, has been realised, although it is hard to demonstrate it from reported cases. The real change has been in the *zeitgeist*: a change in the traditional deference of practitioners to medical practitioners, manifested in a reluctance on the part of defendants to fight cases that are on the borders of *Bolam*-respectability. Expert reports are longer and more copiously referenced than they were in the pre-*Bolitho* days. There are far fewer mere assertions about what amounts to responsible practice.

Bolitho, then, has done its job of getting *Bolam* to clean up its act. We can think of no necessary or desirable changes to the substantive law that would make more satisfactory the operation of the *Bolam* test in clinical negligence cases. We are less happy about the way that *Bolam* operates elsewhere – and particularly in the law relating to the determination of best interests, to the law of consent, and to resource allocation questions.

Best interests

How does one decide whether or not it is in the best interests of an incapacitous patient to undergo a particular treatment? Does the *Bolam* test have any role to play? And if it does, should it? In *Re F (Mental Patient: Sterilisation)*[33], Lord Goff, speaking in the context of whether or not sterilisation was in the best interests of an incapacitous patient, said this:

> "[T]he doctor has to act in the best interests of the assisted person. In the case of routine treatment of mentally disordered persons, there should be little difficulty applying this principle. In the case of more serious treatment, I recognise that its

[33] [1990] 2 AC 1

> application may create problems for the medical profession; however, in making decisions about treatment, the doctor must act in accordance with a responsible and competent body of relevant professional opinion, on the principles set down in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.....Mr. Munby....[deployed] the argument that, in the absence of any *parens patriae* jurisdiction, sterilization of an adult woman of unsound mind, who by reason of her mental incapacity is unable to consent, can never be lawful. He founded his submission upon a right of reproductive autonomy or right to control one's own reproduction, which necessarily involves the right not to be sterilised involuntarily."[34]

The argument based on reproductive autonomy failed. The *Bolam* test was held to have a central place in the determination of best interests. This looked suspiciously like a decision motivated more by a desire to prevent doctors from criticism than one motivated by the imperative of ascertaining the patient's best interests.

Re F raised some awkward questions. The notion of 'best interests' presupposes that there is, theoretically, a definitely right answer to the question: 'Is this intervention in the best interests of X?' – in other words that best interests inquiries are attempts to find where the *objective* best interests of X lie. If that's so, how can the *Bolam* test, which has subjectivity at its heart, properly have a voice at the table at all – let alone a decisive voice? What was the role of the court? Was it merely to satisfy itself that the clinicians concerned had assessed best interests in a way that would be endorsed by a responsible body of clinicians? What if there was a responsible body that said that it was not in the patient's best interests to be sterilized?

Surely questions about the sterilization of an incapacitous adult can never be definitively resolved by reference only to the narrowly clinical criteria with which *Bolam* is most commonly (and most obviously properly) concerned. They will necessarily be infused with the ethics of the profession and the individual morality of the clinicians. *Re F* failed to acknowledge this. Its retreat into *Bolam* was an abdication of judicial responsibility. That abdication created terrible problems for the law. It is a good and depressing illustration of what happens when judges fail to judge.

Yet what happened next (10 years later) is a good and heartening indication that when judges do judge, things get better. And here we begin to lay the ground for our contention that law should be unafraid to assert its primacy over ethics. In *Re S (Sterilisation: Patient's Best*

[34] At 78. Lord Bridge agreed: see 52, as did Lord Brandon (66-68) and Lord Griffiths (69)

Interests)[35] the Court of Appeal addressed the questions begged by *Re F*. It was bracingly pragmatic.

> "I would suggest that the starting point of any medical decision would be the principles enunciated in the *Bolam* test, and that a doctor ought not to make any decision about a patient that does not fall within the broad spectrum of the *Bolam* test. The duty to act in accordance with responsible and competent professional opinion may give the doctor more than one option since there may well be more than one acceptable medical opinion. When the doctor moves on to consider the best interests of the patient he/she has to choose the best option, often from a range of options. As Mr Munby has pointed out, the best interests test ought, logically, to give only one answer."

