

**An Inquiry into the Emergence of Health Care Law in England and Wales as a
Distinct Body of Law - What Lessons Can be Drawn From this in Relation to
Ghana?**

by

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DECLARATION

I confirm that the thesis is my own work; that it has not been submitted in substantially the same form for the award of a higher degree elsewhere; and that all quotations have been distinguished and the sources of identification specifically acknowledged.

PUBLISHED SECTIONS OF THE THESIS TO DATE

- Part of Section 1.4 of Chapter is based upon my publication - E Owusu-Dapaa, 'Ghana' in H Nys (ed), *International Encyclopaedia of Laws: Medical Law* (Alphen aan den Rijn, (NL: Kluwer Law International 2014) 131
- A World Medical Law Association's journal published my article in 2014 substantially extracted from Sections 5.0 and 5.1.2 of Chapter Five and the article is entitled 'Historical Development Of Health Care Law And Bioethics In England And Wales: A Symbiotic Relationship' (2014) 33 (1) *Medicine and Law* 22
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ABSTRACT

IN THIS THESIS, IT IS POSTULATED that a discrete body of health care law (HCL) can *potentially* offer more benefits to patients by providing protection for their rights and improving healthcare delivery as a result of making healthcare professionals and workers more aware of their legal duties towards patients than is the case where a field of HCL is absent. The emergence of a discrete body of HCL in England and Wales has not received a great deal of attention in the academic literature; there has not, as of yet, been any thorough study of the questions of how and why this relatively new field of law emerged three decades ago. This thesis addresses this gap in the literature and explores those attractive elements of HCL in the law of England and Wales that may be emulated by a jurisdiction like Ghana, which is seeking to develop this field of the law. A combination of legal history and empirical legal research methodologies are deployed to unpack the development of HCL in England and Wales as a response to the quest for patient empowerment in healthcare and the need to recognise the voice of society in mediating ethical dilemmas generated by rapid advances in medicine. The characteristics of HCL and rationale for its emergence in England and Wales are used as a basis of comparison within a functional comparative analytical framework in order to explore the need for the development of HCL in Ghana, as well as any lessons that may be drawn from the former.

DEDICATION

Ad Majorem Dei Gloriam.

My Wife, Afia and daughters Akua Owusuwaa and Akua Pinamang.

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CHAPTER ONE

INTRODUCTION: SETTING THE SCENE

1.1. BACKGROUND AND CONTEXT

Ghana and Great Britain (in particular England and Wales) are two countries in stark contrast to each other, whilst at the same time sharing some discernible similarities in the context of healthcare delivery. Ghana is a Republic which gained independence from Great Britain in 1957. Consequently, Ghana's legal system is modelled upon the English common law tradition.¹ Within World Bank classification, Ghana is a developing country with lower middle income status² and as of 2012, had a population of 25.37 million.³ The healthcare system in Ghana has undergone many changes as a result of the various transformations in its political economy and now almost 70% of healthcare in Ghana is delivered by the public sector,⁴ which has been financed through a national health insurance scheme since 2004.⁵ According to the World Health Organisation (WHO), Ghana's health expenditure in 2011 was only 4.8% of its GDP.⁶ Meanwhile, the total expenditure on health per capita was just USD 90.⁷ Life expectancy at birth around the same period was 62 years for men and 65 for women.⁸ The physician to population ratio (per 10,000 population) was one doctor to 10,000 patients.⁹ The nursing and midwifery personnel to population ratio (per 10,000

¹ RF Oppong, *Private International Law in Ghana* (The Netherlands: Kluwer Law International, 2012), 15.

² World Bank Country Profile: Ghana, <http://data.worldbank.org/country/Ghana> (accessed: 7/4/2014)

³ Ibid.

⁴ J Akazili, B Garshong, M Aikins, J Gyapong and D McIntyre, 'Progressivity of health care financing and incidence of service benefits in Ghana' (2012) 27 *Health Policy Planning* (Suppl. 1), 113-122.

⁵ Ibid.

⁶ WHO African Region: Ghana, <http://www.who.int/countries/gha/en/> (accessed: 10/9/2012).

⁷ Ibid.

⁸ Ibid.

⁹ WHO: Ghana Publications, <http://www.afro.who.int/en/ghana/ghana-publications.html> (accessed: 10/9/2012).

population) is one nurse to 6,705 persons.¹⁰ The HIV/AIDS mortality rate¹¹ (per 100,000 population) in Ghana as at 2007 was 89.¹² Furthermore, there have been numerous complaints of patient abuses and scandalous practices in healthcare institutions reported in the media, but there have never been any formal or open public inquiries into the operation of healthcare or patients' experiences in Ghana.

England and Wales, on the other hand, is a monarchical democracy with an unwritten constitution.¹³ Its legal system is the home of the common law tradition dating back to AD 1066. With a population of approximately 63 million, it has a Gross National Income per capita of 37,340 USD and spends 9.3% of its GDP on healthcare.¹⁴ As part of the establishment of its welfare state, England and Wales (and the entire UK) have operated the National Health Service (NHS) since 1948, which is publically funded through taxation. For the purpose of the discussion in this section, I shall focus on the NHS in England, where the physician population per capita is 1:440.¹⁵

There have been many scandals in healthcare delivery which have triggered the setting up of public inquiries.¹⁶ These public inquiries have served various purposes, including establishing facts; learning from events; catharsis or therapeutic exposure; public

¹⁰ Ibid.

¹¹ Ibid.

¹² This is a significant improvement on the 500-plus of previous decades. This increased life span of HIV patients can be attributed to free antiretroviral drugs.

¹³ Solely for the purposes of my outline of the country's health profile, I propose to use 'United Kingdom' interchangeably with 'England and Wales', since the latter is subsumed under the UK.

¹⁴ WHO Countries: United Kingdom, <http://www.who.int/countries/gbr/en/> (accessed: 11/4/2014).

¹⁵ Office of Health Statistics: <http://ohe.org/page/index.cfm> (accessed: 14/4/2014).

¹⁶ Examples include: *Clothier Report Independent inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital* (London: HMSO, 1994) (Clothier inquiry); *The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: learning from Bristol* (Cm 5207, 2001) (Kennedy inquiry); *The Royal Liverpool Children's Inquiry Report* (London: The Stationery Office, 2001) (Redfern inquiry); *The Mid Staffordshire NHS Foundation Trust Public Inquiry*, HC 947 (London: The Stationery Office) (Francis inquiry). See Chapter Six for a more nuanced discussion of public inquiries in healthcare.

reassurance; accountability, and blame and retribution.¹⁷ These inquiries, which are given significant media publicity, have also usually culminated in elaborate reports serving as a basis for reforms and the drafting of relevant bills, such as the *Human Tissue Act, 2004*, brought about as a consequence of, among things, the Alder Hey organs scandal,¹⁸ where the organs of deceased children had been retained by the Alder Hey Children's Hospital without consent, and the Kennedy inquiry into heart surgery on children at the Bristol Royal Infirmary.¹⁹ Besides the new legislative intervention in these virtually uncharted waters, the courts have also increasingly become involved in the resolution of moral dilemmas in medical practice, in ways that were previously inconceivable, such as deciding when to withdraw or discontinue lifesaving nutrition and treatment, as in *Airedale NHS Trust v Bland*.²⁰ What will therefore become apparent in this thesis is that the question of whether the courts successfully rise to the occasion when it comes to determining these moral or ethical dilemmas, is contested among commentators.²¹ Nonetheless, for now, what is significant is that unlike many decades (and indeed centuries) before the significant period of the 1980s²², many cases that would have been previously not presented to the courts now come before them.²³ The novelty of the cases emanating from medicine for judicial resolution in England and Wales has challenged the boundaries of common law and necessitated the rethinking of the applicability of conventional or settled doctrines to previously un-litigated aspects of medicine. As will be discussed, the tension between

¹⁷ N Black and N May, 'Public inquiries into Health Care in the UK: A Sound basis for Policy-Making?' (2013) 18 *Journal of Health Services Research & Policy*, 129.

¹⁸ Redfern inquiry, n. 16 above.

¹⁹ Kennedy inquiry, n. 16 above.

²⁰ [1993] 1 All ER 821 at 872

²¹ See generally: J Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship* (Oxford: Hart Publishing 2007).

²² See section 1.5.2 of the Thesis for a justification of choice of 1980 as a significant period of reference.

²³ See, for example, the court's intervention in contraception therapy for girls under 16 in *Department of Health and Social Security v Gillick* [1985] 3 All ER 402; discontinuation of artificial life-sustaining nutrition and hydration in *Airedale NHS Trust v Bland* [1993] 1 All ER 821.

patient rights, professional discretion and the need for unimpeded progress in medicine has called into question the proper role of law vis-à-vis medicine in judicial, parliamentary and academic circles.

Although Ghana is relatively underdeveloped compared to England and Wales, broadly speaking, it is still possible to study the changing response of law to medicine in both jurisdictions. This is particularly apposite since, as noted, both countries share the common law legal tradition (as a result of colonial legacy) and operate a national public sector-funded healthcare system.

1.2. THE RESEARCH PROBLEM AND HYPOTHESIS

There has been increasing concern over patients' clinical experiences and healthcare in general in Ghana. This concern (as will become apparent in Chapters Four and Six), is evidenced by frequent complaints brought against healthcare institutions and professionals in the media and recent cases brought before the courts, as well as before quasi-judicial bodies. The issues arising from healthcare and medical practice which make headlines in the media²⁴ reveal multiple layers of complexity that transcend the micro-issues of doctor-patient relations to macro-thematic areas, like access to healthcare and the regulation of ethically sensitive medical advances being imported into Ghana. These media headlines include 'Doctors render woman barren ...after leaving towel in her abdomen'²⁵; 'Killed by a Doctor'²⁶; '200 Children cry for help to undergo treatment'²⁷; 'Nsawam hospital has no

²⁴ See: Chapter Six, particularly 6.1 and 6.2 for a more detailed discussion of these matters that make the headlines.

²⁵ The Mirror Reporter, 'Doctors render woman barren ...after leaving towel in her abdomen' (*The Mirror*, 22/09/2012 edn) <http://mobile.ghanaweb.com/wap/article.php?ID=251108> (accessed: 1/9/2014).

²⁶ The Insight Reporter (*The Insight*, 2014 edn) <http://www.ghanamma.com/killed-by-a-doctor/> (accessed: 12/3/2014).

²⁷ MY Jafaru, '200 Children cry for help to undergo treatment' <http://graphic.com.gh/news/general-news/23023-200-children-cry-for-help-to-undergo-treatment.html> (accessed: 17/5/2014).

incubators'²⁸; and 'MoH gives ultimatum to KATH [Komfo Anokye Teaching Hospital] to produce five stillborn babies.'²⁹ The reported media stories and the few available judicial decisions portray not only excessive medical paternalism but, more worryingly, the general exploitation of vulnerable patients by health professionals.³⁰ Some examples suggest that health professionals are free to behave towards patients as if the law and even their professional ethics imposed no obligations on them towards patients. Symptomatic of this tendency was a public debate on a popular radio station in 2011 which took place between two medical practitioners over whether a doctor had a duty in law to explain the implications of a prescription to his or her patients.³¹ This conundrum is exacerbated by the fact that a significant segment of the patient population in Ghana is largely unaware of the rights provided for them in their clinical experience. There is also the cultural attitude of accepting statements or decisions from the elderly (including experts in this case) without challenge. Moreover, Ghana's economic realities complicate the matter. The expectations of the citizenry, as regards healthcare from state-sponsored health facilities, are not pursued with sufficient vigour, as the obligations of the state in this regard are neither neatly calibrated nor adequately appreciated by the patients. The upshot of this is that even patients who use publicly funded healthcare institutions tend to see such institutions as doing them a favour and are thus reluctant to complain about any disregard for their rights during their clinical encounters.

²⁸ The Reporter, 'Nsawam hospital has no incubators' <http://www.ghanaweb.com/GhanaHomePage/health/artikel.php?ID=304824> (accessed: 21/5/2014).

²⁹ R. Quaicoe-Duho, 'MoH gives ultimatum to KATH to produce five stillborn babies' - <http://graphic.com.gh/news/general-news/18467-moh-gives-ultimatum-to-kath-to-produce-five-stillborn-babies.html> (accessed: 21/5/2014).

³⁰ See: Chapter Six, particularly Section 6.1 and Section 6.2 below.

³¹ *ibid.*

A separate but not completely unrelated issue to the matters identified here involves the challenges attendant upon the absence of any legal regulation of the technological advances in reproductive and organ transplantation being imported into Ghana. While some of these advances are being lauded³² for the solution they promise to provide to the situation faced by many families, at the same time legitimate concerns are being registered by members of the public and organised groups against scandalous practices associated with them. For example, the increasing commercialisation of sperm for fertility treatment has been condemned by various sections of the Ghanaian public.³³ Such difficult issues confronting patients and healthcare delivery in general in Ghana provoke a question about the role of law in all these developments. Is it the case that these matters are not adequately regulated by the law at all; or that the law addresses aspects of those matters in an incoherent manner; or is it that the legal community, and perhaps the healthcare profession, have not yet come to realise that healthcare is an area with unique characteristics that warrants special study or analysis, rather than merely being subsumed under more general law? In considering this, it is also helpful to take into account the historical context of law in Ghana.

As noted above, Ghana gained independence from Great Britain on 6th March, 1957. Consequently, Ghana's legal system was derived from English common law, and the traditional branches of law as conceptualised under common law also exist in Ghana. Similarly, the curriculum in legal education reflects those divisions of law.³⁴ It has not generally been considered that healthcare necessitates a special approach in law. Indeed,

³² EE Abbey, 'Infertility conference attracts over 1,500' <http://graphic.com.gh/news/general-news/19539-infertility-conference-attracts-over-1-500.html> (accessed: 21/5/2014).

³³ 'Catholic Bishops conference condemns sale of sperms in Ghana' <http://edition.myjoyonline.com/pages/news/201309/112759.php> (accessed: 24/3/2014).

³⁴ Copies of the Curriculum Handbook of Law Faculties of the University of Ghana and Kwame Nkrumah University of Science and Technology are available in my folder.

until 2013, when a statute was passed in Ghana to specifically deal with healthcare, no special normative standards were incorporated into it to demonstrate that legal issues in healthcare are significantly unique from all other areas. An apt description of the reality of Ghana's legal system in relation to healthcare is that it has no discrete body of health care law (HCL),³⁵ but rather a patchwork of texts from criminal, contract, tort and constitutional law. Thus, to understand the legal position on an issue arising from healthcare or medical advances in Ghana, one must look at all these branches of the law and the relevant case law under each of them. What aggravates the patchy legal situation is that there has not been any systematic effort to draw together all the relevant aspects of these different branches of the law into a coherent analytical study.

In contrast, in England and Wales there has emerged a dedicated field of law, which deals with healthcare.³⁶ Thus, there has been recognition among the legal community, politicians and healthcare professions in England and Wales that healthcare is a uniquely sensitive and risky area of human endeavour that necessitates a different way of thinking and analysis. Even where the conceptual tools for analysis have been borrowed from traditional areas of the law, they have been bent or adapted to suit the special circumstances of the healthcare. A typical example here is the standard of care in medical negligence, compared to the judicial approach towards other professional negligence in tort law. Brazier and Miola have aptly noted that the decision in *Bolam v Friern Hospital Management Committee*³⁷ and its subsequent application in many cases created the impression that litigant in medical negligence cases only needed to get experts to testify

³⁵ See: Section 1.5 below for an explanation of my choice of the term 'HCL'.

³⁶ See: Chapter Three.

³⁷ [1957] 1 WLR 582

that they would have done virtually the same as the defendant did.³⁸ In contrast, in other professional negligence litigation, the courts will ensure that ‘the expert evidence is demonstrably reasonable and responsible.’³⁹ It is noteworthy that health care law (HCL) as a discipline was not part of English law until after 1980. It is my contention that understanding the circumstances concerning how and why a discrete body of HCL emerged in England and Wales can assist in exploring pathways that Ghana may follow towards the development of its own HCL.

A fundamental assumption I make in this thesis is that a discrete body of HCL coupled with other liberalising factors can offer more benefits to patients by providing protection for their rights and improving healthcare delivery, as a result of making healthcare professionals and workers more significantly aware of their legal duties towards patients than is the case where a field of HCL is absent. It is pertinent to pinpoint at the outset that development of a distinct body of HCL by itself did not automatically bring about patient empowerment in England and Wales but so many other factors interacted to liberalise this area of the law.

On the basis of this fundamental assumption, the research question being investigated in this thesis is two-fold, namely: how and why a discrete body of HCL emerged in England and Wales, and secondly, what lessons can Ghana draw from the English and Welsh experience? The first limb of the research question presupposes that a discrete body of HCL has not always been part of the recognised divisions of the law of England and Wales, but only emerged some time later, as will be demonstrated in Chapter Three of this thesis. It is also implicit in this aspect of the research question that there is an identifiable or discernible body of HCL in England and Wales. The other limb of the question suggests two possible

³⁸ M Brazier and J Miola, ‘Bye Bye Bolam - A Medical Litigation Revolution?’ (2000) 8 *Medical Law Review*, 85, 88.

³⁹*Ibid.*

scenarios in relation to Ghana. One possibility is that there is an absence of a discrete body of HCL in Ghana, for which reason an effort is being made to draw lessons from a jurisdiction like England and Wales, which has a matured field of HCL. The other possible interpretation of the second limb of the research question could be that a discrete body of HCL is already extant in Ghana, but it is woefully inadequate or unsatisfactory, so there is the need to draw lessons from England and Wales in order to make improvements in Ghanaian HCL. In this thesis, I shall adopt the first interpretation of the second limb of the research question. Consequently, the thesis proceeds on the fundamental assumption, which I test and confirm in Chapter Four, that Ghana does not have a discrete legal field that may be called HCL, or which may go by any of the equivalent labels usually assigned in the field.

In order to probe this two-limbed research question, it is necessary to reduce it to a hypothesis, which can be tested. In relation to the first limb, the hypothesis can be stated as: the quest for patient empowerment and the legal academic interest in medical advances accelerated the emergence of HCL as a distinct body of law in England and Wales. The import of the first hypothesis is that the field of HCL in England and Wales did not emerge in a vacuum, but was the product of a complex interaction between an increasing demand for respect for patient rights and the research interest which legal academics have developed in issues arising from medical advances. The second hypothesis of this thesis, which may be derived from the other limb of the research question, may be stated as: the need to protect patients' rights and enhanced public awareness of the implications of medical advances should necessitate the development of a distinct body of HCL in Ghana.

1.3. RESEARCH OBJECTIVES AND JUSTIFICATION OF CHOICE OF COMPARATOR JURISDICTION

This thesis seeks to achieve four objectives, namely:

- a. to clarify the status of healthcare law as a legal field and academic discipline in England and Wales;
- b. to explore the historical context of the development of HCL in England and Wales;
- c. to survey Ghanaian law for the existence or absence of a distinct body of HCL through the prism of English and Welsh HCL, and
- d. to explore potential lessons that can be drawn by Ghana from the development of HCL in England and Wales.

Notwithstanding the existence of many other countries with a discernible field of HCL, my choice of England and Wales as a comparator jurisdiction is a well-considered one and can be justified on historical, doctrinal and practical grounds. As noted above, historically, Ghana was a British colony and its legal system is modelled upon the legal system and legal tradition of the former colonial ruler. Consequently, both Ghana and England and Wales (broadly speaking, Great Britain) share a common conceptualisation of law. Related to this historical nexus is a doctrinal compatibility. The judicial practice in Ghana reveals that Ghanaian courts continue to follow legal concepts and reasoning as embodied in English and Welsh decisions and rarely depart from them, except where absolutely necessary. The tendency to follow English and Welsh legal doctrines is also observable in the context of law-making via Parliament. Some statutes adopted even after independence draw inspiration from English statutes.⁴⁰ Thus, the historical and doctrinal links make it reasonable to use England and Wales as a basis for exploring the case for the development of a discrete body of HCL in Ghana. There are other common law jurisdictions, like Canada, Australia, and New

⁴⁰ For example, see: Ghana's Contract Act, 1960; the Data Protection Act, 2012, and the UK's Law Reform (Frustrated Contracts) Act, 1943 and Data Protection Act, 1998.

⁴¹ K Veitch, *The Jurisdiction of Medical Law* (Aldershot: Ashgate Publishing Limited 2007) 149.

Zealand that have a discrete body of HCL, but they do not have historical connections with Ghana.

1.4. ORIGINALITY AND SIGNIFICANCE OF THE STUDY

Undoubtedly, some commentators have earlier endeavoured to explore whether HCL has attained the status of a field of law (or a discrete body of law), they do so in rather perfunctory manner. Nevertheless, Veitch's monograph, *The Jurisdiction of Medical Law*, is the only work which is specifically dedicated to exploring the nature of HCL as a legal discipline in England and Wales. It seeks to test the rhetoric of academic medical law that 'ethical issues arising in the course of medical practice and from applications of technological developments in biomedical science should be determined outside of medicine, and that the most appropriate site for this ought to be the law.'⁴¹ Veitch concludes that the realities of the institutional framework of common law within which the courts operate tend to result in a situation whereby the real ethical or moral conundrum presented by HCL cases is side-stepped by the courts. Veitch's work does not follow traditional approaches to the subject, as can be found in the textbooks⁴² which explore almost all the key themes⁴³ of the discipline, and in the monographs⁴⁴ that usually address one HCL theme, since the discussion and analysis do not revolve around a particular area of, or issue within HCL. In fact, cases from different spheres of HCL are used for the purpose of

⁴¹ K Veitch, *The Jurisdiction of Medical Law* (Aldershot: Ashgate Publishing Limited 2007) 149.

⁴² For textbooks, see: J K Mason and GT Laurie, *Mason and McCall Smith's Law and Medical Ethics* (8th edn, Oxford: Oxford University Press 2010); J Montgomery, *Health Care Law* (1st edn, Oxford: Oxford University Press 1997); M Davies, *Textbook on Medical Law* (2nd edn, London: Blackstone Press Ltd 1998).

⁴³ As established by an empirical survey reported in Chapter Three.