In these difficult cases where the medical profession seeks a declaration as to lawfulness of the proposed treatment, the judge, not the doctor, has the duty to decide whether such treatment is in the best interests of the patient. The judicial decision ought to provide the best answer, not a range of alternative answers. There may, of course, be situations where the answer may not be obvious and alternatives may have to be tried. It is still at any point the best option of that moment which should be chosen.'[36]

This was surely right. It put *Bolam* in its place (as an initial check to ensure that maverick doctors did not contribute inappropriately to best interests determinations), preserved the crucial notion that best interests determinations are objective determinations, and, most significantly, reasserted the principle that it is the law, not professional, ethics-infused opinion, which is the ultimate arbiter of medical action and inaction.

Informed consent

We have touched on this already, and need not address it again in any detail. *Bolam* used to rule (or be perceived as ruling) in clinical negligence cases involving allegedly inadequate counselling. The cornerstone case was (and is) *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital*[37]. As so often happens in medical law, the case was perceived as laying down something very different from what it in fact says. The ratio of *Sidaway* is actually very elusive. Yet it was uncritically cited as authority for the proposition that in consent cases a doctor would escape liability if the information he had supplied was

[35] [2000] 2 FLR 389

[36] Per Butler-Sloss P at 400; see too Thorpe LJ at 402-3. In this formulation, the *Bolam* element tends to protect clinicians; while the 'wider considerations' element tends to protect patients.

[37] [1985] AC 871

that that would have been supplied by a responsible body of medical opinion. There are elements in the speeches that support that proportion, and there are elements that do not. The dogmatic citation and re-citation of the simple *Bolam* reading became a self-fulfilling prophecy. Practitioners and first instance judges assumed that that is what it said. But, as we have noted, the case was eventually re-read. Lord Scarman's view, previously buried, was disinterred; the 'prudent patient' test crossed the Atlantic and found its way into some professional guidelines[38], and the scene was set for the assertion, in *Chester v Afshar* [39], for a formulation based squarely on patient autonomy.

The decision in *Chester* is hard to defend in its entirety. Surely the right thing to have done was not to have assessed quantum as the entire value of the injuries that accrued to the claimant as a result of the operation. That outraged, entirely unnecessarily, the useful conventions of proximity, foreseeability and reasonableness in the law of tort. The claimant should have received modest damages for the breach of her Article 8 right to be informed properly. *Chester* was not about the *Bolam* test. It was agreed that the defendant should have given a warning that he failed to give. But the main point here is that *Chester*'s decisive move away from the traditional ways of analysing clinical negligence cases indicated a very welcome judicial readiness to judge – to the point of changing the law when it is thought to be deficient.

Resource allocation

Resource allocation is notoriously difficult legally, ethically and morally. We make no attempt to summarise the law here.[40] The basic public law position was summarised by Buxton LJ in *R v North West Lancashire Health Authority ex p A*:

> "1. A health authority can legitimately, indeed must, make choices between the various claims on its budget when, as will usually be the case, it does not have sufficient funds to meet all of those claims.
>
> 2. In making those decisions the authority can legitimately take into account a wide range of considerations, including the proven success or otherwise of the proposed treatment; the seriousness of the condition that the treatment is intended to relieve; and the cost of that treatment.

[38] Notably those of the Senate of Surgery

[39] Supra

[40] For a short summary see C Foster, 'Simple rationality? The law of healthcare resource allocation in England' J Med Ethics 2007; 33:404-407

> 3. The court cannot substitute its decision for that of the authority, either in respect of the medical judgments that the authority makes, or in respect of its view of priorities."[41]

The traditional public law position pertains: the court will not interfere unless the decision is *Wednesbury* unreasonable (frankly irrational: a very high hurdle to clear) or procedurally flawed.[42] To state the obvious: healthcare resource funding decisions kill, maim and save. It is perhaps curious (although understandable) that such obviously repercussive decisions are quite so hard to review.

In making decisions about healthcare resource allocation, NHS bodies will (effectively non-reviewably) take into account not only data justified by the objective utilitarian tools of Quality Adjusted Life Years per Pound, but also views which can only bear the name of ethical or moral. The courts' reluctance to adjudicate must partly be a distaste for getting embroiled in this ethical/moral battleground – as well as a concern about opening the floodgates to litigation by disaffected patients, so clogging the courts.

But precisely *because* the decisions are so difficult, and so 'ethical', we think that the courts should (with appropriate procedural safeguards to stop tidal waves of litigation swamping the court lists) be prepared to grapple with these life and death funding decisions. It is arguably anomalous to spend a huge amount of intellectual and emotional energy, as well as a great deal of money, deciding whether it is in the best interests of a patient in PVS to have artificial nutrition and hydration withdrawn, and yet turn a Nelsonian blind eye to the fact that the continued maintenance of that PVS patient necessarily means the death of many entirely salvageable people whose treatment could have been paid for with the funds spent on the nasogastric feeding.

There are some encouraging signs of judicial frustration with the status quo of non-intervention. In *Bull v Devon Health Authority* (which concerned the allegedly inadequate provision of staffing for the post natal care of a child) Mustill LJ, obiter, noted that the courts might not be able to dodge for ever the issue of liability for policy decisions concerning funding.[43]

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[41] [2000] 1 WLR 977 at 997

[42] Associated Picture Houses v Wednesbury Corporation [1948] 1 KB 223

[43] [1993] 4 Med LR 117. See too the comments of Pill LJ in Knight v Home Office [1990] 3 All ER 237

Problems in medicine do not come neatly packaged with a label saying 'legal' or 'ethical'.[44] But most problems in clinical negligence claims, other than those involving informed consent and resource allocation, are uncontroversially the province of the law. Problems concerning consent (and particularly the determination of best interests), confidentiality, resource allocation, the withdrawal and withholding of treatment, reproductive technology and the use of body parts will generally have a significant ethical component. In these 'ethical' areas, which should take the lead? Law or ethics? We have seen that the question has to be answered in order to avoid an embarrassing and sometimes dangerous philosophical pass-the-parcel, with law passing the buck to ethics, and ethics handing it back again.

We think the answer is clear: the law. The law has in place, as bioethics does not, structures and procedures for the detailed examination and adjudication of ethical questions. The courts are not as good as Parliament at taking societal temperatures (they do not have the time, the resources or the expertise), but they are better than the GMC. The regulatory codes of the professional bodies are often intelligent, thoughtful and useful documents, compiled after wide consultation. But the processes of consultation, however thorough, are not and cannot be anything like as transparent as the process of examination that occurs in a public courtroom. The consultation exercises are disproportionately affected by the representations of vocal pressure groups, the process of taking account of the responses and grafting them into the final code is often obscure, and only if there is a gross failure of process or a barn-door illegality in the final product will the code be reviewable. There is too much of the smoky room for these codes to have the same sort of credibility as an Act of Parliament or a judicial decision reached after prolonged public argument. It cannot be forgotten, either, that the regulatory organisations may have their own internal politics or (unspoken) ethical presumptions – luxuries denied to the judges.

The law has the advantage, too, of having to decide.[45] That is often uncomfortable, but it produces a quality of thought that is absent when one simply has to say what principles might, in the abstract, apply. There is a reason why comments made *obiter* do not have the same authority as those which are part of the *ratio decidendi*. Ethics, even when embodied in a formal code that purports to circumscribe acceptable professional conduct, will necessarily be unable to be as prescriptive as the law. Ethics will have to take into account the penumbra of acceptable opinion. It will never be able to shake off the objections to

[44] Jurisdiction over medical problems can be correspondingly difficult to determine. That is one (bad) reason to approve of the holistic jurisdiction of the regulators, who unblushingly and unreflectively conflate questions of law and ethics.

[45] See C. Foster, *Choosing Life, Choosing Death* (supra), 182-3. It should also be noted that there is some resistance amongst some teaching ethics to the notion that there can be 'right answers' – see, for example, A. C. Molewijk, T. Abma, M. Stolper and G. Widdershoven, "Teaching Ethics in the Clinic: The Theory and Practice of Moral Case Deliberation" (2008) 34(2) *Journal of Medical Ethics* 120.

Bolamisation that we have identified above. The amorphous must always give way to the structured, for reasons of certainty, transparency and fairness.

And the law has a final, decisive advantage: power. It has the authority to decide, and the obligation to do so. A regulatory tribunal can, wielding its own domestic statute book (its regulatory code) have a crucial impact on a profession and on the individuals who make up the profession. There is nothing unreal about the power of the GMC to strike a doctor's name from the register. But when all is said and done, the GMC is a creature of the Medical Act, the procedures of the tribunals by which its powers are exercised are creatures of subordinate legislation, and both are ultimately reviewable by the court. We have not delineated the exact boundaries of law, ethics and morality. It is impossible and undesirable to do so. We have indicated that ethics and law often mix. We would not want it otherwise. Law unleavened by ethics would be cold and unfit for its purpose of serving warm humans.