⁴⁴ For examples of just two of the many HCL monographs, see: S Fovargue, *Xenotransplantation and Risk: Regulating a Developing Biotechnology* (Cambridge: Cambridge University Press 2012); A McLean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (Cambridge Law: Medicine and Ethics 2009).

developing his arguments.⁴⁵ This is one point of intersection between Veitch's work and my thesis.

Nevertheless, I do not merely repeat or rehearse his work since my thesis goes further than such boundaries. In the first place, as far as the first limb of my research question is concerned, unlike Veitch's work, my thesis explores the existence of this field of law through an empirical investigation and doctrinal evaluation. Another aspect of originality within my thesis with respect to the first limb of the research question is that it does not limit its scope of investigation purely to common law but includes statutory and quasi-statutory sources in its investigations; at least to the extent of gauging the empirical foundation of HCL's claim to a discrete status. Moreover, this thesis has systematically collected and analysed empirical data to verify the assertion in the literature that HCL is a distinct discipline because it has secured a place in the curriculum of law schools and research agenda of academics. Additionally, I have ascertained the views and reflections of pioneering scholars on the evolutionary trajectory of this field of law through empirical research; this aspect fills an important gap in the existing literature which has hitherto failed to provide such a detailed account of the contribution of the first generation of HCL academics in the development of the discipline.

The significance of this study should not be overstated; its remit is evident from the focused statement of the double-barrelled research question. Nevertheless, two points are worth canvassing in relation to the two jurisdictions to be studied. It is certainly true that an enormous amount of academic research has been conducted in relation to English HCL, but, as pointed out above, there is a missing link in the literature concerning the historical evolution of this field of law as seen through the lens of pioneering scholars. This thesis

⁴⁵ K Veitch, n 41 above, 9.

seeks, among other things, to fill this gap. With respect to Ghana, it is therefore both historic and significant, one central argument being that the development of a discrete body of HCL - currently lacking in Ghana – together with other social and cultural changes could assist in containing the existing excessive medical paternalism and would thereby facilitate patient empowerment. An important related aspect of this thesis is the plea being made to initiate the legal regulation of medical advances imported from abroad into healthcare in Ghana. It is significant to note that until this research was undertaken, there had never been a comprehensive, focused analysis of Ghanaian law and its relationship with healthcare. As a legacy of this thesis, its initial exploratory research⁴⁶ culminated in the first ever entry on Ghana in the *International Encyclopedia of Medical Law*.⁴⁷ This maiden entry further reinforces one of the central arguments in this thesis, that until my present research, there was no instance in the literature where all the relevant Ghanaian statutes and cases on healthcare were brought together into a single analytical work. However, it is important to clarify here that the contribution on Ghana to this international encyclopaedia does not suggest there is a discrete field of HCL in Ghana. Indeed, this contribution is just the first step in a long journey towards a matured field of HCL in Ghana which would be functionally equivalent to the role of HCL in England and Wales.

1.5.0. SOME PRELIMINARY ISSUES

In order to situate the thesis in a proper context it is necessary to address some preliminary issues including appropriate label or description of the field of law to which the thesis belongs as well as a justification for a watershed period or commencement of this field of law.

⁴⁶ That is, research leading to a write-up of Chapters Four and Six.

⁴⁷ E Owusu-Dapaa, 'Ghana' in H Nys (ed), *International Encyclopaedia of Laws: Medical Law* (Alphen aan den Rijn, (NL: Kluwer Law International 2014) 131.

1.5.1 TERMINOLOGICAL CLARIFICATION

The existing literature is replete with varying labels or designations for this field. Typically, one may come across terms such as ‘medical law’, ‘health care law’, ‘health law’, or ‘law and medicine’. Some of these designations may also quite rightly have ‘ethics’ attached to them. My overriding concern in this thesis is to chart the legal aspects of healthcare or medical practice within the remit of my research question. Consequently, I exclude the ‘ethics’ component from my present analysis in this section, as regards designations for the field. It is indisputable that HCL goes hand in hand with ethics and so my decision to exclude ethics from the title of this thesis should not be taken to suggest I contend that ethics is irrelevant, but rather that law is my central concern. Nevertheless, the line between ethics and law in the context of healthcare is often difficult to draw. As Jackson has aptly noted, ‘it would be artificial to draw a sharp distinction between medical law and ethics.’⁴⁸ Ethical discourse plays a role in legal analyses in this field of the law. Indeed, the number of textbooks written by pioneer scholars in this field, as presented in Table 2 in Chapter Three, which do not include ethics in their titles, substantially outnumber those that do, despite the fact they still include ethics in their treatment. The extent of the usage of ‘ethics’ in designations for this field of law in school curricula in England and Wales is addressed in Chapter Three.

The name or title by which a field of law is identified is a signpost to its nature and scope. However, the challenge of finding an appropriate name for a discipline is not unique to this area of law. There are many examples of naming a subject based upon a key aspect of identity and, sometimes, of its very existence. These include Tort versus Torts; Conflict of

⁴⁸ E Jackson, *Medical Law –Text, Cases, and Materials* (Oxford: Oxford University Press 2010) 3.

Laws versus Private International Law, and Comparative Law versus Law of Comparison.⁴⁹ In the evolution of HCL, different names have been adopted by scholars in referring to this new field. Montgomery, and McHale and Fox use the 'health care law' label for their works,⁵⁰ whereas 'medical law' is the preferred description put forward by Kennedy and Grubb,⁵¹ Hope,⁵² and Brazier and Glover.⁵³

Each of the different titles adopted by scholars of this discipline has its underlying assumption regarding the subject matter or core themes of the discipline. Those who adopt the title 'medical law' or its variants, such as 'medical law and ethics', tend to perceive the core subject matter as the legal enforcement of the resolution of ethical dilemmas arising in the doctor-patient relationship. For example, Kennedy and Grubb have argued that medical law is 'essentially concerned with the relationship between health care professionals (particularly doctors and to a lesser extent hospitals or other institutions) and patients.'⁵⁴ This approach to delineating the scope of this field begins with the work of doctors and proceeds outwards. The doctor-patient relationship is thus at the heart of the discipline, and this influences both the content of the subject and its underlying conceptual coherence. Montgomery has critiqued such an approach for individualising its focus in the application of ethical principles to the context of relationship.⁵⁵ The problem inherent in the approach led by Kennedy and Grubb to the field is that by restricting the subject's scope to issues raised in a clinical or medical context, a number of important areas are potentially excluded. Areas of

⁴⁹ See generally: E Orucu, *The Enigma of Comparative Law Variation on Themes for the Twenty-First Century* (Leiden: Martinus Nijhoff Publishers 2004) 7-18; PD Cruz, *Comparative Law in a Changing World* (London: Routledge-Cavendish 2007).

⁵⁰ J Montgomery, *Health Care Law* (Oxford: Oxford University Press 2003); J McHale and M Fox, *Health Care Law: Text and Materials* (2nd edn, London: Sweet and Maxwell 2007).

⁵¹ I Kennedy and A Grubb, *Medical Law: Text and Materials* (3rd edn, London: Butterworths 2000).

⁵² RA Hope, 'The Birth of Medical Law' (1991) 11 *Oxford Journal of Legal Studies*, 247, 253.

⁵³ M Brazier and N Glover, 'Does Medical Law Have a Future?' in D Hayton (ed), *Law's Future(s)* (Oxford: Hart Publishing 2000) 371.

⁵⁴ I Kennedy and A Grubb, *Medical law* (London: Butterworths 1989) 1.

⁵⁵ Montgomery, n 50 above, 1.

equal importance that risk exclusion under this paradigm include other health professionals, the health institutions that provide the platform for the delivery of health care, and public health and global health issues.⁵⁶ It is thus not surprising that some scholars, including Sheldon and Thomson⁵⁷, Hervey and McHale⁵⁸ and Cruz⁵⁹ have questioned the suitability of Kennedy and Grubb's label and definition of the discipline.

In contrast, Montgomery, one of the leading proponents of the title 'health care law', rejects the doctor-patient paradigm. Rather, he contends that the subject ought to be defined in terms of the country's 'international obligation to tackle health problems and ensure that citizens have access to health care that they need.'⁶⁰ His approach appears attractive, except in one significant respect. The attempt to define HCL in terms of the state's obligation under international instruments to address health problems can potentially overstate the boundaries of the subject, due to the elastic nature of the concept of health, which could result in almost every aspect of law and policy being considered as falling within the scope of the subject. The objection to defining HCL as having illimitable scope is that it would risk a lack of coherence or conceptual unity and undermine its claim to a discrete status in the legal academy.

Nevertheless, a broad conception of the subject as contemplated by Montgomery's approach has 'the advantage that it extends beyond those legal measures, to link health law and policy to other social policy fields, such as poverty or social exclusion'.⁶¹ Despite Montgomery's personal preference for the label 'health care law', he concedes that what is

⁵⁶ Ibid.

⁵⁷ S Sheldon and M Thomson (eds), 'Health Care Law and Feminism: A Developing Relationship' in S Sheldon and M Thomson, *Feminist Perspectives On Health Care Law* (London: Cavendish Publishing 1998) ch 1.

⁵⁸ TK Hervey and JV McHale, *Health Law and European Union* (Cambridge: CUP 2004) 17.

⁵⁹ PD Cruz, *Comparative Healthcare Law* (London: Cavendish Publishing Ltd 2001) iv.

⁶⁰ Montgomery, Ibid n 50.

⁶¹ J McHale and M Fox, *Health Care Law: Text and Materials* (London: Sweet and Maxwell 2006) 8.

in vogue since the emergence of the discipline is the 'medical law' label.⁶² For the purposes of this thesis, my preferred label for this field is HCL because it provides the discipline with a broader focus and encompasses other health care professionals, such as nurses. It offers a truer representation of the legal regulation of health care delivery than the narrower focus of the doctor-patient relationship that medical law suggests. In their contribution to 21st century reflections on British legal developments, Brazier and Glover comment on the different titles or labels used for the discipline:

The difference between these two approaches [medical law and health care law] is more than just nomenclature. Medical law which focuses on a relationship between doctors and patients remains in essence a creature of private law. Albeit NHS patients have no contractual relationship with their doctors, echoes of contract still haunt their encounters. Health care law is located more firmly in public law. Doctors are shifted to the margins of debate. The needs, and even rights, of individual patients must be viewed within a wider context of protecting health and promoting public goods. A shift from medical law to health care law seems inevitable. We suggest that what we now call medical law will undergo much greater upheaval than simply a change of name. Society's understanding of illness is in flux.⁶³

These observations are an accurate assessment of the state of affairs with respect to this discipline, but the suggestion that medical law is a creature of private law and that HCL is located in the realm of public law is not a complete portrayal of the public/private law dimensions of this discipline. Brazier and Glover argue that medical law is a private law creation because it focuses on the doctor-patient relationship, but since the emergence of the discipline post-1980, and even before the more modern label of HCL, the focus has not only been on the doctor-patient relationship. In fact, issues such as the institutional arrangements of healthcare delivery, resource allocation and public health have also

⁶² J Montgomery, 'Medical Law in the Shadow of Hippocrates' (1989) 52 *Modern Law Review*, 566-576; J Montgomery, 'Time for a Paradigm Shift? Medical Law in Transition' (2000) 53 *Current Legal Problems*, 363 - 408.

⁶³ *ibid* n 53.

engaged the attention of scholars and law makers.⁶⁴ In my view, whether the discipline is labelled 'medical law' or HCL, it generates issues that transcend the private/public law dichotomy. As the subject matter of the discipline expands in leaps and bounds, it may be desirable to conceptualise medical law as a subset of HCL. For example, Brazier and Glover have predicted that since significant aspects of healthcare enjoyed by the young and aged are delivered by both 'social care and healthcare providers', it is indicative of the fact in the foreseeable future HCL may be integrated social welfare law.⁶⁵ Nevertheless, as stated above, my preferred label throughout this thesis will be HCL. My preference for HCL is further reinforced by the view 'that while the regulation of the doctor-patient relationship is important, such a restricted focus in determining a field of socio-legal enquiry has the effect of excluding a number of other key areas, and is thus in danger of providing an unrepresentative approach to the legal regulation of healthcare delivery.'⁶⁶

1.5.2 ATTEMPTING TO DATE THE COMMENCEMENT OF HEALTH CARE LAW AS DISTINCT BODY OF LAW.

It is not an easy task to pinpoint time period within which HCL emerged with exactitude. In my view, identifying a precise commencement date for the discipline of HCL is rather difficult. This is especially so since, in a broad sense, it could be argued that there has always been some sort of medico-legal regulation from the very inception of law in society. Thus, there has always been some form of regulation of medicine even going 'as far back from the Hammurabi Code of the ancient Babylonian empire, through the Hippocratic Code of Greek

⁶⁴ JK Mason and GT Laurie, *Mason & McCall Smith's Law and Medical Ethics* (Oxford: Oxford University Press 2006) ch 1-3; E Jackson, *Medical Law –Text, Cases, and Materials* (Oxford: Oxford University Press 2010) ch 2, 6 and 7; I Kennedy and A Grubb, *Medical Law* (3rd edn, London: Butterworths 2000) ch 2 and 3.

⁶⁵Ibid n 53.

⁶⁶ TK Hervey and JV McHale, *Health Law and European Union* (Cambridge: CUP 2004) 15.

Medicine which spread into the Roman Empire.⁶⁷ Nevertheless, a reasoned estimate of the temporal context will illuminate our appreciation of the historical trajectory of the discipline. As I have noted elsewhere it would be ‘helpful to identify an *era* in which the discipline became visible in academic circles and public discourse.’⁶⁸ There are differing opinions as to when HCL was ‘born’ or ‘developed’ in England and Wales. One could date HCL in England and Wales back to 1858, ‘when, after 20 years of negotiation, the British Medical Association’s (BMA) Medical Reform Committee, successfully secured the passing of the Medical Act, 1858.’⁶⁹ The Act established the General Medical Council (GMC) and the Medical Register, which distinguished, for the first time, between qualified and unqualified practitioners.⁷⁰ Roberts has opined that the passage of the Act was ‘a distinctive version of medical reform’ since ‘MPs were acting to mediate, not just between divergent strands of a still fluidly defined profession, but between professional and lay conceptions of the role of the medical practitioner as well.’⁷¹ Thus, if HCL is understood merely as the existence or creation of statutes to regulate the practice of medicine in order to safeguard the public from the hazards of quackery, then 1858 may be a viable proposition as the date HCL first appeared. On the other hand, if HCL as a distinct body is to be understood as having a well-defined place in the legal academy and in particular having attained most of the defining characteristics identified in Chapter Three, then 1858 would not be the start date for the discipline. HCL was not then taught as a course in universities, nor did it have a significant

⁶⁷ D Konold, ‘Codes of Medical Ethics (History)’ in *Encyclopaedia of Bioethics* (New York: McMillan 1978) 162-172.

⁶⁸ E. Owusu-Dapaa, ‘Historical Development Of Health Care Law And Bioethics In England And Wales: A Symbiotic Relationship’ (2014) 33 (1) *Medicine and Law* 22, 28.

⁶⁹ MJD Roberts, ‘The Politics of Professionalisation: MPs, Medical Men, and the 1858 Medical Act’ (2009) 53 *Medical History*, 37, 38. (references omitted)

⁷⁰ *Ibid.*

⁷¹ *Ibid.*

volume of dedicated legislation or case law in this jurisdiction.⁷² Scholarly writing in the area was virtually non-existent compared to the situation post-1980.⁷³

Another possible start date for HCL may be 1958, when Glanville Williams published the seminal HCL-related book entitled, *'The Sanctity of Life and the Criminal Law.'* He presented controversial arguments relating to thought-provoking issues, such as euthanasia, abortion, contraception, sterilisation and artificial insemination. Undoubtedly, Williams' work was remarkable for being a pioneering effort by an academic lawyer to engage in an analysis of these complex ethical issues arising in the delivery of healthcare. However, it did not have a dramatic impact on the evolution of HCL as a discrete subject. A plausible explanation for this is that the major medical advances which were to excite public interest in the legal regulation of bioethical dilemmas had not then crystallised. Therefore, while literature⁷⁴ on the interface between law and healthcare has been published since the nineteenth century, I consider the period between 1980 and 2000 to be the defining years for HCL as a distinct branch of English law because it was during those two decades that the discipline became sufficiently visible and effectively met the criteria identified in Chapter Three as the hallmark of a distinct body of law.

As it has been argued in Chapter Five there is no doubt that there has always been a relationship between law and medicine. Nevertheless, it is my submission that an exploration of the emergence of HCL as a distinct discipline needs a particular moment of commencement. Thus, the use of 'new' as a qualifier to HCL is intended to avoid creating a misleading impression that healthcare or medical practice became subject of legal

⁷² See: Chapter Three of this thesis.

⁷³ Ibid.

⁷⁴ For example, AS Taylor, *Elements of Medical Jurisprudence* (London: Deacon 1836); JT Smith, *The Laws of England Relating to Public Health* (London: S. Sweet Ltd. 1848); DH Kitchin, *Legal Problems in Medical Practice* (London: Butler and Tanner Ltd. 1936).

regulation after 1980. On the contrary, the period 1980-2000 has been carefully selected in this thesis as the most plausible period during which HCL in England and Wales fully exhibited the working criteria or characteristics of a legal field. A more nuanced justification for the choice of the historical period is provided for in Chapter Five.⁷⁵

At this stage of the setting the scene for the substantive discussions few key points are worth underscoring. In the first place, in accordance with the overwhelming consensus of pioneering HCL scholars (as discussed in Chapter Five) that period 1980 to mid 1980 is a watershed moment in academic interest in HCL due largely to the huge public interest generated by Ian Kennedy's *Unmasking Medicine's* lecture and publication. Secondly, it might be contended that the period mid-1980 to early 1990s are the most conservative period in English HCL, with *Bolam* running rampant and patients' rights totally ignored. Brazier and Miola⁷⁶ as well as other commentators⁷⁷ have rightly noted that the courts application of Bolam test suggested that they had abandoned their judicial duty to protect patient rights by failure to examine professional judgement of medical doctors. It was rather surprising that the courts were extremely deferential towards doctors (unlike other professionals) leading to neglect of the patient.⁷⁸

⁷⁵ See Section 5.1.6 of the Thesis below

⁷⁶ M. Brazier, J. Miola, 'Bye- Bye Bolam- A Medical Litigation Revolution?' (2000) 8 *Medical Law Review* 85.

⁷⁷ For example, see J. Keown 'Doctor Knows Best? The Rise and Rise of "The Bolam Test"' (1995) *Singapore Journal of Legal Studies* 342.

⁷⁸ *Ibid*, 364.

1.6. KENNETH VEITCH'S *JURISDICTION OF MEDICAL LAW* IN EXPLORING THE NATURE OF HEALTH CARE LAW

As earlier pointed out Kenneth Veitch is one author who has extensively engaged the issue of what HCL (or Medical Law) is. It is helpful that his work is used as a foundation for the discussion in this thesis relating to the relationship between development of a discrete discipline of HCL and its potential to contribute towards patient empowerment. The question concerning what is the nature of Health Care Law (HCL) is a proper one to ask as for many good reasons. Firstly, it 'relates to the attempt to determine the scope of the subject', that is, 'identifying the nature of the actors and topics that ought to constitute the subject's focus of study'.⁷⁹ Secondly, it is necessary intellectual inquiry because of 'its novelty as an academic subject'.⁸⁰ Moreover, reflecting on the nature of HCL enables us to 'delineate its boundaries'⁸¹ and its relationship with other branches of law including tort, criminal law, property law, contract and public law. Engaging the question relationship between HCL and other branches of law is a worthy intellectual effort because of the argument by critics that HCL is just 'an amalgam of traditional categories of tort and criminal law'.⁸²

HCL is to be properly seen as 'a responsibility' rather than as 'a prescriptive set of legal category'.⁸³ Indeed, Veitch rightly contend that '[m]edical law is not simply about law; rather the questions and issues with which it is concerned have "philosophical, ethical sociological and political dimensions" too'.⁸⁴ The question of defining 'medical law' is not

⁷⁹ N 41 above, 14.

⁸⁰ Ibid.

⁸¹ Ibid 14.

⁸² Ibid 15. (reference omitted)

⁸³ Ibid; Also see I Kennedy, A. Grubb, *Medical Law* (1st edn, London: Butterworths,1989), p.3

⁸⁴ Ibid 16. (reference omitted)

really about ‘the need to delineate boundaries’ rather ‘it points to the need to acknowledge that medical law transcends the traditional legal requirement for a clear and settled framework’.⁸⁵ According to Veitch, ‘if medical law has a definable feature at all it might be thought to reside in the nature of the problems it seeks to address (problems arising from developments in medicine and biomedical science that engage questions of human values)’.⁸⁶ These problems studied in HCL are said to be ‘multifaceted’ and so ‘pressing’ that they defy ‘clear boundaries’.⁸⁷

The academic study of HCL tends to challenge medical profession’s monopoly over resolution of ‘moral problems in medical practice’ that fall outside the technical knowledge properly so-called- ‘diagnosis, prognosis and treatment options available’.⁸⁸ On the contrary academic HCL contend that ‘the ground rules of settling moral’ or ethical dilemmas in medicine ‘must be set by society’ through instrumentality of law.⁸⁹ Indeed, Kennedy and other HCL scholars basically identify protection of rights of patients (in the sense of negative and not-claim right) and the external determination of ethical standards in medicine as the ‘guiding features of medical law’.⁹⁰ Veitch has argued that the ‘claim for jurisdiction’ for law in the resolution of moral/ethical dimensions of medicine has also got the other collateral benefit of ‘legitimizing’ the sphere of HCL academics.⁹¹

Veitch has expressed a well-founded concern that ‘the aspirational character of much of the legal academic commentary in this field- together with the need to stress the significance of ethical principles as a means by which to distinguish medical law as a subject in its own

⁸⁵ Ibid.

⁸⁶ n 41 above,16.

⁸⁷ Ibid 17.

⁸⁸ Ibid 19.

⁸⁹ Ibid 19 (reference omitted)

⁹⁰ Ibid 25.