We are conscious that we have elided the question of the relationship between law, ethics and morality and the question of who should be the ultimate arbiter of questions to which law, ethics and morality each have something to contribute. Given the forensic realities, that seems to us to be inevitable. It does not follow from this that we do not support enthusiastically methods of resolving conundrums in medical life which do not involve the courts. Far from it. We endorse, for instance, Richard Huxtable's view that Clinical Ethics Committees (CECs) have a significant role to play in such problems.[46] There is no contradiction in that endorsement. It is inconceivable that a rightly directed CEC would recommend an illegality, and final recourse would always be to the courts.

With the law's power comes responsibility – the responsibility to decide. As we have noted, that responsibility has often been inappropriately shirked. That shirking has sometimes been because of a feeling by the courts that they are not intellectually equipped to second-guess doctors (*Bolam* at its worst – more or less corrected by *Bolitho*), or, even if so equipped, should not (*Sidaway*, as conventionally understood, and perhaps *Re F*). Sometimes it has been a constitutionally understandable concern about the appropriate limits of judicial intervention (some of the resource cases), or a worry that if jurisdiction is accepted, the courts will be swamped (some of the resource cases). Sometimes, though, it has been because of a failure or a refusal to acknowledge the primacy of the law. This generally comes with a failure to realise that the law, properly wielded, can respect and embody both professional ethics and personal morality.

[46] R Huxtable, Law, Ethics and Compromise at the Limits of Life: To Treat or not to Treat? Routledge, 2013

The relationship between professional ethics and personal morality is a relationship which the law must, now, take into account – at least when it is dealing with public authorities, as will usually be the case in medical litigation. Article 8 of the ECHR will be in play in many disputes. Private concerns (including moral concerns) are the business of 8(1): societal concerns (including broader ethical considerations) are the business of 8(2). It is the court's job to resolve the tension between those (often competing) concerns. Accordingly, even if it was acceptable, prior to the Human Rights Act 1998, to ignore ethical and moral concerns, it is acceptable no longer. The law, then, should set the minimum standard. If regulators want to demand more of their professional members (ethics): fine. If an individual member wants to demand more of herself than the law/the regulator (morality): fine.

Setting the minimum standard requires some judicial creativity. That creativity has often been stifled by over-ready deference to medical ethics. But the law can do the job whose responsibilities entail the status of final arbiter. There was no need for Lord Donaldson's unhappy formulation in *Re W*. Should the unwilling 17 year old be forced by her parents to have an abortion? No. But that is really because abortion is a rather special type of 'treatment'. It cannot simply be lumped together with appendicectomies. A little bit of nuance would have gone a long way. The case wasn't beyond the creative powers of the common law.

What About the Danger of 'De-moralisation?

At this point we should consider the danger warned of by Jonathan Montgomery, who has argued that the move away from *Bolam* and other factors have led to the law sucking the moral shape out of medicine. More precisely, he argues that the increased focus on 'choice' for patients, (both within the NHS and in the law more generally) has created a marketplace where 'anything goes'. Thus,

> "the discipline of healthcare law is at risk of being transformed – moving *from* a discipline in which the moral values of medical ethics (and those of the non-medical health professions) are a central concern, *to* one in which they are being supplanted by an amoral commitment to choice and consumerism. In other words, that the morality is being taken out of medicine by legal activity."[47]

[47] J. Montgomery, "Law and the Demoralisation of Medicine" (2006) 26(2) *Legal Studies* 185 at 186.