⁹¹ Ibid 19.

right-'has resulted in the neglect of the 'fundamental business of inquiring into the actual working practices of the common law and the consequences of the manner in which these operate'.⁹² In this regard there arises a need to justify the status of a HCL as 'a legitimate new subject whose conceptual foundations and specific field of competence can clearly be distinguished from other more traditional , legal subjects as contract, tort and criminal law'.⁹³ The ultimate outcome of developing legal jurisdiction through the development of a discrete body of HCL 'is meant to convey to medicine and science that they can no longer expect to exercise exclusive control over the consequences of their practices'.⁹⁴ That said, there still remains a question as to what relationship exist between the HCL and other law subjects particularly the such traditional branches as tort, contract, criminal law, property and public law. Exploring these relationship will invariably illuminate our appreciation of the boundaries between HCL and those other legal disciplines.

1.7. HEALTH CARE LAW AND OTHER BRANCHES OF LAW

The assertion that HCL is a discrete subject or field of law like others is likely to be greeted with the expectation as to whether it has got its own framework of substantive rules or principles like the others. It is thus crucial that one develops a better understanding of the status of HCL in order not to conflate it with settled doctrinal framework as in tort and others. Davies aptly sets the tone for exploring the relationship between HCL and 'the general law' when he remarks that:

Criminal law, the law of torts, property, contract, family law and public law may at times apply in the medical context, but the traditional rules of those branches of

⁹² Ibid 31.

⁹³ Ibid 31.

⁹⁴ Ibid 32.

law have been strained and bent, if not at times broken, where medicine is in issue.⁹⁵

To start with HCL relies upon tort principles in some type of cases. Typically, grievances in the nature of medical injuries or malpractices may be pursued as either negligence or battery. Although the conventional requirements of tort must be satisfied, HCL presents additional dimension in the analysis as to whether certain elements are met or not. For example, in establishing the tort of battery it is critical to negative consent but what constitutes a valid consent may be given strained meaning in HCL. A consent which was not based upon adequate disclosure to the patient may, for example, not be considered as valid consent. Thus, tort principles are deployed but in a unique context and given a different emphasis.⁹⁶

Similarly, when claims from healthcare context are framed as tort of negligence all the usual ingredients of that tort need to be established but standard of care in relation to breach of duty as well as causation (for determining resultant or consequent damage) will be bent or modified to reflect peculiar consideration of HCL.⁹⁷ Indeed, Miola has ably noted that the Bolam principle enunciated originally for medical negligence had been extended to shape many areas of HCL until recently.⁹⁸ Furthermore, conventional principles for quantification of damages for breach of contract are modified in some respect when they are being applied to HCL cases. For example, due to inability to give absolute assurance

⁹⁵ M. Davies, *Text Book on Medical Law* (2nd edn, London: Blackstone Press Ltd 1998), 3.

⁹⁶ See Extract of Interview with Professor Grubb, Appendix 1. I have discussed this in a nuanced way in Chapter 5.

⁹⁷ For extensive discussion of these see, J. Miola 'Bolam v Friern Hospital Management Committee [1957]: Medical Law's Accordion' in J. Herring & J. Well (eds.) *Landmark Cases in Medical Law* (Oxford: Hart Publishing, 2015), Ch.2;

⁹⁸ Ibid.

regarding treatment or procedures involving human health, it has been held that an action for breach of contract in the event of pregnancy after vasectomy will not lie.⁹⁹

What the foregoing examples suggest is that HCL still relies on other branches of law with some necessary modifications appropriate to the special circumstances of healthcare. It needs to be emphasized that this borrowing from other branches of law does not deprive HCL of its status as a discrete subject. Thus, the claim of HCL being a discrete body is to be properly understood as a distinct academic discipline. This has been discussed extensively in Chapters Three and Five.

1.7. THE STRUCTURE OF THE THESIS

Following on from the present introductory chapter, the thesis has six chapters, including the Conclusion. Chapter Two explains and justifies the methodology adopted for the research. It is indicated in Chapter Two that a blend of three legal research methodologies is utilised for investigating the research problem. These are: functional comparative methodology, legal history and empirical legal studies. Functional comparative methodology (FCM) proceeds from the premise that the transplantation of a panacea designed in one legal jurisdiction as an answer to a legal conundrum in another jurisdiction is conceptually flawed due to the unavoidable cultural and other factors underlying the legal institutions in each country. Nevertheless, FCM concedes that legal problems extant in one country may be equivalent or approximate to the legal problems encountered in other countries that have some similarities in the underlying characteristics of their legal systems. Consequently, as will be apparent in Chapter Two, FCM suggests that so long as some

⁹⁹ *Thake v. Maurice* [1986] Q.B. 644

common features can be identified as being shared by two jurisdictions, a legal problem can be conceptualised for the purpose of exploring legal solutions devised in one jurisdiction that serve the equivalent function of the answers provided in the other jurisdiction. Thus, the emphasis of FCM, as further elaborated upon in the chapter, is not to locate a similar or exact replica of a legal panacea for a problem adopted by a reference jurisdiction in the other jurisdiction being compared. Rather, it explores the degree of functional equivalence between solutions adopted by two jurisdictions in response to a common problem. In relation to HCL and in tandem with the emerging trend in the literature, I have adapted FCM slightly for the purpose of undertaking a sensible examination of the research problem. To this extent, I have borrowed the methodology of 'lesson-drawing' as a slight modification of the FCM. This means that for some areas of the legal problem being studied, where functional equivalence is not realistic due to the absence of effective incorporation of certain medical technologies into healthcare in Ghana (obviously due to economic constraints), I seek to explore useful lessons that Ghana may draw from England and Wales as it comes to regulate those aspects of healthcare in the foreseeable future. The actual application of FCM and its supplementary lesson-drawing are indicated in a more nuanced manner in the chapter.

Moving on to Chapter Three, the thesis examines the assumption often taken for granted in the literature that HCL in England and Wales is a discrete body or distinct legal field. Four key issues will be addressed in the chapter. In the first place, I shall contextualise the issue of the discrete status of HCL by looking beyond HCL to a more fundamental question in legal theory of what constitutes a legal field (or discrete body of law). The chapter concedes that there is no formulaic prescription of what a legal field is, but draws upon reflections by some commentators on the issue of the legitimacy of certain new

disciplines of law as discrete fields. This yields a working framework that enables the chapter to construct what may be taken as indicia of a discrete body of law. Equipped with these indicators of a legal field, the chapter proceeds to evaluate HCL as constituted in England and Wales (between 1980 and 2000) in order to determine whether those requirements or characteristics of a legal field are satisfied. Chapter Three utilises empirical data from two surveys conducted to buttress some aspects of its claim that HCL emerged as a discrete field of law during the last four decades. Another issue explored in the chapter is the scholarship orientation that can be discerned so far from scholarly works in the field of HCL. Four strands of scholarship are identified, namely: the medical ethics-oriented approach; the human rights-based approach; the multi-method or pragmatic approach, and socio-legal approaches.

In Chapter Four, proceeding from the FCM framework and aided by the lesson-drawing technique, the thesis explores the existence or absence of a discrete body of HCL in Ghana through the prism of proven characteristics of HCL in England and Wales. Consistent with the two limbs of the working hypothesis, the thesis identifies two cardinal problems in Ghana: the disempowerment of patients through longstanding, unchallenged and excessive medical paternalism and the regulatory vacuum in relation to legal and ethical dilemmas medical advances imported into the country. Having already contended in the previous chapter that a discrete body of HCL in England and Wales emerged largely in response to these two problems, Chapter Four explores first whether a discrete body of HCL exists in Ghana and secondly, whether the two major factors contributed to the development of a field of HCL in England and Wales are discernible in Ghanaian society.

The contributory factors for the emergence of a discrete body of HCL in England and Wales are considered in Chapter Five. First, the chapter explores the extent to which the

revival of liberalism and human rights thinking in the post-Second World War era impacted on the evolutionary trajectory of this field of law. The projection of individual liberty and its concomitant assertive citizenry are assessed in the chapter. Related to this is the distrust of the healthcare profession and biomedical science in general following the scandalous scientific behaviour reported during the Nuremberg Trials and questionable medical experiments undertaken on both sides of the Atlantic prior to 1970. The phenomenal role played by the media in stimulating public awareness and interest in various aspects of healthcare is explored in this chapter. In this regard, I contend that the media has assisted by unearthing scandalous medical practices and publicising formal inquiries into healthcare scandals. A related argument advanced in this chapter is that the media does not just convey disturbing news about healthcare, but also positive and exhilarating news regarding breakthroughs in medical advances. In particular, the spectacular effect of the BBC Reith Lecture series (1980-81) on the theme, *“Unmasking Medicine”* in providing a platform for a nationwide critical reflection on perceived excessive medical paternalism and medicalisation will be analysed in this chapter. Also, the chapter explores how popular culture contributed to liberalisation of the law. Finally, the chapter fills an important gap in the literature on HCL by presenting for the first time the views and concerns of pioneer scholars in the field regarding HCL’s development and orientation.

In Chapter Six, I examine the issue of whether a case can be made for the conscious development of a discrete body of HCL in Ghana. Proceeding from the premise of the second hypothesis - that *the need for protecting patients’ rights and enhanced public awareness of implications of medical advances could facilitate the development of a distinct body of HCL in Ghana* - I shall first argue in this chapter that the reality reveals patient disempowerment in Ghana as a result of many factors. The multiple layers of this

phenomenon are concretised by documentary analysis of media reports and the factual matrices of decided cases. Secondly, the chapter engages in the lesson-drawing aspect of FCM by carefully adumbrating those aspects of the English and Welsh experience that can provide useful lessons for Ghana as it seeks to develop its HCL. Moreover, the chapter develops an argument for a human rights paradigm of HCL to take centre stage in the development of a discrete body of HCL in Ghana. Essentially I argue that the features of a human rights-based approach can fit easily in Ghana as it has nurtured a constitutionally-based human rights culture since 1993. This will set the tone for the concluding chapter (Chapter Seven).

In Chapter Seven, I provide a closing argument to conclude the thesis. The chapter revolves around four themes. First, I shall provide a summary of the salient arguments and findings advanced in each of the preceding chapters. Then I shall engage with the research question and hypotheses in the light of the research findings so far articulated, with a view to assessing the extent to which the research objectives have been achieved. Thirdly, I shall present considered recommendations to assist Ghana in its quest to develop HCL. Finally, I shall highlight the limitations of my thesis and flag up certain issues for further research.

CHAPTER TWO

RESEARCH METHODOLOGY AND THEORETICAL ORIENTATION

2.1. INTRODUCTION

This chapter provides an articulation of the methodology underpinning the thesis. Explaining the methodology adopted in this thesis is not merely an example of pedantry or a luxury, but it is critical for the epistemological validity of the contribution this research adds to knowledge. The utility of demonstrating awareness of accepted conventions and norms is that it adds to the credibility of the research just as explicit methodology contributes to reliability of scientific research.¹⁰⁰ Until recently, a reflection on a methodology that underpins a research project in law would have been quite uncommon largely due to the fact that for so many centuries legal education has been organised and delivered in a manner which does not emphasise the necessity of clear articulation of one's methodological choices. The status of law as discipline in which academic research can be undertaken like other disciplines for purely epistemological utility has vigorously been commented upon by many scholars.¹⁰¹ It is noteworthy that unlike the longstanding scholarly approach of other disciplines, law in many parts of the world for a long time has

¹⁰⁰ See generally, CW Collier, 'The Use and Abuse of Humanistic Theory in Law: Reexamining the Assumptions of Interdisciplinary Legal Scholarship' 41 *Duke Law Journal*, 193-94; S Bartie, 'The Lingering Core of Legal Scholarship' (2010) 30 *Legal Studies*, 363; M McConville and HW Chui, *Research Methods for Law* (Edinburgh: Edinburgh University Press 2007) 1.

¹⁰¹ See for example, D Manderson and R Mohr, 'From Oxymoron to intersection: an Epidemiology of Legal Research' (2002) 6 *Law Text Culture*, 159.

been taught through vocational training and apprenticeship.¹⁰² The concomitant effect of such an approach has aptly been stated by Chynoweth:

Law, as an academic discipline within universities, has traditionally seen itself as the servant of the legal profession. This has tended to generate a scholarship that replicates the professional work, and the underlying assumptions, of its practitioners.¹⁰³

As a result of this reality, methodological awareness extant in academic research in other fields of knowledge until recently has not engaged attention of legal scholarship.¹⁰⁴ Nevertheless, the inevitability of confronting methodological issues thrown up by legal research has been highlighted by Salter and Mason:

It is not possible to avoid questions of methodology because all researchers inevitably bring to their tasks a certain interpretation of the meaning and purpose of research. What one discovers through research will always be determined, to some extent, by how one initially sets up the project, the type of questions [one raises] and [the] choice of materials to be studied.¹⁰⁵

In the light of the foregoing the three tasks of this chapter are: first, an exposition of the aims and tenets of the chosen methodology and theories that underpin the research; second, the contextualisation of the selected methodology in relation to the research question, and finally, a justification of its suitability for the thesis.

2.2. THE CHOICE OF A RESEARCH METHODOLOGY FOR MY THESIS AND THEORETICAL ORIENTATION

¹⁰² M Thornton, 'The idea of the University and the Contemporary Legal Academy', 28 *Sydney Law Review*, 487.

¹⁰³ P Chynoweth, 'Legal Scholarship: A Discipline in Transition' (2009) 1 *International Journal of Law in the Built Environment*, no page number. Available at: http://www.emeraldgroupublishing.com/products/journals/news_story.htm?id=1564 (accessed: 2/4/2014).

¹⁰⁴ P Chynoweth, 'Legal Research' in A Knight and L Huddocks (eds), *Advanced Research Methods in the Built Environment* (England: John Wiley & Sons 2009) 28-29.

¹⁰⁵ M Salter and J Mason, *Writing Law Dissertations - An Introduction and Guide to the Conduct of Legal Research* (Essex: Pearson Education Limited 2007) 43.

Undertaking research in law may broadly follow either the traditional black-letter law (doctrinal analysis) approach or socio-legal approaches (I am utilising the term 'socio-legal' here as an umbrella term for all approaches that recognise law as a social phenomenon, including feminism),¹⁰⁶ or a blend of aspects of these approaches. The black-letter law approach looks at the law as a self-contained entity.¹⁰⁷ This approach is anchored upon the thesis of legal positivism that 'in any legal system, whether a given norm is legally valid, and hence whether it forms part of the law of that system, depends on its sources, not its merits'.¹⁰⁸ Thus, a black-letter law researcher would dwell on statutes, case law and academic commentaries on those sources of law as his data for any investigation. A doctrinal research tends to analyse the law 'from an internal view point'.¹⁰⁹ One major criticism of the doctrinal approach is its propensity 'to exclude the context of the law'.¹¹⁰ The unduly narrow focus of this approach 'insulates law from its social, economic, political and cultural contexts that explain how law operates in context.'¹¹¹ In order to overcome this deficit of the black letter approach it may be necessary to adapt or borrow from social science or social theories. This is particularly relevant in HCL, where academic lawyers preoccupation with the interaction between 'bioethical requirements and patients' rights' results in emphasis being placed on the law as it ought to be rather than as it is.¹¹² In this

¹⁰⁶ M Salter and J Mason, *Writing Law Dissertations - An Introduction and Guide to the Conduct of Legal Research* (Essex: Pearson Education Limited 2007) 43.

¹⁰⁷ *Ibid* 43.

¹⁰⁸ J Gardner, 'Legal Positivism: 5 ½ Myths,' (2001) 46 *American Journal of Jurisprudence*, 199.

¹⁰⁹ C. McCrudden, Legal Research and the Social Sciences. *Law Quarterly Review*, 2006; Oxford Legal Studies Research Paper No. 33/2006. Available at SSRN: <http://ssrn.com/abstract=915302> (accessed: ???)

¹¹⁰ R Cotterrell, *Law's Community: Legal Theory in Sociological Perspective* (Oxford: Oxford University Press 1995) 296-314.

¹¹¹ *Ibid*.

¹¹² J. Montgomery. Caroline and H. Biggs, 'Hidden Law-Making in the Province of Medical Jurisprudence' **77(3)** *Modern Law Review* 343, 378; Also see generally J Montgomery, 'The Compleat Lawyer - Medical Law as Practical Reasoning: Doctrine, Empiricism, and Engagement' (2012) 20 *Medical Law Review* 18.

regard, the other methodologies subsumed under the term *socio-legal*, which are non-doctrinal in orientation, are appropriate for the type of research my thesis is founded upon.

Much ink has already been spilt in enunciating the nuances of socio-legal methodology; it is therefore unnecessary to rehearse them.¹¹³ It suffices to succinctly remind the reader core essence of this methodology. Socio-legal approach basically requires the research not only look at the text of the law and judicial decisions but also all other relevant factors and circumstances that variously influence the law and people's behaviour towards the law and its institutions., The research undertaken for my thesis employs a blend of socio-legal methodologies: functional comparative law approach, legal history and empirical legal studies. Having specified my choices of appropriate research methodologies, it is necessary to consider the nature and relevance of each.

2.2.1. FUNCTIONAL COMPARATIVE LAW METHODOLOGY

According to Reitz, 'the comparative method consists in focusing careful attention on the similarities and differences among the legal systems being compared, but in assessing the significance of differences the comparatist needs to take account of the possibility of functional equivalence.'¹¹⁴ The core emphasis of functional comparative law is not really about 'locating the strict formal components of the comparatist's chosen legal system in the foreign law but more crucially the operation of the foreign law in the relevant areas of law'.¹¹⁵

¹¹³ See generally: A Bradshaw, 'Sense and Sensibility: Debates and Developments in Socio-Legal Research Methods' in PA Thomas (ed), *Socio-Legal Studies* (Aldershot: Dartmouth Publishing 1997) 99-122; DR Harris, 'Development of Socio-Legal Studies in the United Kingdom' (1983) 3 *Legal Studies*, 315.

¹¹⁴ JC Reitz, 'How to Do Comparative Law' (1998) 46 *The American Journal of Comparative Law*, 617, 620.

¹¹⁵ K Zweigert and H Kötz, *An Introduction to Comparative Law* (3rd edn, Oxford: Oxford University Press 1998) 34.

Although I am a Ghanaian lawyer, for the purposes of this thesis I use England and Wales as the legal system to be compared with. This is due to the reasons adduced in Chapter One as informing my choice of research question in this thesis. Indeed, my focus in this thesis is not to identify an exact replica of a distinct discipline of HCL, as constituted in England and Wales, in the Ghanaian legal system. Thus, within the language of comparative law, Ghana becomes the foreign law for this matter. This thesis seeks to explore the extent to which there exist rules, institutions and arrangements in Ghana which perform equivalent functions to the body of HCL in England and Wales. Indeed, Zweigert and Kötz have rightly pointed out that the ‘functionality in comparative law should enable comparatists to study the facts behind the law.’¹¹⁶ Husa has also observed that ‘if we follow the thinking of Zweigert and Kötz’s way of thinking, the methodological skeleton-idea would roughly be as follows:

A solution to legal problems can be provided by a custom or by some other social practice not necessarily in an identifiable legal form. The comparatist is thus, in the ideal case that is, trying to find in a foreign system the norms, which are functionally equivalent to those other rules or principles that have been taken into comparison from the other system. The paramount question is: what socio-legal function does the norm under study fulfil in its own societal context?¹¹⁷

Ultimately, the usefulness of this methodology is contingent upon the level at which comparison is being made. At ‘macro’-level, this methodology suggests that ‘the comparison must extend to the same evolutionary stage of different legal systems under comparison and that they should be at the same stage of development, whether, economic, social or legal.’¹¹⁸ However, ‘at the level of micro-comparison’, it is ‘functional equivalence’ which

¹¹⁶ *ibid.*

¹¹⁷ J Husa, ‘About the Methodology of Comparative Law – Some Comments Concerning the Wonderland’ (2007) 5 *Maastricht Faculty of Law Working Paper*, 9 (citation omitted)

¹¹⁸ E Örüçü, ‘Methodology of Comparative Law’ in J M Smits (ed), *Elgar Encyclopedia of Comparative Law* (Massachusetts: Edward Elgar 2006) 443.

really matters..¹¹⁹ This requires that one explores ‘institutions which have the same role or which solve the same problem’.¹²⁰ The rationale for such approach lies in the suggestion by Zweigert and Kötz that the ‘comparatist must assume that different societies face similar needs and that, in order to survive, any society must have (functionally equivalent) institutions that meet these needs.’¹²¹ Admittedly, England and Wales form part of a developed country and Ghana is a developing country. Nevertheless, the common law tradition underpinning the two legal systems, coupled with the predominantly public-funded healthcare system adopted in both countries, provide a legitimate basis for functional comparison. Following the suggestion by Zweigert and Kötz, noted above, it may be safely anticipated that a conscious effort to stimulate development of a body of HCL in Ghana could contribute towards solution to the conundrum of patient disempowerment in Ghana just as the quest for patient empowerment influenced the emergence of a distinct body of HCL. It is therefore apposite that the thesis explores potential parallels or functional equivalence in these two legal systems.

In undertaking the basic comparative task of identifying similarities and differences, the researcher has to consider the scope of comparison: what is going to be compared with what? Despite the controversy over the extent of ‘the problem of a lack of congruity’ Reitz has opined that ‘there is a high degree of consensus that good comparative analysis should pay careful attention to the problem of equivalency by probing how similar and how different the aspects of each legal system under study are.’¹²² In this regard, it is imperative that to carefully explore whether ‘there are ...functional equivalents of the aspect under

¹¹⁹ *Ibid.*

¹²⁰ *Ibid.*

¹²¹ n. 116 above, 39.

¹²² JC Reitz, ‘How to Do Comparative Law’ (1998) 46 *The American Journal of Comparative Law*, 617,621.

study in one legal system inherent in the other.¹²³ According to Zweigert and Kötz, a convenient way to deal with the conundrum of what is going to be compared with what, is to ‘identify a common denominator called “*tertium comparationis*”¹²⁴

The term ‘*tertium comparationis*’ refers to the common point of departure for the comparison.¹²⁵ Typically, it may be ‘either a real-life problem or an ideal’.¹²⁶ For example, a comparative study of HCL might present the question of how and to what extent each country under study addresses the problem of patient disempowerment vis-à-vis excessive medical paternalism. The practical upshot of locating the ‘*tertium comparationis*’ is that ‘either one legal system has the same legal rule or legal institution as another, or it has different rules or institutions as another, or it has different rules or institutions which perform the same function, or it provides different results for a particular problem, or it does not seem to address that problem at all.’¹²⁷ This calls for ‘integrity,’ which makes the study amenable to the recognition of ‘both similarity and difference’.¹²⁸ Legal history, which is later discussed below, can provide illumination for a comparative lawyer in her task of explicating any differences or similarities which he or she may come across.¹²⁹

This open mindedness in functional comparative law is reinforced by its reliance on ‘hermeneutical point of view,’ which preserves the classical scientific (i.e. objective) approach to the study of law.¹³⁰ The hermeneutical point of view requires that the

¹²³ Ibid.

¹²⁴ Ibid, n. 116.

¹²⁵ Ibid.

¹²⁶ Ibid.

¹²⁷ Ibid.

¹²⁸ J Bell, ‘Legal Research and the Distinctiveness of Comparative Law’ in MV Hoecke (ed), *Methodologies of Legal Research: Which Kind of Method for What Kind of Discipline?* (Oxford: Hart Publishing 2011) 155, 173 - 174.

¹²⁹ J Gordley, ‘Comparative Law and Legal History’ in M Reimann, R Zimmermann (ed), *The Oxford Handbook of Comparative Law* (Oxford: Oxford University Press 2006) ch 23.

¹³⁰ J Bell, ‘Legal Research and the Distinctiveness of Comparative Law’ in MV Hoecke (ed), *Methodologies of Legal Research: Which Kind of Method for What Kind of Discipline?* (Oxford: Hart Publishing 2011) 159.

researcher 'should try to explain the system as it appeared to the participants, even if their views are strange, such as the medieval lawyers who put rats on trial'.¹³¹ Thus, when a researcher makes statements about a foreign legal system, she tries 'to describe those norms within the system which a law-abiding citizen or lawyer within that system ought to follow, based on the norms within that system'.¹³² In this regard the significance of the hermeneutic approach is that the researcher ought to appreciate the institutional context for the law that is being explored.

Another utility of the comparative method is that it can deepen legal knowledge by 'inviting the comparatist to give reasons for the similarities and differences among the legal systems under study'.¹³³ The necessity of accounting for the similarities and any differences would involve going beyond the black letter law to the socio-cultural and economic factors. This stage of comparison open the door for the rest of the humanities and social sciences to enter into picture. Reitz has noted that 'this is where the various "law ands" become relevant: law and history, law and economics, law and society, even law and literature.'¹³⁴ He holds that 'good comparative writing should be informed by at least some of these allied fields and will be to the extent it seeks to explain why there are given similarities or differences among legal systems or seeks to assess the significance of such similarities or differences.'¹³⁵ Indeed, Markesinis has remarked that '[l]ooking at foreign law can bring a deeper understanding of problems...- perhaps even unexpected ideas for solving them - but that will only happen when [comparative lawyers] sharpen their focus by narrowing it.'¹³⁶ As noted before, this thesis among other things seeks to explore the extent to which the

¹³¹ *ibid*, 159.

¹³² *Ibid*.

¹³³ JC Reitz, 'How to Do Comparative Law' (1998) 46 *The American Journal of Comparative Law*, 617,626.

¹³⁴ *Ibid* 627.

¹³⁵ *Ibid* .

¹³⁶ BS Markesinis, 'Comparative Law - A Subject in Search of and Audience' (1990) 53 *Modern Law Review* 1, 21.

emergence of a distinct body of HCL benefitted on the one hand from challenges presented by medical advances and on the other hand contributed towards the quest for patient empowerment against excessive medical paternalism. The functional comparative dimension could furnish useful lessons for addressing some of the similar challenges being faced, or yet to be faced in Ghana.

Furthermore, this methodology facilitates 'the attainment of knowledge of another legal system in order to enhance the understanding of one's own system'.¹³⁷ Becoming aware of how a particular legal system has resolved a problem could equip the comparative lawyer to solve 'problems in one's own legal system'.¹³⁸ As Cruz has aptly noted 'knowledge of how other jurisdictions and/or cultures cope with similar health problems provides a broader and more informed basis for appraisal of one's own system'.¹³⁹ Thus, by using England and Wales as the comparator, this research should afford a better appreciation of what other factors might be necessary to complement a conscious effort to stimulate development of a distinct body of Ghanaian health care law which will contribute towards patient empowerment.

However, notwithstanding the attraction of functional comparative law methodology, it is prone to certain limitations. Bell has noted that there are peculiar challenges in comparative legal research:

The first is to understand the full institutional setting out of which the legal issues and solutions arise: the organisation of the legal system, its legal concepts, presuppositions and mental map of the relationships between legal institutions, its legal procedures, and the broader social and cultural context and assumptions. In one's own system, much of this is tacit knowledge. Second, the hermeneutic approach requires the comparatist to adopt the internal point of view of the

¹³⁷ J Schadbach, 'The Benefits of Comparative Law: A Continental European View' (1998) 9 *Boston University International Law Journal* 331, 335.

¹³⁸ *Ibid.*

¹³⁹ PD Cruz, *Comparative Healthcare Law* (London: Cavendish Publishing Ltd 2001) xxvi.

systems compared, but not necessarily to believe either of them is right, fair or just.¹⁴⁰

The criticisms echoed by Bell against the accessibility of functional comparative law as a research methodology may be valid in relation to comparative studies involving legal systems which do not share a uniform language and tradition. Nevertheless, the comparison being made in this thesis does not face such hurdles as the two legal systems involved belong to the same common law tradition and share a common official language by virtue of the colonial connection. Besides, the two legal systems each predominantly operate a publicly-funded universal healthcare system.

Additionally, functional comparative law has been ‘criticised for being *legocentric*.’¹⁴¹ According to Acuña “[l]egocentrism” denotes the perils of a field that inflates its own importance by suggesting that all political and social issues are solved through law.’¹⁴² Thus, the tendency to be legocentric may lead a situation where comparative law analysis may concern itself with only the formal regime of law. However, diverse socio-economic and cultural conditions would necessarily make legal systems materially different from one another. For example, a developed economy like England and Wales may give greater emphasis to the ethical principles of autonomy and consent and probably relatively less attention to the issue of access to healthcare. The reverse is likely to be the case in a developing country like Ghana. Undoubtedly, this apparent difference in emphasis between these two jurisdictions is attributable largely to socio-economic and cultural disparity. In order to avoid some of the pitfalls alluded to above it would be helpful to adhere to admonition by Acuña that ‘the legal systems under comparative study must be viewed in the

¹⁴⁰ J Bell, ‘Legal Research and the Distinctiveness of Comparative Law’ in MV Hoecke (ed), *Methodologies of Legal Research: Which Kind of Method for What Kind of Discipline?* (Oxford: Hart Publishing 2011) 175.

¹⁴¹ RM Acuña, *Comparative Law from Below: The construction of a critical project in Comparative Legal Studies* (Germany: Lambert Academic Publishing, 2012) 9. (references omitted)

¹⁴² Ibid.

socio-cultural context in which they thrive; this is the only way to develop a critical understanding of the law.¹⁴³

2.2.1.1 THE APPLICATION OF FUNCTIONAL COMPARATIVE LAW WITHIN THIS THESIS

For the sake of convenience, the research question needs to be repeated here: how and in what circumstances did ‘a distinct body of HCL’ emerge in England and Wales¹⁴⁴; what lessons can be drawn in relation to Ghana? The functional comparative law methodology is employed in Chapters Three and Four (see below). This methodology requires that a legal problem for which legal solutions are being compared in a functionally equivalent sense needs to be identified. Thus, in Chapter One, as part of the general introduction to this thesis, I highlight the fact that a combination of social changes pre-1980, coupled with spectacular medical advances, created unprecedented legal and bioethical dilemmas which interplayed (as important triggers) to accelerate the emergence of a distinct body of HCL in England and Wales post-1980. Indeed, I argue that the interaction of various factors brought the issues of excessive medical paternalism and its attendant patient disempowerment into prominence. It will be helpful here to briefly reiterate these triggers. In the first place, the revelation from the Nuremberg trial of cases where doctors were accused of conducting experiments on prisoners in concentration camps, coupled with the popularisation of political liberalism, projected the bioethical values of consent and autonomy onto the centre stage of societal discourse. It has thus been noted that:

... bioethics is about the inclusion of laypersons in the setting of ethical standards for medicine. In the 1970s there was a perceived imperative to do this, to move away from traditional medical ethics, because the medical experimentation documented in the 1945 Nuremberg trials was no longer a macabre Nazi

¹⁴³ Ibid 10. (references omitted)

¹⁴⁴ See generally, E. Owusu-Dapaa, ‘Historical Development of Health Care Law And Bioethics In England And Wales: A Symbiotic Relationship’ (2014) 33 (1) *Medicine and Law* 22

phenomenon of the past; the several-decades-long Tuskegee syphilis experiment, revealed to the [...] public in 1972, suggested that even outside the context of an extreme political ideology, physicians and scientists were failing to set adequate standards for themselves.¹⁴⁵

Another parallel development which has served as an equally important trigger consists of the rapid medical advances which occurred during the period between the 1950s and 1980s. These include haemodialysis, organ transplantation, assisted reproduction technologies (ARTs), life support machines (or respirators) and DNA cloning. Each of these has brought up significant questions for law and bioethics. With respect to organ transplantation technology, kidney transplants present a significant conundrum, including: the '(i) the allocation of scarce resources, where continuing treatment and supporting personnel are required; (ii) the allocation of organs for transplantation and (iii) the creation of resources by salvaging cadaver organs.'¹⁴⁶ Related to these challenges, have been a myriad other critical dilemmas. Sanders and Dukeminier have noted seven issues in this regard:

Who makes the decision, under what circumstances, applying what criteria? What institutional procedures or restraints are imposed upon the decision makers? What protection do the courts offer against arbitrary or irrational selection procedures regarding resource allocation? When can a patient who has been using dialysis be denied access to this life sustaining machine? Are the ethical problems so tough that they should be hidden in a medical judgment? Who bears the cost of treatment? What [financial] arrangements can [and should] be devised to shift the cost from the patient to the government?¹⁴⁷

Implicit in most of the foregoing questions is the vulnerability of patients and the need for their empowerment and protection through instruments of law. Moreover, organ transplantation has not been the only medical advance to generate dilemmas which have

¹⁴⁵ M Brazier and S Ost, *Medicine and Bioethics in the Theatre of the Criminal Process* (Cambridge: Cambridge University Press 2013) 184. (references omitted).

¹⁴⁶ D Sanders and J Dukeminier, 'Medical Advances and Legal Lag: Hemodialysis and Kidney Transplantation' (1967-68) 15 *UCL Law Review*, 357.

¹⁴⁷ *Ibid* 358.

accelerated the emergence of HCL in England and Wales. All the other medical advances enumerated above have generated equally complex and novel questions concerning law and bioethics in England and Wales, but consideration of their nuances is deferred to Chapter Five. Growing public discourse on these unprecedented bioethical legal challenges coupled with expansion of interest of legal academics into exploring solutions to them culminated in the emergence of a discrete body of HCL in England and Wales. It is worthy of note that Brazier and Ost have made a similar observation in concurring with Jonsen's remark that,

The birth of bioethics [and HCL] was *primarily* to do with the public's concern about dramatic scientific and medical progress, such as the occurrence of the first heart transplant in 1967: 'bioethics [and HCL] did not begin with a Big Bang . . . it was a slow accumulation of concerns about the ambiguity of scientific progress that turned the old medical ethics into the new paths of bioethics.'¹⁴⁸

Within the framework of functional comparative law, Chapter Three explores the characteristics of the discrete body of HCL in England and Wales. In order to become aware of and comprehend these characteristics, it is necessary that I examine primary and secondary sources of law in the respective context from the perspective of the interface between law and health care. The primary sources I rely on are common law or case law, specific statutes on healthcare, delegated legislation and quasi-laws. These primary sources are quite broad, reflecting the broad spectrum of healthcare itself. Consequently, the focus of my examination is predominantly on the specific intervention of various sources of law in medicine to empower patients through the overarching value of autonomy. Additionally, secondary sources will be relied upon to illuminate my understanding of the context in which the primary sources of law intervene through the mobilising capacity of HCL to empower patients. The secondary sources include journal articles, text books, and

¹⁴⁸ *ibid* 145.

monographs. Consistent with my hypothesis, that, the need for patient empowerment and medical advances the emergence of a discrete body of HCL, Chapter Three explores the extent to which in the post-1980 era, law was used as a tool for addressing the disequilibrium between doctors and patients, as well as regulating medical advances.

Having identified and analysed the key characteristics and overarching goal of a distinct body of HCL as it is constituted in England and Wales in Chapter Three, it then becomes necessary to compare the situation in Ghana. However, Chapter Four does not necessarily attempt to locate an exact replica of the characteristics identified in Chapter Three, in Ghana. Clearly, such an undertaking would be contrary to the paradigm of functional comparative law. More importantly, in Chapter Four I explore the presence or otherwise of functional equivalents of legal responses to the conundrum of patient vulnerability, autonomy and medical advances in Ghana. I highlight the main commonalities and/or differences that may be uncovered from the research. To achieve this, I survey primary and secondary sources in that context. Thus, I examine the Constitution of Ghana, the statutes, delegated legislation, common law, customary law and quasi-law to ascertain the responsiveness of such to the need to empower patients and regulate medical advances. Secondary sources, including academic commentaries on these laws, will also be considered with the same goal. As I consider these materials on Ghanaian law in Chapter Four, I also evaluate the law's relative strength and weaknesses in the light of the characteristics of the distinct body of HCL in England and Wales highlighted in Chapter Five. Similarly, where it is possible to assess English and Welsh HCL on the basis of functional equivalents from Ghana, the thesis does so.

2.2.2. LEGAL HISTORY

The deployment of legal history as an approach to legal scholarship has increased during the past three decades.¹⁴⁹ Nevertheless, there is no clear statement regarding its methodological aspects.¹⁵⁰ Parrish has aptly, noted that 'legal historical research methodology is learned on one's own, frequently after formal schooling has ended'.¹⁵¹ Legal history as research approach does not necessarily connote a single idea. Ibbetson has rightly observed that 'legal history is by no means a unitary discipline'.¹⁵² In this regard a distinction is drawn 'between "internal" and "external" legal history'.¹⁵³ Ibbetson explains the distinction as:

The former [internal], we might say, is the history of lawyers' law, of legal rules and principles. Its sources are predominantly those that are thrown up by the legal process: principally statutes and decided cases, supplemented where possible with lawyers' literature expounding the rules and occasionally reflecting on them. The latter [external] is the history of the law in practice, of legal institutions at work in society rather than legal rules existing in a social, economic, and political vacuum. The former, defined by its own terms, is bounded within its own field of reference; the latter, in its very nature, is necessarily unbounded.¹⁵⁴

Internal legal history suffers from similar deficiency as the black-letter law approach for 'being too inward looking, too narrow, too technical and too self-referential'.¹⁵⁵ This deficiency can be explained as emerging from its exclusive reliance on formal sources of law. However, such an approach will not fit into HCL research since the legal sources in this branch of law are broader than formal sources in the purely legal positivistic sense. Writing in relation to England and Wales, Montgomery included *quasi-law* as one of the sources of

¹⁴⁹ C Stebbings (ed), *Making Legal History- Approaches and Methodologies* (Cambridge: Cambridge University Press 2012) ch 1.

¹⁵⁰ Ibid.

¹⁵¹ J Parrish, 'A Guide to an American Legal History Methodology with an Example of Research in Progress' (1994) 86 *Law Library Journal*, 105, 106.

¹⁵² D Ibbetson, 'Historical Research in Law' in M Tushnet and P Cane (eds), *The Oxford Handbook of Legal Studies* (Oxford: Oxford University Press 2005), 864.

¹⁵³ Ibid.

¹⁵⁴ Ibid.

¹⁵⁵ C Stebbings, 'Benefits and Barriers: The making of Victorian legal history' in A Musson and C Stebbings (eds), *Making Legal History- Approaches and Methodologies* (Cambridge: Cambridge University Press 2012), ch 6, 86.

HCL.¹⁵⁶ Quasi-law ‘describes rules which may be made without explicit legal authority and which are most important for the guidance they offer rather than sanctions which follow if they are regarded.’¹⁵⁷ Examples of quasi-law in HCL are ‘circulars, guidelines and protocols’.¹⁵⁸ Montgomery further notes that breach of quasi-laws may not necessarily trigger legal consequences, ‘but in most circumstances they will be followed and therefore, any survey of the norms which govern healthcare practice must take them into account.’¹⁵⁹

Indeed, internal legal history does not provide ‘the holistic and interdisciplinary perspective which is seen as increasingly desirable in the context of modern research’.¹⁶⁰ Pound is noted to have observed that ‘the historical search for fundamental legal principles entailed an internal approach to legal history, focusing on the history of legal thought while ignoring the interrelationship between law and society.’¹⁶¹ This way of proceeding by internal approach to legal history is fraught with a misleading presupposition that ‘legal change is caused exclusively by legal phenomena and that current legal issues could be decided by logical deductions from past law’.¹⁶² Since I am using legal history to supplement functional comparative law methodology in my research, it is apposite that I adopt the non-doctrinal or external version of legal history which permits an inquiry extending beyond the traditional formal sources of law to contextual factors. Thus, external approach to legal history with its ‘inherent flexibility of sources can better assist in explaining why change and

¹⁵⁶ J Montgomery, *Health Care Law* (1st edn, Oxford: Oxford University Press 1997) 5.

¹⁵⁷ *Ibid.*

¹⁵⁸ *Ibid* 12.

¹⁵⁹ *Ibid.*

¹⁶⁰ C Stebbings, ‘Benefits and Barriers: The making of Victorian legal history’ in A Musson and C Stebbings (eds), *Making Legal History- Approaches and Methodologies* (Cambridge: Cambridge University Press 2012) ch 6, 86.

¹⁶¹ DM Rabban, ‘Methodology in Legal History’ in A. Musson and C Stebbings (eds), *Making Legal History- Approaches and Methodologies* (Cambridge: Cambridge University Press 2012) 94. (References omitted)

¹⁶² *Ibid* 95.

continuity occurred'.¹⁶³ I proceed now to demonstrate how and why the external approach to legal history has been utilised in the thesis.

2.2.2.1. THE APPLICATION OF EXTERNAL APPROACH TO LEGAL HISTORY WITHIN THE THESIS

In order to chart the path along which HCL evolved as a distinct body of law or discipline in England and Wales, Chapter Five relies on the methodology of legal history. This requires that I examine parliamentary proceedings relevant to specific HCL statutes, Committees of Inquiries reports, and archives of academic legal literature to understand the context in which a corpus of statutes, quasi-law, case law and academic commentaries constituting a discrete field of HCL have evolved. For example, the Hansard coverage of parliamentary proceedings preceding the passing of the Human Fertilisation and Embryology Act, 1990, as well as the related 1984 Warnock Report, are studied in this regard to obtain insights into the complex moral discussions which transpired before some of these novel areas of law could develop. Similarly, within the framework of the external legal history approach, I examine the crucial role played by Ian Kennedy's Report, *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 -1995*,¹⁶⁴ in stimulating academic and public discourse on patient safety in healthcare. Moreover, Chapter Five will survey the historical evolution of scholarship in this field of the law. This requires examination of law journals and other legal literature to trace when and how this field of law caught the interest and attention of legal academics. Furthermore, non-legal literature, including the British Medical Journal, various newspapers and archives of

¹⁶³ KJM Smith and JPS McLaren, 'History's Living Legacy: An Outline of Modern Historiography of the Common Law' (2001) 21 *Legal Studies*, 251, 312.

¹⁶⁴ I Kennedy (Chair), *Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-95* (CM 5207(1) (London: HMSO 2001).

news websites, which reflect on matters pertaining to the historical context, within which the field has developed are explored as part of the external legal history underpinning the research. The comparative law dimension of the research requires that the research endeavours to uncover the constellation of factors in Ghana that account for lack of development of a distinct body of HCL. Thus, in examining the case for developing a distinct body of HCL in Ghana in Chapter Six, the thesis will draw on similar external legal historical sources, such as the *Ghana Medical Journal*, literature from medical sociology in Ghana and news archives.

2.2.3. EMPIRICAL LEGAL STUDIES

The term ‘empirical’ basically indicates something which is grounded in observation, experience, experiment or investigation. Empirical studies of how law works provide a contextual understanding and knowledge of law’s internal point of view.¹⁶⁵ In the most recent authoritative work on this approach to legal research, Cane and Kritzer very helpfully illuminate our understanding of it as follows:

For our purposes, ‘empirical’ research involves the systematic collection of information (‘data’) and its analysis according to some generally accepted method. This information can come from a wide range of sources including surveys, documents, reporting systems, observation, interviews, experiments, decisions and events. While the data can be retained as text or images, systematic analysis will often involve coding or tagging units of text or images using symbols that may or may not have numeric properties(in the sense that they can be manipulated algebraically, or compared in terms of absolute or relative size). The analysis can involve simple counting, sophisticated statistical manipulation...matching of patterns, or simple labelling of themes. Ultimately, the analyst engages in a process of interpreting the results of the analysis in order to link those results to the question motivating the research.¹⁶⁶

¹⁶⁵ C McCrudden, ‘Legal Research and the Social Sciences’ (2006) 122 *Law Quarterly Review*, 632.

¹⁶⁶ P Cane and HM Kritzer (eds), *The Oxford Handbook of Empirical Legal Research* (Oxford: Oxford University Press, 2010) 4.

Thus, empirical legal studies may be either qualitative, quantitative, or a blend of the two, known as the multi-method. Qualitative observation identifies the presence or absence of something, whereas quantitative observation involves measuring the degree to which some feature is present.¹⁶⁷ However, both share four basic steps: project design, the collection and coding of data, analysis and the presentation of results.¹⁶⁸ In view of the broad nature of this approach, I will not give a general explanation of it here, but will reserve explanation of those aspects of the methodology I use in explaining their application within the thesis.