He argues that sometimes the *limitation* of choice increases autonomy and ensures that moral values are more fully considered. Since the moral *zeitgeist* of modern medical practice insists that such choice should be increased, not decreased, the moral *zeitgeist*, he suggests, is wrong. In order to demonstrate this demoralisation in action, Montgomery provides the example of the law relating to informed consent (which governs how much information a doctor needs to give to a patient about the risks, benefits and alternatives regarding any particular treatment before the patient's consent is legally valid). He notes that the law in the area has been seen to exist to protect patient autonomy in a positive way:

> "In traditional terms, commentators have seen that doctrine as a means of promoting the autonomy of patients – their ability to take control of their lives and to shape them as they wish. The choices they make are one of the ways in which they shape their own life stories. Ensuring that patients receive good quality information is part of the process of enabling them to exercise such autonomy. On this account, autonomy is a positive value reflecting the sort of people we believe fully reflect our human potential."[48]

However the way in which the law has developed has been shaped by its response to medical paternalism, and Montgomery's position – with which we agree wholeheartedly – is that what the law has done *in reality* as opposed to *in theory* has been to seek to limit the power of medical professionals rather than promote the autonomy of patients. The purpose therefore becomes a negative one rather than a positive one, although the concept imagines that the positive notion of autonomy will result from the removal of the negative notion of paternalism. This is important because, as Montgomery demonstrates, the principles can be warped or wrongly deployed to achieve precisely the opposite of what their users intend. He gives the example of the Data Protection Act 1998 and its requirement that if data is to be transferred abroad the controller must either obtain the informed consent of the data subject or take steps to ensure that the same level of privacy protection is in place. He argues that companies far prefer the consent 'route' because this essentially absolves them of responsibility for ensuring standards. In this way,

> "an apparent increase in informed consent has actually served to reduce the obligations of researchers to protect the interests of participants. Promoting participants' ability to shape their lives would be more enhanced by the researchers maintaining the responsibility for protecting privacy. The law has substituted a formal requirement of openness for a substantive one of protection. Perhaps more tellingly,

[48] *Ibid* at 187. We would agree that the law has sought to prioritise autonomy (see, for example, J. Miola, "On the Materiality of Risk: Paper Tigers and Panaceas" *op cit*), although we would also note that the conception of autonomy utilised is simplistic and more akin to liberty (see Coggon and Miola, *op cit*).

> the people protected by informed consent are the researchers and drug companies not the research participants. The legal doctrine of informed consent has actually undermined autonomy as it has reduced the force of the moral obligation on researchers to protect the ability of participants to shape their own lives."[49]

Montgomery criticises the previous generation of medical lawyers, such as Ian Kennedy, for their analysis of the doctor-patient relationship, and medical law generally, as something of a battle between doctor and patient, with the winner being she who gets to decide. He notes that, for authors such as Jo Jacob, rejecting medical expertise was to throw the baby out with the bathwater because "professional knowledge, experience and values are all inculcated in an integrated process of training and apprenticeship".[50] According to Montgomery,

> "one could extrapolate from his argument that to use the *Bolam* test as a benchmark of acceptable practice was not to abandon normative judgement, as some have seen it, but to reinforce the values of the health professions. From this view, the ascendancy of the ideology enshrined in the *Bolam* test is a positive choice to build on the moral nature of medicine."[51]

Yet the Kennedy-ites have won, and the new breed of more interventionist judges have encouraged the marketplace and created a vision of medical practice that is transactional rather than moral in nature:

> "[the new breed of judge] rejects deference to the health professions, sees healthcare as equivalent to other (commercial) enterprises and, therefore, to be regulated from outside without any trust in industry values and without any special rules for healthcare. This constructs the position of the patient as consumer dictating what should happen, with little scope for moral independence of health professionals. Such a construction is essentially value neutral and once more serves to marginalise the moral content of medical law. It can be seen that this new approach to judging healthcare practice is consistent with other developments that serve to 'demoralise' the enterprise of medical or healthcare law."[52]

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[49] Montgomery, *op cit* at 188.

[50] *Ibid* at 200.

[51] *Ibid* at 201.

[52] *Ibid* at 206.

It is a powerful argument, and it is buttressed by his persuasive demonstration that the law has failed to use (or use appropriately) the powers that it has. Given our similar analysis of the law's failing above, it is no surprise when we again declare our agreement with this point. But does Montgomery's thesis present a challenge to ours? By seeking to encourage a more interventionist approach by the law, are we risking losing focus on morality and submitting to a feral marketplace where choice is king?

It does: but the challenge is one that we feel can be met by furthering his argument, which is one with which we broadly agree even if we come to a slightly different conclusion. First, it should be noted that the 'market', which undoubtedly exists, relies not just on demand but also supply. Therefore it is noticeable that in almost all areas of ethical controversy – whether it be extreme cosmetic surgery, removing ANH, performing experimental treatment on patients or any of the myriad other examples that could be used – one always seems to be able to find a doctor who is willing to perform the procedure. It is therefore not enough, in our view, to lament the creation of the market and suggest that there is nothing that can be done to stop it, which is what some might do.[53] Rather, we would argue that something can be done. The supply of the ethically dubious activities can be cut off. Both the law and, in theory, medical ethics are equipped to truncate the supply.

Second: decisions involving issues of ethical complexity are precisely those in which, as we have argued above, doctors have no unique competence. There is therefore no reason why they should fall to be decided by medical professionals and their ethics. Indeed it is worth restating our view that, ironically, the more ethical in nature a decision is, the less justification there is for allowing medical ethics to become the arbiter.

This reclamation of decision-making capacity by the law from the medical profession is central to Ian Kennedy's work, and it stands the test of time very well. Montgomery's counter argument, that judges have come to accept Kennedy's view and that the effect of this has been a demoralisation of medical practice, is equally persuasive. However, we believe that both of their positions can be seen as creatures of their time. Montgomery's argument is both logical and coherent: the law has on several occasions, as we argue above, proved itself unwilling or unable to assess ethical issues adequately. But the reason that a reversion to *Bolam*, which is what Montgomery suggests at the end of his paper, would be a mistake is that Kennedy's argument is equally logical and coherent *in the context of the law as it was when he was writing*. Indeed, if Montgomery's argument is a reaction to judges approaching the law in the way that Kennedy advocates, Kennedy's analysis was equally a reaction to the law as it was being applied when he was writing. We therefore argue that Kennedy was correct about the law being overly paternalistic in the 1980s, and the fact that doctors were

[53] Montgomery, it should be noted, does not argue on this basis.

claiming responsibility for making decisions that were outside of their field of expertise. In this context judicial interventionism and de-medicalisation are entirely reasonable suggestions.

Moreover, it is worth remembering that many of the legal changes that did prioritise autonomy and patient choice were brought about by specific instances of medical misbehaviour – a prime example being the Human Tissue Act 2004 (hereinafter HTA) which was a direct response to the organ retention scandals that laid bare the failings of the previous legislation. When looked at in isolation, the HTA seems to support Montgomery's point: the almost unthinking reliance on individual consent makes it more difficult to obtain organs for transplantation, and thus lessens the number available, to the detriment of society as a whole. But the Act's philosophy is at least comprehensible when placed in context – it was an explicit response to the fact that doctors had been removing and retaining organs without the knowledge and consent of patients or relatives.

And third: a related point. Since there are plenty of examples of poor yet unpunished medical conduct before the law de-*Bolam*ised, we believe that medical ethics has not demonstrated itself to be an effective regulator. Indeed, even after the law's change in attitude, there was nothing to stop medical regulators from actually regulating. To use the example of extreme cosmetic surgery, even if the law allows it, that does not mean that it is not within the ambit of the GMC to refuse to allow registered medical practitioners to perform some or all procedures. Thus if we are to remoralise medicine through *Bolam* we may well simply end up in the situation that we were in before and that is, in our view, a step back rather than forwards.

Conclusion

While we disagree with Montgomery's conclusion, we do not disagree with his diagnosis of the problem. Thus, we would argue that many of the key issues in medical law cases today are not medical but ethical in nature, and that therefore the law is not just entitled but obliged to be the final arbiter. However, we certainly agree with him that the law's treatment of decisions requiring ethical engagement is patchy at best. There are two reasons for this. The first is that, historically, the culture of non-intervention meant that the law simply refused to engage in debates and abrogated responsibility to the medical profession. The second is that, once the paradigm shift in judicial attitudes identified by Montgomery took place, the quality of the law's ethical reasoning has not always been of the highest calibre. Despite this we would argue that, both in terms of legitimacy and structure, the law is potentially best placed to make such ethical decisions. If the structure is right then the content can be improved.

Indeed, this is our solution to the problem: we believe that the law needs to recognise that it has this role. There needs to be a conversation regarding when it should intervene to claim ownership and hence start engaging in ethical debate itself. The circularity we describe has occurred because that conversation has not happened. It is urgently necessary.