2.2.3.1. THE APPLICATION OF EMPIRICAL LEGAL STUDIES WITHIN THIS THESIS

Empirical legal studies, there are aspects of it which can only properly be studied and presented through such an approach. Chapters Three, Five and Six employ aspects of qualitative empirical legal studies. A section of Chapter 3 exploring the teaching of HCL as a distinct discipline in England and Wales employs survey data collection via e-mail. Therefore, an e-mail was sent to all law schools in England and Wales, seeking responses to the questions: '(1) Do you offer an undergraduate module in medical law/health care law? (2) If so, what year did the module commence? If you do offer such a module, I would be most grateful if I could have a copy of the module outline, syllabus or handbook.'¹⁶⁹ In order to analyse the data generated from this e-mail survey and find meaning in its relationship to the research question, it was helpful to rely on a classical analysis of content (CCA). CCA reduces text or data to codes by categorising items in the text and then counting the occurrences of these items to allow inferences to be drawn from the document.¹⁷⁰ In this

¹⁶⁷ J Kirk and ML Miller, *Reliability and Validity in Qualitative Research* (Beverly Hills, Sage Publications 1986) 9.

¹⁶⁸ EM Jones, 'Some Current Trends in Legal Research' (1962) *Journal of Legal Education*, 131.

¹⁶⁹ From an e-mail sent to law schools. A Copy is attached as an appendix.

¹⁷⁰ L Webby, 'Qualitative Approaches to Empirical Legal Research' in P Cane and HM Kritzer (eds), *The Oxford Handbook of Empirical Legal Research* (Oxford: Oxford University Press 2010) ch 38, 941.

regard, the CCA of the data from the law schools enabled me to determine the extent of the reception of HCL into their curriculum, as well as the trends for topics or themes taught in this discipline. This aspect of the empirical studies serves as a frame for verifying the implicit claim made in this thesis, that the emergence of HCL as a distinct body of law is also accompanied by its academic discipline.

Furthermore, in order to complement the legal historiographical study of how HCL evolved in England and Wales as a distinct body of law, two methods of qualitative empirical legal studies are employed in part of Chapter Five. First, for the purposes of data collection, I undertook semi-structured interviews.¹⁷¹ This facilitated an explanation of how and why some legal academics in England and Wales have considered it necessary for categories of English and Welsh law to be opened up to encompass a new field, namely HCL. The target participants were pioneer HCL academics in England and Wales. In this regard, I employed the purposeful sampling technique to recruit my participants. Purposeful sampling entails seeking out key people or events likely to provide rich sources of information or data.¹⁷² The legal history employed in Chapter Five enabled me to identify key academics that pioneered HCL scholarship in England and Wales.¹⁷³ In this way, there is a dialogue between the otherwise disparate methodological choices underpinning this thesis.

Since the participants are human subjects, I sought ethical clearance from the Lancaster University's Research Ethics Committee. The data generated from the interview was transcribed and analysed. To ensure a high degree of accuracy in preserving the actual words of the respondents, Express Scribe, a transcription software, was utilised. A technique for labelling simple themes was employed in analysing the transcript of the interview. This

¹⁷¹ See: 'Sample of Questions for the Interview' attached as an appendix.

¹⁷² MQ Patton, *Qualitative Research and Evaluation Methods* (3rd edn, London: Sage Publications 2002) 45.

¹⁷³ I did not succeed in interviewing three of those I had intended to interview as they failed to respond to three e-mails I sent to them. I was also unable to reach them by telephone.

entailed a careful reading of the transcript for each respondent in order to discern and draw out common and unique themes.

Finally, Chapter Six examines the need to develop a distinct body of HCL in Ghana. Part of the discussion in this chapter explores the reality of patient vulnerability and the regulatory vacuum in relation to medical advances. It has proved helpful to use qualitative document analysis in order to determine these matters before drawing upon some lessons from the English and Welsh experience. Webly has pointed out that the 'mode of analysis' or manner of making sense of data to be derived depend on 'the nature of the documents and the context within which they were written as well as the intended audience.'¹⁷⁴ The documentary sources on Ghana that I analyse here include newspaper articles, internet materials, policy documents, the *Ghana Medical Journal* and other academic journals. My aim in this document analysis was two-fold: (1) to understand whether or not patients lack empowerment in Ghana, and (2) to explore the extent to which medical advances replicated in Ghana are unregulated by law.

2.3. SUITABILITY AND JUSTIFICATION OF THE SELECTION OF COMBINED METHODOLOGY

The research question in this thesis could have been addressed by various methodologies. Nevertheless, I consider a mix of functional comparative law, non-doctrinal legal history and qualitative empirical legal studies as the most suitable methodologies in meeting the objectives of the research stated in Chapter One. As noted, due to the colonial connection between England and Wales (in fact, Great Britain) and Ghana, their legal systems belong to the same common law tradition, which provides some conceptual basis for comparability. Thus, the emphasis on using functional comparative law here is not about the conventional contrast between common law and continental civil law traditions. Rather,

¹⁷⁴ *ibid*, n.170.

it is about how Ghana's legal system has responded to, or is yet to respond to, the conundrum of patient vulnerability and the challenges presented by medical advances, the empowerment and regulation of which in England and Wales have respectively accelerated the emergence of a discrete body of HCL in the latter jurisdiction.

Secondly, the need to employ comparative law methodology in HCL has increasingly been emphasised as a means of addressing issues raised by medical advances that have already been dealt with in some other jurisdictions. For example, in reflecting on new legislation which Belgium passed to govern euthanasia in relation to the legal treatment of the phenomenon in the Netherlands, Adams and Nys employed functional comparative law and cited the political context underpinning the law in the two jurisdictions as being responsible for the differences between them.¹⁷⁵ Related to this utility of comparative law, it was underscored in an editorial of the *European Journal of Health Law*:

The comparative approach may also have an additional benefit. It will facilitate the identification of problems that have yet to be faced in some countries. All too often a society is 'taken by surprise' as technological developments in medicine are introduced without regulation and, often, without thought being given by the society to their implications. Some countries may already have had to address the issue and thus study of their policy solutions can help others to formulate policy responses for the future.¹⁷⁶

Since many aspects of medical advances have already been incorporated into healthcare practice in England and Wales, the legal system concerned has responded elaborately to the challenges presented by them. It is therefore apposite that those legal solutions are studied in juxtaposition to efforts made, or yet to be made in Ghana to respond to medical advances. Clearly, it is functional comparative law which allows this to be pursued.

¹⁷⁵ M Adams and H Nys, 'Comparative Reflection on the Belgian Euthanasia Act, 2002' (2003) *Medical Law Review*, 355. See also: S Halliday, 'A Comparative Approach to the Regulation of Human Embryonic Stem Cell Research in Europe' (2004) 12 *Medical Law Review*, 40; S Ost, *An Analytical Study of the Legal, Moral, and Ethical Aspects of the Living Phenomenon of Euthanasia* (Lampeter: Edwin Mellen Press 2003); M Stauch, *The Law of Medical Negligence in England and Germany* (Oxford: Hart Publishing 2007).

¹⁷⁶ A Grubb, 'Comparative European Health Law' (1995) 11 *European Journal of Health Law*, 292.

Moreover, the use of legal history as a complementary methodology is suitable for realising another aspect of the aims and objectives of the thesis. The fundamental assumption on which the thesis is built is that until the last three to four decades, there was no distinct body of HCL and, for that matter, a distinct academic discipline of HCL in England and Wales. Thus, in order to understand HCL as constituted at present, it is apposite that it is historically contextualised. This requires going beyond the primary sources of law located in the past to illuminate the complex factors which have acted in concert or along parallel lines to catalyse the evolution of this field of law. Non-doctrinal legal history facilitates this process, since it does not limit itself solely to primary sources of law.

Finally the deployment of qualitative empirical legal studies in this may be deemed appropriate for many reasons. First, the need to ascertain the incorporation of HCL into the curricula at law schools can be met through surveys, interviews and content analysis. Although a survey may be quantitative, I consider the qualitative method to be a better research framework for my present purpose as I am more concerned with the trends emerging from views that can be distilled from the data to be collected, than with the mere numerical picture or calibration of certain occurrences in the data. Secondly, the use of the empirical approach serves a further purpose in validating some of the claims made in this thesis, using perspectives from functional comparative law. For example, the *tertium comparationis*, for which reason functional comparison is explored in Chapters Three and Four, is the conundrum of patient empowerment and the regulation of medical advances. The analysis of qualitative documents enables the thesis to confirm whether or not such a problem exists in Ghana.

2.4. CONCLUSION

Articulating methodology that informs one's research will enhance the intellectual validity of the research enterprise. The nature of the questions being explored in this thesis is not amenable to a single methodology. Therefore, I have argued that the research questions warrant a combination of functional comparative law, legal history and empirical legal studies approaches. Admittedly, there does not appear to be any grand theory which necessarily links these approaches together. However, I am more interested in the pragmatic purpose of facilitating an understanding and unpacking the research question. In this regard, the functional comparative law approach enables me to unpack how the law in England and Wales has addressed bioethical and legal dilemmas in healthcare and medical advances, on the one hand, and the approach which Ghanaian law has actually adopted, or could adopt, in dealing with medical advances, on the other. The historical context which has influenced how the law on healthcare and medical advances in England and Wales has developed was investigated using the non-doctrinal legal history approach. In the case of Ghana, various literature of a legal and non-legal character spanning over five decades was studied in order to understand the necessity for developing a discrete body of HCL. In order to verify an often unexamined assumption that HCL is widely taught and studied as an academic discipline, an empirical survey was conducted. Another application of qualitative empirical studies in the research consisted of the extraction and analysis of views offered by pioneer scholars in the field in England and Wales, concerning the trajectory and projection of such development.

CHAPTER THREE

THE DEFINING CHARACTERISTICS OF A DISTINCT BODY OF HEALTH CARE LAW IN ENGLAND AND WALES

3.0. INTRODUCTION

The central argument of the thesis (that the quest for patient empowerment and the increasing interest of legal academics in the regulatory issues in medical advances has served as an impetus for the emergence of HCL) presupposes that HCL has matured into a distinct body of law. Thus, in this chapter, I explore the extent to which this is true of England and Wales. In order to properly accomplish this purpose, the chapter constructs a test for identifying a distinct body of law or legal field and proceeds to examine the available evidence, in consideration of whether the test has been satisfied by HCL in England and Wales.

3.1. WHAT MAKES AN AREA OF LAW A FIELD OF LAW OR DISTINCT BODY OF LAW?

As a prelude to exploring the defining features of a legal field, it is worth asking whether anybody should care at all whether HCL is a distinct legal field or discrete body of law (as opposed to simply exploring laws related to a particular subject). Attempting to determine what constitutes a field of law in relation to HCL is not an empty academic exercise with insubstantial practical application but, as this chapter should demonstrate, will evidence the transformation of the doctor-patient relationship in the healthcare context from being excessively paternalistic to one involving a partnership in which the empowered

patient enjoys rights. The patient, whose right to autonomy and self-determination are increasingly protected by HCL, now takes responsibility for treatment decisions in this new paradigm.

Additionally, such an exploration offers many benefits for legal practice and scholarship. Law is usually organised into 'distinct fields as a form of legal taxonomy in the premise that the classification will facilitate an improved understanding of the law.'¹⁷⁷ A field of law is basically a convenient framework that 'assists the legal community in drawing boundaries between situations that fall within and those that fall outside the field.'¹⁷⁸ Thus, a legal field is simply 'one of the important categories through which the law functions.'¹⁷⁹ Indeed, it has been noted that 'the designation of a situation as falling within, or outside of, a particular legal field often carries powerful associations about how the situation should be understood and what legal rule should apply to it.'¹⁸⁰ In addition, Berman has noted that 'self-definition as a discrete legal field appears to be a precondition for academic legitimacy.'¹⁸¹ Moreover, 'defining a subject as a distinct academic field may also motivate legal practitioners to organize and self-identify along similar lines.'¹⁸² In this way, practitioners can specialise and students can find employment.¹⁸³

Notwithstanding the widespread reference to the concept of a 'field' in legal discourse, it does not have a clear-cut definition. It has been noted that the existing literature does not provide 'an epistemology or *meta*-theory for positively defining the

¹⁷⁷ TS Aagaard, 'Environmental Law as a Legal Field: An Inquiry in Legal Taxonomy' (2010) 95 *Cornell Law Review*, 221,226. (references omitted).

¹⁷⁸ *ibid*,225.

¹⁷⁹ *Ibid* 224.

¹⁸⁰ *Ibid*, 228.

¹⁸¹ ML Berman, 'Defining the Field of Public Health Law' (2013)15 *DePaul Journal Health Care Law*, 45.

¹⁸² *Ibid*.

¹⁸³ J F Blumstein, 'Health Care Law and Policy: Whence and Whither?' (2004) 14 *Health Matrix*, 35.

essential characteristics of a field of law.’¹⁸⁴ However, in the wake of the emergence of new fields of law outside the traditional ones (i.e. contract, tort, criminal law, property, constitutional and administrative law), some commentators have attempted to explore the discrete status of their areas of law and in the process have afforded us some sense of what constitutes a field of law. For example, in his contribution to a symposium on the status of sports law, Carter states:

But what makes a ‘field’ a field? The answer is that a field becomes a field not because it is inherently so but because in our public legal dealings we shape it as such, defining the concepts and legal norms that will prevail uniquely in that context. It becomes a field because enough people with power on all sides are so affected by it to require some special treatment of it in the law. For many years, sports law has been somewhat removed from the things that make a field a field - the litigation that establishes a common law specific to the concerns of the participants, the scholarship that provides conceptual and theoretical guidance (and sometimes misguidance), and the legislative and administrative action that creates a statutory and regulatory base.¹⁸⁵

Thus, according to Carter, a field of law must have sufficient case law, dedicated legislation and regulations, as well as scholarship that provide theoretical direction. Moreover, discussing whether health law meets the traditional characteristics of legal disciplines, Theodore Ruger¹⁸⁶ states four key characteristics of a coherent legal field. First, it must have ‘a reductionist focus on logic.’¹⁸⁷ This means that the field must provide ‘one or a few core conceptual building blocks’ for explicating various legal materials.¹⁸⁸ Second, it must have ‘a

¹⁸⁴ WK Mariner, ‘Toward an Architecture of Health Law’ (2009) 35 *American Journal of Law*, 67, 79.

¹⁸⁵ WB Carter, ‘Introduction: What Makes a "Field" a Field?’ (1999) 1 *Vanderbilt Journal of Sports & Law*, 235, 244.

¹⁸⁶ T Ruger, ‘Health Law’s Coherence Anxiety (2008) 96 *Georgetown Law Journal*, 625, 630.

¹⁸⁷ *Ibid* 630.

¹⁸⁸ *Ibid*.

focus on essential legal form.¹⁸⁹ Third, it must have ‘a linear historical development.’¹⁹⁰

Finally, it must exhibit ‘a high level of institutional specification and centralization.’¹⁹¹

Other criteria for identifying the characteristics of a field of law have been presented by Aagaard in relation to environmental law:¹⁹²

[a]t a minimum, a legal field must exhibit two characteristics: commonality and distinctiveness. An organizational framework for a legal field therefore must focus on identifying a combination of features that, as a group, are common and distinctive to the field.¹⁹³

Commonality in this context refers to ‘a characteristic or set of characteristics shared in common by the situations that arise within the area of law that the field encompasses.’¹⁹⁴

Aagaard has noted that the distinctiveness of a field may occur in one of two ways – ‘it may have unique legal rules that apply exclusively within the field, or yield unique outcomes when general rules are applied to it.’¹⁹⁵ A related hallmark of a distinct body of law is whether it has attracted practice specialisation. In this regard Aagaard has noted that ‘If, on the other hand, lawyers organize their practice by reference to a category, they highlight the category as a potential field and also create a demand for other correlates of a legal field, such as practice materials, conferences, academic research, and law school courses.’¹⁹⁶

Similarly, Mariner has identified three approaches to defining a field of law, namely: ‘(1) subject-matter- taking the history and tradition of rules and customs associated with a particular subject; (2) statutes or sets of related documents, such as constitutional law,

¹⁸⁹ Ibid.

¹⁹⁰ Ibid.

¹⁹¹ Ibid n 186.

¹⁹²TS Aagaard, ‘Environmental Law as a Legal Field: An Inquiry in Legal Taxonomy’ (2010) 95 *Cornell Law Review*, 242.

¹⁹³ Ibid.

¹⁹⁴ Ibid.

¹⁹⁵ Ibid 244.

¹⁹⁶ Ibid 250.

public international law, and (3) the overall purpose of the laws associated with the field.¹⁹⁷

Like other authors considered earlier, Mariner does not appeal to any higher authority for the legitimacy of his proposed criteria for a field. Indeed, he concedes that ‘no ultimate authority exists for defining a field of law.’¹⁹⁸ He maintains that practitioners identify an area as a field of law for their own purposes and ‘ts validity depends upon its acceptability to others.’¹⁹⁹

From the foregoing, it appears that there is no universally accepted criteria or test for the recognition of a distinct field of law. However, I find the indicators of a field stated by Carter and Aagaard above to coincide with most of the views of other authors that have explored the issue. Thus, in this thesis four indicators drawing upon Carter and Aagaard are utilised in exploring emergence of HCL as a legal field. First, a field of law should have sufficient case law evidencing factual peculiarities that require specialised analysis. This will result in a unique judicial application of law from other fields to a specific context. Secondly, the field being considered should see a significant development of interventionist or dedicated legislation to regulate specific relationships. Thirdly, it should have core principles or values which give it commonality and, at the same time, *distinctiveness*. This is crucially important as Tarlock has aptly emphasised that ‘one of the primary characteristics of a distinct area of law is that it contains a relatively unique set of core principles distinguishing it from other areas of the law.’²⁰⁰ Fourthly, a field of law should be able to sustain its existence and relevance by finding a place in legal education and scholarly works. The need for a place in the academy in order to avert the marginalisation and extinction of the field is

¹⁹⁷ WK Mariner, ‘Toward an Architecture of Health Law’ (2009) 35 *American Journal of Law* 67, 81.

¹⁹⁸ *Ibid.*

¹⁹⁹ n 197 above, 82.

²⁰⁰ AD Tarlock, ‘Is There a There in Environmental Law? (2004) 19 *Journal of Land Use and Environmental Law*, 213, 228.

aptly underscored by Tarlock when exploring the discrete status of environmental law. He states that:

[w]ithout a distinctive core and the self-study that the academy provides, an area of law will lose power in the judicial and political arena. It becomes a factor or screen to be considered from time to time rather than a consistent decision driver.²⁰¹

3.2. DOES HEALTH CARE LAW IN ENGLAND AND WALES CONSTITUTE A DISTINCT FIELD OF LAW?

Having identified the key characteristics which a discipline should possess before it may be considered as a distinct body or field of law, I will proceed to demonstrate the extent to which HCL in England and Wales satisfies these requirements. While relying on the four indicators enumerated above, with regard to my understanding of how a field of law is constituted, I submit that HCL in England and Wales became sufficiently developed as a field of law in the post-1980 era.²⁰² Admittedly, literature on the interface between law and healthcare has been published intermittently since 1858,²⁰³ but it was during the post-1980 era that HCL began to manifest the characteristics of a field of law and have a discernible objective.²⁰⁴ I turn now to explore whether the test for a field of law has been sufficiently satisfied by HCL while interrogating my first hypothesis that *the quest for patient empowerment and the legal academic interest in medical advances has accelerated the emergence of health care law as a distinct body of law in England and Wales.*

3.2.1. THE PROLIFERATION OF CASE LAW IN HEALTHCARE

²⁰¹ Ibid.

²⁰² See pp 29-32 for a nuanced justification for choice of period.

²⁰³ For example, AS Taylor, *Elements of Medical Jurisprudence* (London: Deacon 1836); JT Smith, *The Laws of England Relating to Public Health, Including an Epitome of the Law of Nuisances* (London: S Sweet 1848); DH Kitchin, *Legal Problems in Medical Practice* (London: Butler and Tanner Ltd. 1936).

²⁰⁴ I Kennedy, *The Unmasking of Medicine* (2nd rev edn, St Albans: Granada, 1983) ch 1; JK Mason and GT Laurie, *Mason & McCall Smith's Law and Medical Ethics* (7th edn, Oxford: Oxford University Press, 2006) para 5.65.

Three aspects of the proliferation of case law in this field are worth considering in this section. These are: (a) a quantitative increase in litigation, (b) factual peculiarities discernible from the burgeoning case law, and (c) core principles running through the field as a thread which gives it commonality and distinctiveness. Each of these will be considered in turn.

A. THE QUANTITATIVE INCREASE IN LITIGATION

One of the important indicia of a field of law identified above is that it must generate significant quantum of litigation, so that over time, the mediation or resolution of the tensions presented by the litigation will generate some core principles which pervade that field of law and imbue it with some distinctiveness. Montgomery has noted that 'litigation can be seen as one of the ways in which the nature and values of the law can be established and shaped.'²⁰⁵ Morgan and Lee underscore the significance of litigation to this field of law by propounding the concept of a 'stigmata case'. Such cases manifest five cardinal features:

they are relatively novel and ethically controversial; raise the balance of personal interests and public interest; force us to consider the goals of medical practice; they offer an opportunity to take stock of the boundaries between the anomalous and routine, the normal and the pathological; and they require the courts to develop a social, even moral, vision to respond to the social and cultural revolution of contemporary medicine.²⁰⁶

The post-1980 period saw an exponential growth in litigation involving such stigmata cases in this field in England and Wales. In 1985, Kennedy noted the sudden increase in cases, writing:

[s]uddenly, in the last few years, the courts have got into the act. Cases have come rattling along. Medical law is beginning to get a corpus of law.²⁰⁷

²⁰⁵ J Montgomery, 'Law and Demoralisation of Medicine (2006) 26 *Legal Studies*, 185, 189.

²⁰⁶ R Lee and D Morgan, 'Regulating risk society: stigmata cases, scientific citizenship and biomedical diplomacy' (2001) *Sydney Law Review*, 297.

²⁰⁷ I Kennedy, 'The Patient on the Clapham Omnibus' (1984) 47 *Modern Law Review*, 454.

Brazier and Cave have similarly acknowledged the dramatic increase in the number of judicial decisions since the 1980s.²⁰⁸ Indeed, a survey of cases discussed by leading textbooks on the subject reveal that between 1980 and 2000, more than 200 cases²⁰⁹ were decided by the courts.²¹⁰ This frequency of litigation bodes well for the maturation of the field as it gives scholars sufficient material with which to critique and shape the law. The increasing volume of litigation in HCL during the past three decades can partly be attributed to significant medical advances and the coverage of high profile medical cases by the media. This has made the public more aware that it is possible to sue when things go wrong in the NHS. This increasing trend of litigation in the field of HCL was succinctly noted by Lord Bridge in the context of medical negligence:

[L]itigation in the field of medical negligence continues regrettably to grow in volume. The growth is probably attributable to two principal causes: first, the greater awareness of patients of their legal rights and a greater willingness to enforce them; secondly, the ever increasing sophistication of medical procedures. It is ironic but perhaps inevitable that the further advances medical science makes in being able to offer potential cures for conditions previously incurable or fatal, the more the medical profession lays itself open to attack in respect of the mistakes which can occur in the highly complex and delicate procedures necessary to make the cures effective...²¹¹

B. FACTUAL PECULIARITIES

It is not only the quantitative increase in the number of cases which is remarkable; but equally important has been the expansion in the subject matter of litigation. This expansion has also witnessed a number of cases that are factually and procedurally peculiar. Unlike the time before 1980, when the limited number of cases was predominantly concerned with

²⁰⁸ M Brazier and E Cave, 'Why we wrote. . . Medicine, Patients and the Law' (2008) 3(4) *Clinical Ethics*, 205.

²⁰⁹ I recognise that one has to be very cautious about using this to indicate the *total* number of cases that came before the courts during this period. Some may not have gone to appeal and/or not been discussed by these authors. There is also the complexity of what counts as a medical or healthcare law case since there may be cases which are not mainly situated in HCL, but principles of relevance to the field may be propounded.

²¹⁰ M Brazier and E Cave, *Medicine, Patients and the Law* (5th edn, England: Penguin Books 2011) xxiii-xlv; JK Mason and GT Laurie, *Law and Medical Ethics* (Oxford: Oxford University Press 2011) ch 1.

²¹¹ MJ Powers and NH Harris, 'Foreword by Lord Bridge', *Medical Negligence* (London: Butterworths 1990).

medical negligence or (potentially) criminal behaviour,²¹² some of the litigation post-1980 concerned other equally important issues of HCL. For example, *Gillick* was concerned with challenging a policy which sought to empower doctors to offer treatment relating to abortion or contraception to girls under the age of 16 without the need for parental consent.²¹³ Furthermore, the burgeoning litigation at that time not only featured patients as claimants, but sometimes health institutions would approach the court for a declaration on the legality of a proposed treatment or the withdrawal of life-saving treatment, where this was considered to be morally contentious.

Many cases decided during the period provide examples of this.²¹⁴ In one leading case, *Airedale NHS Trust v Bland*, a health authority responsible for the treatment of a persistent vegetative state (PVS) patient brought an application to the court for a declaration that it and the physicians responsible could lawfully discontinue all life-sustaining treatment and medical support measures designed to keep the patient alive in his existing PVS, including ventilation, nutrition and hydration by artificial means.²¹⁵ The House of Lords granted the declaration but reiterated the need for doctors to seek the guidance of the courts before withholding treatment in such cases.²¹⁶ The trial judge in *Bland*, Sir Stephen Brown P, noted that the term 'persistent vegetative state' (PVS) was first coined in 1972 to 'describe a syndrome that was being increasingly encountered as the life-saving and life-sustaining

²¹² For example, *R v Bourne* [1938]; 3 All ER 615 and *R v Bodkin Adams*, [1957] Crim LR 365.

²¹³ *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402.

²¹⁴ *F v West Berkshire Health Authority and another (Mental Health Act Commission intervening)* [1989]; 2 All ER 545; *Re B (a minor) (Wardship: sterilisation)* [1987]; 2 All ER 206; *Airedale NHS Trust v Bland* [1993]; 1 All ER 821

²¹⁵ *Airedale NHS Trust v Bland* [1993] 1 All ER 821

²¹⁶ *Airedale NHS Trust v Bland* [1993]; 1 All ER 821 at 874 per Lord Goff of Chieveley; 880 as per Lord Brown-Wilkinson.

technologies of intensive care were securing the survival of some patients with brain damage of a severity that would previously have proved fatal.²¹⁷

Also in *Re T(adult: refusal of medical treatment)*,²¹⁸ the court was presented with a request for a declaration that doctors could lawfully transfuse blood to a patient who appeared to have ambiguously evinced an intention to refuse blood transfusion, long before she became incapable to consent, in a life-threatening emergency situation. The Court of Appeal granted the declaration, holding that where a genuine decision could not be expressed by an otherwise mentally sound adult patient, treatment could be administered in defiance of any previous vaguely expressed contra-instruction, on the ground of necessity. Lord Donaldson, with whom the rest of the court concurred, noted the tension that can arise between an individual's right to self-determination and the public interest in the sanctity of life. Accordingly, he held that the right of the individual is paramount, but '[i]n case of doubt, that doubt falls to be resolved in favour of the preservation of life, for if the individual is to override the public interest he must do so in clear terms.'²¹⁹

These new areas of medical litigation reinforce the earlier argument that, since 1980, there has been sufficient litigation in HCL to result in an expansion of the common law. This has reflected at least some of the unique concerns of stakeholders in the field. For example, patients' rights to self-determination and autonomy, which often clash with medical paternalism, have contributed to the increasing resort to the courts for declarations regarding the legality of intended treatment. Indeed, the mere fact that since 1980, doctors

²¹⁷ *Airedale NHS Trust v Bland* [1993] 1 All ER 821 at 827

²¹⁸ [1992] All ER 649; also in *Re A (children) (conjoined twins: surgical separation)* [2000] 4 All ER 961, where a hospital applied to the court on behalf of its doctors for a declaration that a proposed invasive surgical operation to separate twins born conjoined at the abdomen, with only one capable of independent existence, was lawful. The Court of Appeal, after considering a blend of legal and ethical arguments, granted the declaration.

²¹⁹ *Re T (adult: refusal of medical treatment)* [1992] All ER 649 at 661

increasingly seek prior judicial validation for their proposed treatments suggests that patients are progressively becoming empowered. Admittedly, emergence of a distinct discipline of HCL per se could not have brought this about but as I contend in Chapter Five so many other factors contributed towards patient empowerment.²²⁰ The rapid increase in litigation also tends to necessitate adaptation of the common law to reflect peculiarities of issues that confront the field.

As a prime example here, since 1980, the courts have increasingly recognised patient autonomy as an overarching ethical principle in HCL.²²¹ In this regard, autonomy refers to the 'bodily integrity and opportunity for individuals to decide when it is appropriate to allow healthcare professionals to have access to their bodies.'²²² The case of *Sidaway* is quite instructive here.²²³ In *Sidaway*, a female patient had an operation to relieve persistent pain in her neck, right shoulder and arms. Regardless of how properly it was done, there were inherent risks in the treatment. These consisted of damage to the spinal column and damage to the nerve roots. She became severely disabled after the operation and sued the hospital for negligence as the doctor failed to disclose those inherent risks. In his dissenting judgment in *Sidaway*, Lord Scarman noted that in order to determine whether there had been a breach of the surgeon's duty of care to his patient, mere compliance with the current state of responsible and competent professional opinion at the time was not sufficient.²²⁴ In his view, an equally important requirement was an adequate level of disclosure of information to the patient prior to her giving consent, because there may be 'other non-medical circumstances, objectives and values that affect her decision on a proposed medical

²²⁰Veitch, n 41 above, ch 1.

²²¹ *Ibid* ch 2.

²²² *Ibid* 78.

²²³ *Sidaway v Board of Governors of the Bethlem Royal Hospital and Maudsley Hospital* [1985] 1 All ER 643, 645

²²⁴ *ibid*.

treatment.²²⁵ Whilst he was the only judge who attached such significance to patient autonomy in *Sidaway*, his focus upon this matter became a dominant approach in HCL cases, which subsequently came before the courts. The 1992, the case of *In Re T* is quite poignant on this.²²⁶ Here, *T* - a 34 year old pregnant woman - had informally evinced an intention to refuse blood transfusion due to the undue influence of her mother, who was a Jehovah's Witness. After being treated for accident injuries, her condition deteriorated, as an emergency caesarean operation had to be performed. She needed a blood transfusion but was put on ventilator and could not express consent. In an application to the court for a declaration as to the lawfulness of a forcible blood transfusion, the Court of Appeal agreed that the doctors could lawfully administer the blood transfusion as a matter of necessity. Lord Donaldson affirmed the primacy of autonomy when he observed:

[t]he patient's interest consists of his right to self-determination- his right to live his own life how he wishes, even if it will damage his health or lead to his premature death. Society's interest is in upholding the concept that all human life is sacred and that it should be preserved if at all possible. It is well established that in the ultimate the right of the individual is paramount.²²⁷

Moreover, an examination of some of the leading HCL cases decided post-1980 will reveal that not only were novel legal and bioethical dilemmas presented, but they also had peculiar factual characteristics attributable to advancements in medicine. Medical advances had increased the capacity to keep patients alive in situations which previously would have made this impossible, but they had also created the phenomenon of medical futility, which means that 'the proposed therapy should not be performed because available data show that it will not improve the patient's medical condition.'²²⁸ The resolution of these issues by the courts

²²⁵ *Ibid.*

²²⁶ *In re T. (Adult: Refusal of Treatment)* [1992] All ER 649

²²⁷ *Ibid* 661.

²²⁸ JL Bernart, 'Medical futility: definition, determination, and disputes in critical care' (2005) 2 *Neurocrit Care*, 198-204.

projected tensions which could arise between sanctity of life and quality of life on one hand, and the best interests of the patient on the other. Thus, to return again to the *Bland* case, a court in England and Wales was presented for the first time with a question relating to the discontinuation of treatment of a PVS patient who could be kept alive so long as he continued to receive artificial hydration and nutrition by means of a nasogastric tube. The advancement of medical technology had changed the traditional test of death, but this did not help the Law Lords in *Bland*. Lord Keith of Kinkel stressed that the principle of sanctity of life was not an absolute one.²²⁹ The House of Lords confirmed that despite Anthony Bland being, in reality, in a state of living death, in law he was still alive because his brain stem continued to function,²³⁰ but that withdrawing life-sustaining treatment was lawful because treatment was futile. Doctors were thus under no duty to continue to treat him. In view of the obvious peculiarities of this kind of case, the court directed that in similar future cases, the doctors and health authority concerned must seek the prior approval of the court before terminating treatment which would result in death for a PVS patient. *Bland* further underscores the real challenge which medical advances posed, namely whether to keep a patient in PVS alive. Reflecting on the *Bland* case, Singer instructively remarked that ‘with this decision the law has ended its unthinking commitment to the preservation of human life that is a mere biological existence.’²³¹ Thus, *Bland* recognised that ‘at a minimum, consciousness is essential if continued life is to be worth having.’²³²

A number of cases involving PVS patients subsequently came before court. In *Re H (adult: medical treatment)*, the court applied *Bland* and held that life-sustaining treatment

²²⁹ *Airedale NHS Trust v Bland* [1993] 1 All ER 821 at 872

²³⁰ *Ibid* 866.

²³¹ P Singer, *Rethinking Life & Death: The Collapse of Our Traditional Ethics* (Oxford: Oxford University Press 1994) 80.

²³² *Ibid*.

could be discontinued for an insentient patient who was unable to communicate or to acknowledge anything taking place and who was completely dependent on artificial feeding by tube, on a tracheostomy for breathing, and on round the clock nursing for all physical needs.²³³ Also in *Frenchay Healthcare NHS Trust v S*,²³⁴ the doctor responsible for treating a patient who was in PVS, in his and the other experts' view, applied to the courts for a declaration authorising discontinuance of life-prolonging therapy (replacement of the gastrostomy tube in the patient's stomach). The Court of Appeal upheld the declaration granted and held that an application of that nature required determination of what was in the best interests of the patient. The court indicated it would accept the decision of the doctor of the PVS patient concerning the best interests of the patient, unless 'the court had real doubt about the reliability, bona fides or correctness of the medical opinion.'²³⁵ It is worth noting here that the best interest in the case of mentally incapacitated patients is now assessed via the *Mental Capacity Act, 2005*. Again, in *Re D (adult: medical treatment)*,²³⁶ where the doctor in charge of a PVS patient could not definitively conclude that all the criteria contained in the *1996 Guidelines of the British Medical Association (BMA)* had been met, the court examined the evidence and granted the declaration for the discontinuation of treatment following *Bland*. What is significant about the foregoing cases in terms of factual peculiarities is the fact that although healthcare treatment might have been discontinued many times previously, the doctors and primary care trusts began to seek the prior approval of the courts in the wake of medical advancements which had made the prolongation of life possible, even when a patient is persistently, and to put it crudely (but nonetheless realistically), a vegetable. In my view, the resort to the courts for declarations of

²³³ [1998] 3 FCR 174

²³⁴ *Frenchay Healthcare NHS Trust v S* [1994] 2 All ER 403

²³⁵ [1994] 2 All ER 403 at 411

²³⁶ [1998] 2 FLR 22

the legality of proposed medical procedures, as in *Bland* and subsequent cases, could be explicated by the issue of futility of treatment which had become part of the reality of healthcare as a result of medical advances. These cases also suggest that the medical profession was testing the boundaries regarding how definitive the PVS diagnosis needed to be. Indeed, the advancement of medical technology has increased the capacity to keep bodies alive, even when the patient cannot appreciate any quality of life.

From the foregoing case law analysis, one key conclusion is worth drawing here. The possibilities created by medical advances have meant that certain clinical decisions ought not to be unilaterally made by healthcare professionals without seeking the endorsement of the courts in order to avert future liabilities. This obviously demonstrates the deficit of the law as it existed before those cases were presented to the courts. The gap or lacuna in English and Welsh law in the wake of medical advances, coupled with the increasing popularity of liberalism²³⁷ (particularly individual autonomy) partly explains the emergence of this field of law.

C. COMMONALITY AND DISTINCTIVENESS: ARE THERE CORE PRINCIPLES OF HEALTH CARE LAW IN ENGLAND AND WALES?

As noted above, in order for an area of law to stand out as a field of law, it must have commonality of legal doctrine. Indeed, Mariner has opined that: health [care] law should be described in a manner that gathers all the disparate legal doctrines into a comprehensible whole with observable commonalities, but without necessarily forcing it to adopt any normative goal.²³⁸

Thus, if it is a field of law, HCL should have the capacity to exhibit some sort of core principles or values which will provide an explanatory framework for the majority or all of

²³⁷ I explore this liberalism further in Chapter Five, Section 5.1.1.

²³⁸ WK Mariner, 'Toward an Architecture of Health Law' (2009) 35 *American Journal of Law*, 69.

the disparate areas of the field. Undoubtedly, locating core principles which could imbue the field of HCL with some degree of coherence or conceptual unity is an uphill task. According to Grubb, the obligations imposed on doctors in the context of doctor-patient relationship must be put on some theoretical footing.²³⁹ Thus, he points out that ‘the ethical principles of autonomy, beneficence, non-maleficence, justice, promise-keeping and truth-telling are all reflected somewhere in the law and the inevitable conflicts and tensions that arise between them have to be resolved in the law.’²⁴⁰ Although the first four of these principles were popularised by Beauchamp and Childress²⁴¹ as the conceptual tools for ethical evaluation in medicine, they have become a crucial analytical framework in HCL in England and Wales for addressing complex and novel cases, as I discuss below. Indeed, Kennedy, a pioneering HCL scholar, has stressed the need for adopting ethical analysis in order to imbue the field with coherence.²⁴² Despite the claim by Kennedy and Grubb that the ethical precepts stated above have the power to organise and give unitary coherence to this field, it appears that in litigation before the English and Welsh courts, the tensions posed by autonomy and its allied ethical precepts are often subtly or surreptitiously evaded when the cases are decided. I demonstrate this further in the discussion below. Indeed, Veitch has argued that there is a gap between what academic HCL scholars prescribe as the underlying ethical principles of HCL and what the courts actually do when deciding HCL disputes.²⁴³

Notwithstanding the description by some commentators,²⁴⁴ that HCL is an amalgam of different branches of the law without any overarching principles, I submit that it is possible

²³⁹ A Grubb, ‘The Emergence and Rise of Medical Law and Ethics (1987) 50 *Modern Law Review*, 241-267.

²⁴⁰ *Ibid* 244-245.

²⁴¹ TL Beauchamp and TF Childress, *Principles of Biomedical Ethics* (1st edn, Oxford: Oxford University Press 1979).

²⁴² I Kennedy, *Treat Me Right: Essays in Medical Law and Ethics* (Oxford: Clarendon Press 1988) 3.

²⁴³ Veitch, n 41 above, ch 4.

²⁴⁴ M Gregg Bloche, ‘The Invention of Health Law’ (2003) 91 *California Law Review*, 247, 249-50.

to discern certain core principles which commonly emerge from litigation in this field. As the quest for recognition of patient rights in healthcare propelled the development of HCL, many cases decided during the period under study have demonstrated the prominence of the principles of autonomy, sanctity of life and quality of life. Nevertheless, some of the decided cases reveal not only tension between these principles, but also their legal pervasiveness.

Autonomy is considered by some of the pioneering literature on HCL as ‘the most significant value to have influenced the evolution of contemporary medical law.’²⁴⁵ Traditionally, autonomy in the HCL field concerns ‘controlling access to one’s body and what can be done to it.’²⁴⁶ The bodily integrity, which is protected by the ethical value of autonomy, was underscored by Cardozo J in the USA long before the emergence of HCL as a field of law in England and Wales. He remarked:

[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without the patients consent commits an assault.²⁴⁷

From the above quotation, it is clear that there is an important link between bodily integrity and consent. Thus, autonomy can be conveniently considered as ‘the representation of the ethical value underlying consent to and refusal of medical treatment.’²⁴⁸ Litigation in the field of HCL between 1980 and 2000 demonstrates that autonomy is also viewed as the right to self-determination. In his powerful dissenting opinion in the afore-mentioned *Sidaway* case, Lord Scarman stated that:

...the question whether or not the omission to warn constitutes a breach of the doctor's duty of care towards his patient is to be determined not exclusively by

²⁴⁵ JK Mason and GT Laurie, *Mason and McCall Smith’s Law and Medical Ethics* (8th edn, Oxford: Oxford University Press 2010) 8.

²⁴⁶ Veitch, n. 41 above, 78.

²⁴⁷ *Schloendorff v Society of New York Hospital* 105 NE 92 (NY, 1914).

²⁴⁸ K Veitch, *The Jurisdiction of Medical Law* (Aldershot: Ashgate Publishing Limited 2007) 79.

reference to the current state of responsible and competent professional opinion and practice at the time, though both are, of course, relevant considerations, but by the court's view whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes.²⁴⁹

In the course of the judgement, Lord Scarman adopted the phrase 'right to self-determination' to describe the right of a patient to determine for herself whether she would or would not accept the doctor's advice.²⁵⁰ The other case where similar views were espoused is the aforementioned case of *Re T*.²⁵¹ Lord Donaldson, reflecting on the conflict between the interest of the patient and the interests of the society pertaining to the situation stated:

The patient's interest consists of his right to self-determination - his right to live his own life how he wishes, even if it will damage his health or lead to his premature death. Society's interest is in upholding the concept that all human life is sacred and it should be preserved if at all possible. It is well established that in the ultimate the right of the individual is paramount. In the case of doubt, that doubt falls to be resolved in favour of the preservation of life, for if the individual is to override the public interest he must do so in clear terms.²⁵²

In *Bland*, Lord Goff underscored in similar language the right to self-determination as a dimension of autonomy when he said:

[I]t is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so.²⁵³

²⁴⁹ *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital and others* [1985] 1 All ER 643 at 645.

²⁵⁰ *Ibid* 650.

²⁵¹ *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649

²⁵² *Re T (adult: refusal of medical treatment)* [1992] All ER 64, 661.

²⁵³ *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 864

The dicta, from the above and other cases,²⁵⁴ emphasises autonomy in terms of the nexus between the right to self-determination and consent to treatment.²⁵⁵ It has therefore been rightly contended that the linking of autonomy with this right has rendered autonomy synonymous in HCL with ‘the generic idea of patients’ rights itself, such that the term patient autonomy is often just another way of referring to patient’s rights.’²⁵⁶ The prominence of autonomy in this field of law post-*Sidaway* was not only unassailable but became what Veitch calls ‘an ideological tool deployed as a means by which judges [could] justify the court’s contemporary relevance in resolving disputes arising in the course of medical practice.’²⁵⁷

Despite the presence of autonomy in HCL’s discourse and litigation, there exists a tension between the ethical value of autonomy reflected in consent to treatment and the doctrine of sanctity of life. Admittedly, whilst sanctity of life gained prominent coverage in the 1950s in Glanville William’s seminal book²⁵⁸ and still remains an important principle of HCL, it is submitted that autonomy appears to be increasingly pervasive in HCL discourse .²⁵⁹ However, the judicial approach to the refusal of consent to life-prolonging treatment in some of the cases decided between 1980 and 2000 seems to create impression of leaning towards sanctity of life.²⁶⁰ Such cases reveal that the courts tend to mediate the tension between autonomy (as the right to self-determination) and sanctity of life by setting a high

²⁵⁴ Also in *Chester v Afshar* [2004] All ER 587, at 613, Lord Walker highlighted Lord Scarman’s description of the patient’s right to self-determination in *Sidaway* as a basic human right and noted that since *Sidaway* was decided, ‘the importance of personal autonomy has been more and more widely recognised’.

²⁵⁵ Also noteworthy is: *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR 334, 339 which stresses the need for reasonable steps to be taken for a patient to understand information prior to consenting.

²⁵⁶ Veitch, n 41 above, 79.

²⁵⁷ *Ibid* 80.

²⁵⁸ *The Sanctity of Life and the Criminal Law* (Alfred A. Knopf, 1957) examines the philosophical basis for laws against contraception, sterilisation, artificial insemination, abortion, suicide and euthanasia.

²⁵⁹ Although not in every instance, for example, in assisted dying.

²⁶⁰ For example, see: *Airdale NHS Trust v Bland* [1993] 1 All ER 821; *Re G (Persistent Vegetative State)* [1995] 2 FCR 46; *Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782

threshold of capacity as a prerequisite for recognising a decision by a patient to refuse treatment. Harrington, bemoaning the fact that tests of valid consent have proved so 'malleable as to be of little use in advancing patient's interests', notes that:

Patients seeking compensation on the basis of non-disclosure of risks which have occurred are faced with [a] minimalist test of consent, which predicates validity, more or less on the amount which a reasonable doctor would disclose. On the other hand *patients refusing treatment* who have or seek to deviate from medical and social norms in favour of treatment are faced with maximalist tests of valid consent in the form of capacity requirements.²⁶¹

Thus, in *Re T*, Lord Donaldson emphasised the absolute right of a patient to choose or refuse medical treatment provided he or she has no mental incapacity.²⁶² Therefore, it appears from the jurisprudence of the courts relating to the refusal of treatment that autonomy is characterised as the goal and (provided one has mental capacity) exercising one's right to refuse is viewed as the process of arriving at the goal.²⁶³

In fact, it may not be inaccurate to assert that the judicial approach to cases of the refusal of treatment suggests a lack of interest in the exercise of autonomy or self-determination to refuse life-prolonging treatment. On the contrary, Veitch contends that the courts are being pretentious, since, in reality, 'the regulation of continued existence of human life is at the root of law's function.'²⁶⁴ The logical upshot is that the courts are rather over-zealous to uphold the sanctity of life at the expense of autonomy by masquerading under stringent tests of mental capacity to bring into question the validity of refusals of medical treatment.²⁶⁵ Whether one is satisfied with the protection of life, which, according

²⁶¹ JA Harrington, 'Privileging the Medical Norm: Liberalism, Self-determination and Refusal of Treatment (1996) 16 *Legal Studies*, 348, 363.

²⁶² *Re T (adult: refusal of medical treatment)* [1992] All ER 64, at 652-653.

²⁶³ JA Harrington, 'Privileging the Medical Norm: Liberalism, Self-determination and Refusal of Treatment (1996) 16 *Legal Studies*, 348.

²⁶⁴ Veitch, n 41 above, 84.

²⁶⁵ For example, see: *Bolton Hospitals NHS Trust v O* [2003] 1 FLR 824

to Veitch, lies at the heart of judicial reasoning, is largely contingent upon the side that one takes in the philosophical debate over the nature and role of law in society.²⁶⁶

The prominence of autonomy in HCL cases decided during the period under study may be rationalised by the need to empower patients against medical paternalism, which came under severe criticism in the 1970s and 1980s.²⁶⁷ Arguments based on individual autonomy are used to urge the courts 'to maximise the transfer of information and decision-making from doctor to patient.'²⁶⁸ As Veitch aptly notes, 'one obvious reason would be the need to ensure that patients' voices are heard and respected.'²⁶⁹ Another reason he advances for the prominence of autonomy is that it allows the judiciary to present the law as 'a social institution that assists in the process of redressing the traditional imbalance of power between doctor and patient.'²⁷⁰ In this way, it presents an opportunity for the courts to 'claim to meet the expectations of individuals today - their desire for choice, self-determination and the exercise of rights.'²⁷¹

The traditional academic presentation of HCL as being organically linked to ethics has been noted as inadequate for understanding the role of autonomy in this field of the law.²⁷² Consequently, an explanation that goes beyond a priori reasoning in ethics is needed here. To achieve this alternative explanation, Veitch draws upon inter-professional politics, as used by Montgomery.²⁷³ Veitch argues that the insistence of the courts that mental capacity

²⁶⁶ For example, natural law proponents, like Finnis, support the view that the preservation of life is the ultimate goal of law. See: J Finnis, *Natural Law and Natural Rights* (Oxford: Clarendon Press 1980).

²⁶⁷ See: I Illich, *Limits to Medicine: Medical Nemesis, the Expropriation of Health* (London: Penguin 1977); M Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (London: Tavistock Publications Ltd. 1973); I Kennedy, *The Unmasking of Medicine* (London: George Allen & Unwin 1981).

²⁶⁸ JA Harrington, 'Privileging the Medical Norm: Liberalism, Self-determination and Refusal of Treatment (1996) 16 *Legal Studies*, 348-367.

²⁶⁹ Veitch, n. 41 above, 99.

²⁷⁰ *Ibid.*

²⁷¹ *Ibid.*, n.269 .

²⁷² *Ibid* 101-103.

²⁷³ *Ibid* and citing J Montgomery, 'Law and Demoralisation of Medicine' (2006) 26 *Legal Studies*, 185-210.

should be satisfied as a precondition of the genuine and valid exercise of a right to refuse treatment is a strategy employed 'to reduce the power of the medical profession vis-à-vis the patient.' Thus, Veitch has noted:

The split constructed within the courts between the nature of patients' decisions (something which cannot be questioned) and tests for mental capacity (which, because they are designed to assess understanding and use of treatment, are supposed to be neutral) is meant to subvert the possibility of medical paternalism by confining the medical professional's role to that of judging the state of the patient's mind, while allowing the courts to assert the importance of individual autonomy.²⁷⁴

Despite the optimism that Veitch's analysis of the courts' approach holds for safeguarding patient autonomy, Harrington has advocated a shift from 'contract models of medical relationship' to a fiduciary approach, if the law is to have a 'prospect of redressing medical paternalism and the disempowerment of patients.'²⁷⁵ Harrington draws upon two leading Canadian cases²⁷⁶ and rightly contends that unlike contract or tort, the fiduciary approach explicitly recognises the power imbalance inherent in the doctor-patient relationship, and imposes obligations on that basis.²⁷⁷ While the cases from this era which I have discussed present moral dilemmas in their particular factual matrix, the courts often subtly or surreptitiously gloss over the moral undertones of the dispute.²⁷⁸ This is evident in, for example, the cases involving the refusal of life-saving treatment which are considered above. It has been seen that the courts evade the hard question of the primacy of autonomy over sanctity of life by taking refuge behind technical barriers, such as erecting the hurdle of mental capacity to ascertain autonomy or self-determination. Nevertheless, the

²⁷⁴ K Veitch, n. 248 above, 101-102.

²⁷⁵ n.268 above, 366.

²⁷⁶ *Norbeg v Wynrib* [1992] 93 DLR (4th) 415; *McInery v MacDonald* [1992] 92 DLR (4th) 449.

²⁷⁷ *Ibid.*

²⁷⁸ J Montgomery, 'Law and Demoralisation of Medicine' (2006) 26(2) *Legal Studies*, 185, 190.

jurisprudential conundrum concerning whether it is the province of the court of law to decide on matters of ethics lingers on.

Although the substantial quantitative increase in case law on healthcare matters in this jurisdiction is largely beyond the realm of contestation, it is not enough for this area of the law to be recognised as a field unless the other indicia of a legal field identified above are met. One such important indicator of the maturation of HCL in England and Wales as a distinct body of law is the enactment of specific statutes to address emerging issues in the field. In the next segment, I explore the existence of dedicated statutes and other soft law on healthcare and in particular, those which portray patient empowerment and the regulation of medical advances.

3.2.2 THE DEVELOPMENT OF INTERVENTIONIST LEGISLATION AND QUASI-LAW TO REGULATE HEALTHCARE PRACTICES AND MEDICAL ADVANCES

A. DEDICATED HCL LEGISLATION

The moral and legal complexities associated with medical advances and the public debate such advances trigger engaged the attention of lawmakers and culminated in the passage of numerous specific HCL statutes during the period under discussion.²⁷⁹ Reproductive technologies, organ transplantation, life support machines and genetic research are important achievements of modern medicine. These developments have raised novel questions that transcend legal norms and generate major bioethical debate. As will be discussed further in Chapter Five, they have precipitated the enactment of the statutes in Table 1 below: Dedicated HCL Statutes 1980-2000.

²⁷⁹ M Brazier and E Cave, *Medicine, Patients and the Law* (5th edn, England: Penguin Books 2011) xxiii-xlv.

SHORT TITLE OF THE STATUTE	KEY SIGNIFICANCE TO HCL
Human Organ Transplant Act 1989 (now repealed)	<ol style="list-style-type: none"> 1. Prevented commercial dealings in human organs for transplantation. 2. Responded to reported instances of the purchase of kidneys from live donors overseas by prohibiting the traffic in organs.²⁸⁰ 3. Regulated transplantation through live donation.
Human Fertilisation and Embryology Act 1990 (HFE)	<ol style="list-style-type: none"> 1. Endorsed the primacy of the ethical principle of autonomy by requiring the consent of donors before their gametes or embryos could be used for treatment. It established a regulatory body comprising a majority of lay members to keep medical practice and scientific research relating to IVF and other assisted reproduction technologies (ARTs) within acceptable legal and bioethical limits through a licensing scheme and to produce periodic guidelines and consultation documents on new areas of ARTs. 2. Regulated the creation, use and storage of human embryos and human admixed embryos <i>ex utero</i> for treatment or research purposes.
Access to Health Records Act 1990	Unlike the (now repealed) Data Protection Act 1984, which allowed access only to computer-held information, this Act protects patients' right of access to their own manually-held records within defined parameters.
Surrogacy Arrangements Act 1985	Does not prohibit surrogacy but outlaws commercial surrogacy agencies.
Abortion Act 1967 amended by s 37 of HFE Act 1990	<p>Since passed and amended, the Act has provided four key conditions under which pregnancy can be terminated. First, s. 1(1)(a) permits abortion up to 24 weeks if the pregnancy would pose a greater risk to the physical or mental health of the pregnant woman or children than a termination. Second, s. 1(1)(b) permits abortion to prevent grave permanent injury to the woman's physical or mental health. Third, s. 1(1)(c) allows abortion if continuing the pregnancy would carry risk to the life of the pregnant woman and finally, s. 1(1)(d) legalises abortion if there is substantial risk that if the baby was born it would be seriously handicapped.</p> <p>The amendments brought about by the HFE</p>

²⁸⁰ M Jackson-Robert, 'The Transplant of Human Organs Bill' Research Paper 01/2316 March 2001 <http://www.parliament.uk/documents/commons/lib/research/rp2001/rp01-023.pdf> (last accessed: 22/11/2012).

	Act 1990 meant that apart from s. 1(1)(a), where there is a time limit ²⁸¹ for undertaking abortion for what are regarded by some as ‘social’ reasons, all the other instances (relating to medical and disability) do not provide any time limit. Thus, there has been substantial liberalisation of abortion.
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Table 1: Dedicated HCL Statutes 1980-2000.

Notably, the statutes enumerated above were purposefully enacted to regulate certain, often inherently sensitive, aspects of healthcare, due to the moral dilemmas they provoke.

B. QUASI-LAW: THE RAPID INCREASE IN PROFESSIONAL GUIDELINES, DIRECTIVES AND CIRCULARS AS A PROACTIVE RESPONSE TO ETHICAL AND LEGAL DILEMMAS IN HEALTHCARE

It has been suggested that HCL cannot be fully understood without appreciating that it is a combination of hard law and collegiate norms.²⁸² Indeed, Montgomery has contended that *quasi-law* also constitutes a significant segment of the body of HCL. Quasi-law ‘describes rules which may be made without explicit legal authority and which are most important for the guidance they offer rather than sanctions which follow if they are disregarded.’²⁸³ The post-1980 period saw a marked increase in the drawing-up of clinical guidelines and codes of practice to deal with potentially controversial clinical situations, in order to help instil public confidence in healthcare and also to protect healthcare professionals.²⁸⁴ For example, the Shipman Inquiry and ensuing government response emphasised the need for explicit standards to describe the quality of care which patients can expect to receive.²⁸⁵ Some of

²⁸¹ The time limit was reduced from 28 to 24 weeks so the first subsection was made more restrictive.

²⁸² J Montgomery, ‘Time for a Paradigm Shift? Medical Law in Transition’ in M. Freeman (ed), *Current Legal Problems* (Oxford: OUP 2000) 363.

²⁸³ J Montgomery, *Health Care Law* (Oxford: Oxford University Press 1997) 5.

²⁸⁴ A Samanta, MM Mello, C Foster, J Tingle and J Samanta, ‘The Role of Clinical Guidelines in Medical Negligence Litigation: A shift from Bolam Standard?’ (2006) *Medical Law Review*, 321-366.

²⁸⁵ ‘Safeguarding Patients: Lessons Learned From the Past—Proposals for the Future’ (Fifth Report, Cmnd. 6394 2004) <http://webarchive.nationalarchives.gov.uk/20050202182438/the-shipmaninquiry.org.uk/fifthreport.asp> (accessed: 15/4/2013); ‘Safeguarding Patients (The Government’s response to the recommendations of the Shipman Inquiry’s fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries) http://webarchive.nationalarchives.gov.uk/20050202182438/http://the-shipmaninquiry.org.uk/images/fifthreport/SHIP05_COMPLETE_NO_APPS.pdf (accessed: 15/4/2013).

these guidelines emanate from non-statutory health professional associations like the British Medical Association (BMA) or statutory bodies, such as the General Medical Council (GMC), the Royal Medical Colleges, the Department of Health, and the National Institute for Health and Care Excellence.²⁸⁶ It is pertinent to consider a few examples to demonstrate how the emergence of HCL has necessitated a modification of our traditional understanding of law-making or legislation.²⁸⁷ Firstly, the Department of Health has issued several circulars, including the circular on contraceptive services for young people, which precipitated the *Gillick* case.²⁸⁸ Similarly, NICE has published guidelines in three thematic areas: ‘the use of health technologies within the NHS (such as the use of new and existing medicines, treatments and procedures), clinical practice (guidance on the appropriate treatment and care of people with specific diseases and conditions), and guidance for public sector workers on Health promotion and ill-health avoidance.’²⁸⁹ As a further example, the Medical Ethics Committee of the BMA has issued more than thirty clinical and ethical guidelines since 1980.²⁹⁰ Moreover, in 1983, the Association of the British Pharmaceutical Industry produced a code for dealing with problems relating to the compensation of volunteers injured during drug trials.²⁹¹

²⁸⁶ NICE set up in 1999 and re-organised in 2005 with a new name, has published many guidelines. See National Institute for Health and Care Excellence, ‘NICE Guidelines’ <http://guidance.nice.org.uk/CG/Published> (accessed: 15/4/2013).

²⁸⁷ See generally: J Montgomery, *Health Care Law* (Oxford: Oxford University Press 1997), 5.

²⁸⁸ *Gillick v W. Norfolk & Wisbech AHA* [1985] 3 All ER 402

²⁸⁹ National Institute for Health and Care Excellence, ‘About NICE’ <http://www.nice.org.uk/aboutnice/> (last accessed: 15/4/2013).

²⁹⁰ British Medical Association, ‘Ethics A to Z’ <http://bma.org.uk/practical-support-at-work/ethics/ethics-a-to-z> (last accessed: 14/6/2012).

²⁹¹ APBI, ‘Guidelines on Clinical Trials - Compensation for Medicine-induced Injury’ (1983) 287 *British Medical Journal*, 675.

The legal effect of guidelines has been the subject of intense debate²⁹² in the legal and medical literature and there is an emerging consensus affirmed by the dicta of the courts that a doctor who complies with directions in guidelines could have a good defence if subsequently challenged in court.²⁹³ Two leading cases are instructive on the place of quasi-law in this field of law. These are *W v Egdell*²⁹⁴ and *Bland*. First, in *W v Egdell*, a convicted serial killer being detained in a mental health institution contracted an independent psychiatrist to examine him and produce a report. Due to the adverse content of the report, its intended application (to indicate that the patient could be released) was abandoned, but the psychiatrist disclosed the content of the report to the hospital where the patient was being cared for and also to the Home Office. In the appeal regarding the patient's action for breach of confidentiality, the Court of Appeal needed to determine the balance to be struck between the public interest in the preservation of professional confidence and the public interest in disclosure of confidential information for public safety. Despite having stated that the 'Advice on Standards of Professional Conduct and of Medical Ethics' contained in the General Medical Council's 'Blue Book' on professional conduct and discipline, 'do not themselves have statutory authority,' the Court of Appeal, like the court below, relied extensively on the guidelines in its reasoning, upholding the displacement of confidentiality by public safety concerns.²⁹⁵ The copious reference to these guidelines in the Court's decision reinforces the view espoused by Montgomery that in this field of the law, one

²⁹² See generally: J Tingle and C Foster (eds), *Guidelines: Law, Policy and Practice* (Cavendish 2002); D Black, 'Guidelines or Gumption? The Role of Medical Responsibility: A View from the Profession' in SR Hirsch and J Harris (eds), *Consent and the Incompetent Patient: Ethics, Law and Medicine* (London: Royal College of Psychiatrists 1998).

²⁹³ H Teff, 'Clinical Guidelines, Negligence and Medical Practice' in M Freeman and A Lewis (eds), *Law and Medicine Current Legal Issues Volume 3* (Oxford University Press 2000) 67–80; A Samanta, MM Mello, C Foster, J Tingle and J Samanta (2006) 'The Role of Clinical Guidelines in Medical Negligence Litigation: A shift from Bolam Standard?' *Medical Law Review*, 321-366.

²⁹⁴ [1990] 1 All ER 835

²⁹⁵ *W v Egdell*, [1990] 1 All ER 835, at 843, 845-846.

cannot know the full scope of the relevant principles or rules without also having recourse to quasi-law. Similarly, in *Bland*, the House of Lords considered guidelines²⁹⁶ produced by the BMA regarding the discontinuation of artificial nutrition and hydration (ANH).²⁹⁷ Lord Goff noted that if a doctor 'acts in accordance with the medical practice now being evolved by the Medical Ethics Committee of the BMA, he will be acting with the benefit of guidance from a responsible and competent body of relevant professional opinion, as required by the Bolam test.'²⁹⁸ Thus, it would seem that what constitutes 'proper' medical treatment (and thus treatment that is more likely to be *lawful*) is largely ascertained by considering whether it is in accordance with professional guidance.

In addition to the above, the GMC has issued numerous guidelines in the wake of high profile medical scandals, including the Bristol Inquiry and the Harold Shipman Inquiry.²⁹⁹ In terms of standards of medical practice regarding consent to treatment and disclosure, it has been argued that the GMC's guidelines³⁰⁰ set a higher threshold than what the courts have determined since the celebrated *Bolam* case.³⁰¹ However, in 2008, when the GMC revised its guidelines on consent,³⁰² it was pointed out by commentators that it was taking a retrograde

²⁹⁶ Medical Ethics Committee of British Medical Association, *Discussion Paper on the Treatment of Patients in Persistent Vegetative State* (London: BMA, 1992); British Medical Association, *Withholding or Withdrawing Life-prolonging Medical Treatment: Guidance for Decision Making* (London: BMJ Books, 1999). Note that these guidelines are no longer up-to-date but for the purposes of this research they are cited. For more current ones, see: *British Medical Association Access to health records – Guidance for health professionals in the United Kingdom* (London: BMA 2008) www.bma.org.uk/ethics

²⁹⁷ *Airedale NHS Trust v Bland* [1990] 1 All ER 835, especially 843, 845-846, 872.

²⁹⁸ *Ibid.*

²⁹⁹ For example: Good Medical Practice 2013 (effective from April, 2013) sets out the high level principles of good practice expected of all doctors http://www.gmc-uk.org/guidance/news_consultation/20477.asp (last accessed 16/4/2013).

³⁰⁰ For example: GMC, *Seeking patients' consent: the ethical considerations* (London: General Medical Council 1998); GMC, *Good Medical Practice* (London: GMC 1995); GMC, *Good Medical Practice* (London: General Medical Council 1998).

³⁰¹ S Fovargue and J Miola, 'One step forward, two steps back? The GMC, the common law and 'informed' consent' (2010) *Journal of Medical Ethics*, 494-497

³⁰² General Medical Council (GMC) *Consent: patients and doctors making decisions together* (London: GMC 2008).

step in applying a lowered standard of care than the one set by the courts.³⁰³ This was because previous versions of the GMC guidelines imposed a higher standard for doctors than was prescribed by the prevailing common law. It is submitted that the standards set by GMC ought to be higher than those set by courts or law makers, since self-regulation in the healthcare context should observe higher ethical standards.

The recognition of HCL as an important subject worthy of discrete status is further evidenced by increasing reliance on these guidelines by lawyers in their litigation strategy. An empirical survey to determine practising lawyers' perceptions of the use of guidelines in medical negligence litigation in England and Wales, undertaken by Samantha et al, revealed that a high proportion of respondent barristers and solicitors were familiar with the guidelines, had used them as part of a trial strategy, and also expected guidelines to play a greater role in medical litigation in the future.³⁰⁴ That said, the normative standards of healthcare embodied in professional guidance and other forms of quasi-law are sometimes challenged. Two examples will be discussed here to illustrate this point. First, as noted earlier in *Gillick*, the Department of Health issued a circular on contraceptive services for young people. Mrs Gillick³⁰⁵ challenged the circular in court because it envisaged that in exceptional circumstances, a doctor might offer contraceptive advice and treatment to a child below 16 years without parental consent. However, the majority of the House of Lords held the circular to be consistent with the law. Secondly, in *Burke*,³⁰⁶ the applicant was suffering from a cerebral ataxia, a terminal degenerative condition that at some point would require him to receive artificial nutrition and hydration (ANH) to prolong his life; at that

³⁰³ S Fovargue and J Miola, 'One step forward, two steps back? The GMC, the common law and 'informed' consent' (2010) *Journal of Medical Ethics*, 494-497

³⁰⁴ A Samanta, MM Mello, C Foster, J Tingle and J Samanta, 'The Role of Clinical Guidelines in Medical Negligence Litigation: A shift from Bolam Standard?' (2006) *Medical Law Review*, 324.

³⁰⁵ *Gillick v W. Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402

³⁰⁶ *R (on the application of Burke) v General Medical Council* [2005] 3 FCR 169

stage he would remain conscious and competent for a considerable time until the disease reached its final stages. He was concerned by the tenor of the GMC's guidance to doctors in *Withholding and Withdrawing Life-prolonging Treatment: Good Practice and Decision Making*.³⁰⁷ This Guidance implied that unless the patient was actively refusing ANH, its continuation was contingent upon the discretion of a doctor in charge of his care. Mr Burke accordingly challenged the Guidance's legality in relation to both common law and human rights. The Court of Appeal held that contrary to strenuous effort by the judge in the first instance to demonstrate the incompatibility of the Guidance with the patient's right to life-prolonging ANH, there was nothing wrong with the advice contained in the Guidance. It is thus significant to note that, in both the above examples, the courts were prepared to uphold the legality of quasi-law.

3.2.3. SUSTAINABILITY OF THE FIELD: TEACHING AND SCHOLARSHIP

A. THE TEACHING OF HEALTHCARE LAW IN UNIVERSITY LAW SCHOOLS IN ENGLAND AND WALES

Brazier and Cave have noted that, until the 1980s, 'university courses on medical law were virtually unknown.'³⁰⁸ Thus, in ascertaining whether HCL is taught at universities, the course titles used and the content of courses will provide useful evidence of the existence of HCL as a discrete subject in England and Wales. I, therefore, undertook an e-mail-based survey in law schools to elicit responses to three questions, namely: '(1) Do you offer an undergraduate module in medical law/healthcare law? (2) If so, which year did the module commence?' Finally, I asked whether the school did offer such a module and whether they could provide me with a copy of the module outline, syllabus, or handbook.

³⁰⁷ This was published in August 2002.

³⁰⁸ M Brazier and E Cave, *Medicine, Patients and the Law* (5th edn, England: Penguin Books 2011) xxiii-xlv.

I. PRESENTATION OF FINDINGS

Table A: POPULATION: UNIVERSITIES IN ENGLAND AND WALES, 2012

Categorisation of University Programme	Number of Universities	Percentage
Law Degrees Offered	89	77.4
No Law Degrees Offered	26	22.6
Total	115	100

TABLE B: UNIVERSITIES OFFERING UNDERGRADUATE LAW DEGREES WITH HEALTHCARE LAW AS A MODULE IN ENGLAND AND WALES, AS AT SEPTEMBER, 2012

Categorisation of University Programme	Number of Universities	Percentage
Health Care Law Offered	59	66
No Health Care Law Offered	30	34
Total No. of Universities Offering Law	89	100

TABLE C: UNIVERSITIES OFFERING LAW DURING STATED PERIODS WHICH SUPPLIED THEIR COURSE HANDBOOK TO THE RESEARCHER

Approximate Period of Commencement	Number of Universities Offering Health Care Law	Percentage
1980-1990	3	3
1990-2000	14	15
2000-2010	8	9
2010-2012	3	3
Unspecified/Unknown*	57	64
Total	89	100

*Universities that could not specify the approximate period of commencement due to the unavailability of tutors who first taught HCL, or the absence of records.

TABLE D: TOPICS /THEMES TAUGHT UNDER HEALTHCARE LAW IN ENGLISH AND WELSH LAW SCHOOLS

SN	Key Topics/ Themes Taught on HCL Courses	Number of Universities Offering Health Care Law/ Medical Law
1	The Doctor-Patient Relationship	6
2	Autonomy & Consent to Treatment	12
3	Informed Consent and Capacity	17
4	Refusal of Treatment	4
5	Access to Medical Records/Confidentiality & Privacy	12
6	Medical Malpractice/Medical Negligence	14
7	Resource Allocation	9
8	Human Rights & Health Care	8
9	Regulating Medical and Genetic Research	7
10	Issues at the End of Life/Death, Dying & Assisted Dying/ Euthanasia	29
11	Organ Donation, Transplantation and Human Tissue	15
12	Public Health	2
13	Pharmaceuticals, Regulation and Research	2

14	Wrongful Conception & Prenatal Injury	4
15	Abortion	8
16	Assisted Reproduction	13
17	Law and Mental Illness/Mental Health	3
18	Complementary/Alternative Therapies	1
19	Structure of the UK Healthcare System	3
20	The Role of Law and Morality in Developing Bioethics	2

TABLE E: DESCRIPTIVE TITLES GIVEN TO 'HEALTH CARE LAW' COURSES IN LAW SCHOOLS IN ENGLAND AND WALES

Description of the Course	Number of Universities Offering Health Care Law/ Medical Law
Medicine, Ethics and Law	5
Medical Law	41
Medical Law and Ethics	20
Health Care Law/Health Care Law and Ethics	14
Health law	5
Law and Medicine/Medicine and Law	4

II. ANALYSIS

Table B indicates that 66 per cent of a total of 89 universities with law schools offer an undergraduate course or module in HCL. Thus, as at 30th September, 2012, when data was collected, well over 60 per cent of law schools in England and Wales were already offering HCL as a course, at least at undergraduate (LLB) level. Since the study sought, among other purposes, to inquire into the period when HCL was taught in the universities, the various time periods embodied in the responses elicited by the questionnaire were critical. Unfortunately, from Table C, 57 of the schools offering HCL - representing 64 per cent of the general population in the survey - could not even 'guesstimate' when their school had started offering the course. The dominant justification provided by those law schools was that the first lecturer to have taught the course was no longer available, coupled with records being untraceable. Nevertheless, the responses from the remaining schools revealed that whereas only 3 schools had commenced offering HCL courses between 1980 and 1990, between 1990 and 2000, another 14 law schools had also introduced the course at LLB level.

Thus, during the first two decades of the emergence of academic HCL in England and Wales, judging by these responses, only 17 law schools offered the course. This conclusion is a cautious one, due to the inability of 57 law schools to specify or speculate as to when the courses were initially offered in their respective schools. This caution is largely impelled by findings from a survey of law schools undertaken in 1996 by Harris and Jones.³⁰⁹

The 1996 survey found that as at the 1994/95 academic year, there were 26 law schools in the United Kingdom offering HCL as an option at LLB level. This earlier finding obviously does not include the period after 1995. It is interesting that the survey I undertook in 2012 found that, between 1980 and 2000, only 17 law schools offered the course in England and Wales. The contrast between 26 law schools (up to 1995 as per the 1996 survey) and 17 law schools (up to 2000 as per the current survey) is quite striking. Two reasons can be advanced to explain the divergence in the findings. First, it is worthy of note that whereas the present survey only targeted law schools in England and Wales, the 1996 survey used the entire United Kingdom as its target population. This inevitably causes the two surveys to differ in their results. The other reason is that it is highly likely that some of the 57 law schools which could not specify when their HCL commenced might have started offering HCL courses before 2000. The probable inference that most of the 57 law schools might have commenced offering such courses before 2000 is reinforced by Brazier's and Glover's observation in 2000, that HCL had matured as a distinct discipline in the way it was being taught in many universities.³¹⁰

Apart from the visibility of HCL in the curricula of law schools, Table D presents interesting findings concerning the topics or content of the course in various law schools. 20

³⁰⁹ P Harris and M Jones, 'A survey of law schools in the United Kingdom, 1996' (1997) 31 *The Law Teacher*, 38-126.

³¹⁰ M Brazier and N Glover, 'Does Medical Law Have a Future?' in D Hayton (ed), *Law's Future(s)* (Oxford: Hart Publishing 2000) 371-389.

topics or thematic areas were found to be covered in HCL courses in England and Wales. Before proceeding further with this analysis it is pertinent to note a caveat that the figure of 20 might look large at first glance, but upon closer observation, some of the topics are similar or may overlap. Nevertheless, it was considered prudent to present them in their existing form because the research relates purely to what is stated in course handbooks and not necessarily in lecture notes. Consequently, it was not possible to assume that similarly couched topics might necessarily cover the same breadth of relevant subject matter. Beyond this unavoidable limitation, the frequency of topics distributed among the research population offers interesting revelations. The most popular topic taught in HCL comprises 'Issues at the End of Life/Death, Dying and Assisted Dying/Euthanasia', which is taught in 29 law schools. The next most popular topic taught in as many as 17 law schools is 'Informed Consent and Capacity.' This particular topic could also have ranked first if the 12 law schools offering 'Autonomy and Consent to Treatment' had been added to the former. Significantly, autonomy and self-determination are, of course, important aspects of these two topics. Thus, the popularity of these topics lends some credence to the earlier argument made that autonomy stands out as a core principle of HCL. 'Organ Donation, Transplantation and Human Tissue' ranks as third most popular, being taught in as many as 15 law schools. The least popular topics taught in less than three law schools include Public Health, Complementary/Alternative Therapies and Pharmaceuticals Regulation and Research. It is submitted that the topics taught in eight or more schools can largely be taken as constituting the basic syllabus for HCL. Using these criteria, the popular HCL topics taught in law schools are:

- Issues at the End of Life/Death, Dying and Assisted Dying/Euthanasia;
- Informed Consent and Capacity;

- Autonomy and Consent to treatment;
- Organ Donation, Transplantation and Human Tissue;
- Medical Malpractice/Medical Negligence;
- Assisted Reproduction;
- Access to Medical Records/Confidentiality and Privacy;
- Resource Allocation;
- Human Rights and Healthcare, and
- Abortion.

Undoubtedly, one of the reasons for HCL entering the teaching curriculum in universities was that it was (and is) an attractive field of research for legal academics. Indeed, HCL has stimulated vibrant scholarship, culminating in an abundance of HCL journals, monographs, textbooks and research centres.

B. BURGEONING HEALTHCARE LAW SCHOLARSHIP AND ITS IMPACT ON SHAPING LEGAL DOCTRINE

As Carter notes above, it is important for a field of law to have scholarship that provides conceptual and theoretical guidance or sometimes misguidance. Despite its seeming oddity, misguidance may inspire a plurality of ideas in the field. This finds support in Tarlock's³¹¹ remarks noted earlier above³¹² and is a criterion which has been sufficiently met by HCL in England and Wales, as I will demonstrate in this section. The evolution of HCL as a discrete body of law has also stimulated the development of its academic discipline. Apart from the widespread teaching of HCL, its coming of age as an academic discipline can also be measured through the rapid increase in the volume of literature produced in the field, and

³¹¹ AD Tarlock, 'Is There a There in Environmental Law?' (2004) 19 *Journal of Land Use and Environmental Law*, 228.

³¹² *Ibid.*

the establishment of many HCL-oriented academic research centres. Undoubtedly, a textbook or treatise on an area of law constitutes a compelling indicator of its emergence as a discrete subject. Since 1980, there has been phenomenal growth in the publication of literature exploring and critiquing HCL topics, as shown in Table 2 below. I have only selected textbooks published between 1980 and 2000 and compared their first and last edition as at 2012, since this was necessary to establish the quantitative increment of those texts to infer the degree of expansion in the field.

TABLE F: HEALTHCARE LAW TEXTBOOKS PUBLISHED

AUTHOR(S)	TITLE	YEAR	EDITION	NO. OF PAGES
S McLean and G Maher	Medicine, Morals and the Law	1983	1 st	214
JK Mason and RA McCall Smith	Law and Medical Ethics	1983	1 st	275
PDG Skegg	Law, Ethics and Medicine	1984	1 st	278
M Brazier	Medicine, Patients and the Law	1987	1 st	337
I Kennedy	Treat Me Right - Essays in Medical Law and Ethics	1988	1 st	428
I Kennedy and A Grubb	Medical Law: Cases and Materials	1989	1 st	1210
J Montgomery	Health Care Law	1997	1 st	476
J McHale, M Fox and J Murphy	Health Care Law: Text, Cases and Materials	1997	1 st	963
I Kennedy, A Grubb and J Laing	Principles of Medical Law	1998	1 st	1191
I Kennedy and A Grubb	Medical Law: Cases and Materials	2000	3 rd	2303
J Montgomery	Health Care Law	2002	2 nd	515
J McHale, M Fox and J Murphy	Health Care Law: Text, Cases and Materials	2007	2 nd	1204
JK Mason and RA .McCall Smith	Law and Medical Ethics	2010	8 th	824
M Brazier and E Cave	Medicine, Patients and the Law	2011	5 th	612

According to the preface to some of these textbooks, the growth in the length of each new edition may be explained by the increasing resort to the courts for the resolution of HCL cases, as well as the increasing intervention by law-makers in this field.³¹³

Apart from the textbooks, there has also been a considerable increase in journal articles on HCL between 1980 and 2000. I conducted an electronic search of all law journals in England and Wales held on the Lexis and Westlaw databases in order to survey the trend of articles on HCL themes during the temporal remit of my research. This revealed that 16 articles were published in the *Modern Law Review*; *Legal Studies* published 8 articles during the same period and the *Cambridge Law Journal* also published 2 articles. 2 specialist journals on HCL established during the period were the *Medical Law Review* and *Medical Law International*.³¹⁴ In the inaugural issue of the *Medical Law Review*, published in 1993, the editorial note by Kennedy and Grubb stated that ‘the appearance of the Review represents part of the process of the coming of age of medical law as a subject.’³¹⁵

Besides these dedicated journals, university research centres were established during the period with a focus on cutting-edge issues in HCL. As early as 1976, the Centre for Medical law and Ethics was established by Ian Kennedy at King’s College, London.³¹⁶ Its founder became the first Professor of HCL in 1983.³¹⁷ Ten years later, the Centre for Social Ethics and Policy was established in the University of Manchester with a mandate to undertake ‘research and teaching courses in bioethics and biolaw.’³¹⁸

³¹³ M Brazier and E Cave, *Medicine, Patients and the Law* (5th edn, England: Penguin Books 2011) v.

³¹⁴ But I did not find it necessary to report the number of published articles in these journals since their stated editorial policy is towards the publication of HCL-related themes only.

³¹⁵ The Editors, ‘Introduction’ (1993)1 *Medical Law Review*, [i].

³¹⁶ Centre for Medical Law and Ethics, Kings College London, <http://www.kcl.ac.uk/law/research/centres/medlawethics/index.aspx> (accessed: 6/3/2012).

³¹⁷ LO Gostin, ‘Honouring Ian McColl Kennedy’ (1997)14 *Journal of Contemporary Health Law & Policy*, v. xi

³¹⁸ Centre for Social Ethics and Policy, University of Manchester, <http://www.law.manchester.ac.uk/research/centres/csep/> (accessed: 6/3/2012).

A research body, unaffiliated to any particular university, is the Nuffield Council on Bioethics. It was established in 1991 to examine bioethical issues.³¹⁹ It is independent of government in its origin and funding and seeks to provide advice to assist in the formation of public policy and to foster public understanding.³²⁰ Its methodology involves public consultation and publication of its reports. Between 1991 and 1999, the Council produced reports dealing with genetic screening,³²¹ uses of human tissue,³²² xenotransplantation,³²³ genetics³²⁴ and mental disorders.³²⁵ These reports can be accessed by the general public and policy-makers and have been very influential in shaping discourse on the subject, policy and law-making. For instance, the report on Genetics and Human Behaviour³²⁶ was extensively quoted by the House of Commons' Standing Committee on Science and Technology in its Fifth Report on the review of the Human Fertilisation Embryology Act, 1990, particularly in exploring the ethical basis for pre-implantation genetic diagnosis.³²⁷ Since the Council's report is expected to reflect consensus from its public consultation, the use of its report in Parliamentary debates helps ensure that carefully studied public views are reflected or considered in those debates. It is instructive that in 1994, after the Council³²⁸ released its report, the Secretary for Health was questioned in the House of Lords as to when the

³¹⁹ Nuffield Council on Bioethics 1992-99 (London: Nuffield Council on Bioethics 2000).

³²⁰ Ibid 5.

³²¹ Nuffield Council on Bioethics, *Genetic Screening: Ethical Issues* (London: Nuffield Council on Bioethics 1993).

³²² Nuffield Council on Bioethics, *Human Tissue: Legal and Ethical Issues* (London: Nuffield Council on Bioethics 1993).

³²³ Nuffield Council on Bioethics, *Animal-to-Human Transplants the ethics of xenotransplantation* (London: Nuffield Council on Bioethics 1996).

³²⁴ Nuffield Council on Bioethics, *Genetics and Human Behaviour: The Ethical Context* (London: Nuffield Council on Bioethics 2002).

³²⁵ Nuffield Council on Bioethics, *Mental Disorders and Genetics* (London: Nuffield Council on Bioethics 1998).

³²⁶ 'The Report of the Committee of Inquiry into Human Fertilisation and Embryology', Cmnd. 9314, para 1.2.

³²⁷ 'HC Standing Committee on Science and Technology', 14 March 2005, para 109.

³²⁸ National Health Service, Blood and Transplant http://www.organdonation.nhs.uk/ukt/about_transplants/transplantation_milestones/transplantation_milestones.asp (accessed: 02/4/2012).

government was going to respond to the issues raised in it.³²⁹ The report recommended that 'the Department of Health in consultation with the appropriate professional bodies formulate detailed criteria for introducing genetic screening programmes, and establish a central coordinating body to review genetic screening programmes and monitor their implementation and outcome.'³³⁰ It can be argued that this report substantially informed the government's decision to set up two new advisory committees. These were 'an Advisory Committee on Genetic Testing [which] would oversee aspects of the manufacture and sale of genetic tests by commercial companies, and the Human Genetics Advisory Commission [which] would provide early assessment of the broader issues arising from the development of genetic science.'³³¹

It has been stated above that another important indicia of the existence of a field of law is that its scholarship should influence judicial approaches to disputes in that field. The teeming interest in HCL among academic lawyers since 1980 not only resulted in numerous articles, monographs and textbooks, but also inspired the thinking of judges in adjudicating medico-legal cases. There are many instances of the use of opinions of HCL commentators in court judgments between 1980 and the 2000. For example, in 1984, Kennedy wrote an article entitled '*The Patient on the Clapham Omnibus*'³³² in which he reviewed the trial court and Court of Appeal's decision in the *Sidaway*³³³ case that a doctor's obligation in law was to give the patient that information which a reasonable and responsible member of the medical profession would think it proper to give. Kennedy contended that the ruling was

³²⁹ House of Commons, 'Genetic Screening', *House of Commons Debates*, 22 February 1994, Vol. 238, c205W.

³³⁰ Nuffield Council on Bioethics, *Genetics and Human Behaviour: The Ethical Context* (London: Nuffield Council on Bioethics 2002) 85.

³³¹ R Jacobs, 'Genetic screening — uses, potential abuses and ethical issues' (1997) 47 *Occupational Medicine*, 387, 388.

³³² (1984) 47 *The Modern Law Review*, 454.

³³³ I Kennedy, *Treat Me Right: Essays in Medical Law and Ethics* (Oxford: Clarendon Press 1988) 175-212.

unhelpful as it failed to recognise that the emerging trend of medical practice was a shared partnership, which required the patient to be given all the information necessary to enable them to properly consent to treatment.³³⁴ When a further appeal was made in the *Sidaway* case to the House of Lords in 1985, Lord Scarman acknowledged the assistance he had gained from the Kennedy article.³³⁵ Indeed, I have pointed out in section 3.2, above that Lord Scarman recommended the adoption of the transatlantic doctrine of informed consent into English law.

Secondly, an article by Robertson,³³⁶ entitled '*Informed Consent to Medical Treatment*' was extensively relied upon by Lord Scarman in the *Sidaway* case.³³⁷ Having reviewed a long line of English cases from 1950 to 1981, Robertson bemoaned the fact that it was judicial policy not to expand the liability of the medical profession, since this was an obstacle to the recognition of the informed consent doctrine that could meaningfully safeguard the patient's right to self-determination.³³⁸

Thirdly, during the House of Lord's consideration of an appeal against the declaration that it was lawful to withdraw lifesaving treatment and allow the PVS patient to die, Lord Goff repeatedly cited Kennedy's article '*Switching off Life Support Machines: the legal Implications*', to support his vote against the appeal.³³⁹ Furthermore, Lord Browne-Wilkinson, in analysing whether the removal of the nasogastric tube from a PVS patient

³³⁴ (1984) 47 *The Modern Law Review*, 454, 459.

³³⁵ *Sidaway v Board of Governors of the Bethlem Royal Hospital and Maudsley Hospital* [1985] 1 All ER 643, 652.

³³⁶ G Robertson, '*Informed Consent to Medical Treatment*' (1981) 97 *Law Quarterly Review*, 102.

³³⁷ n 335 above, 652-653.

³³⁸ G Robertson, '*Informed Consent to Medical Treatment*' (1981) 97 *Law Quarterly Review*, 124.

³³⁹n 336 above,

would constitute a positive act of commission for the purposes of the offence of homicide, cited Skegg's³⁴⁰ discussion of switching off a ventilator in his textbook.³⁴¹

Again, the influence of writings by HCL academics on judicial decision-making was clearly manifested in the seminal case of *Re A (Children) (Conjoined Twins: Separation)*, where the Court of Appeal had to decide whether it was appropriate to separate conjoined twins in order to save the stronger twin's life, despite the parents' refusal to consent to the operation.³⁴² This was significant for the emergence of HCL as a discrete subject because the acknowledgement of the work of these scholars suggested that academic HCL was making an impact on medico-legal litigation. Indeed, in his analysis of the ethical and legal dilemma inherent in the question of whether to save the life of the stronger baby, while causing the death of the weaker twin through the separation, Ward LJ extensively drew upon John Keown's³⁴³ analysis, that the sanctity of life doctrine rejects quality of life because 'it denies the ineliminable value of each patient and engages in discriminatory judgments, posited on fundamentally arbitrary criteria such as physical or mental disability, about whose lives are "worthwhile" and whose are not.' The learned judge noted that:

When considering the worthwhileness of the treatment, it is legitimate to have regard to the actual condition of each twin and hence the actual balance sheet of advantage and disadvantage which flows from the performance or the non-performance of the proposed treatment. Here it is legitimate, as John Keown demonstrates, and as the cases show, to bear in mind the actual quality of life each child enjoys and may be able to enjoy.³⁴⁴

³⁴⁰ PDK Skegg, *Law, Ethics and Medicine: Studies in Medical Law* (Oxford: Clarendon Press 1985) 169.

³⁴¹ *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 881

³⁴² [2000] 4 All ER 961. In considering the legal position on where a proposed course of action would terminate life, Ward LJ cited the *Bland* case but pointed out that the case had been the 'subject of much academic scrutiny by Kennedy and Grubb'. 'Withdrawal of Artificial Hydration and Nutrition: Incompetent Adult' [1993] 2 *Med L Rev*, 359; I Kennedy and A Grubb, *Medical Law* (2nd edn, London: Butterworths 1994) ch 16; J Finnis, 'Bland, Crossing the Rubicon?' (1993) 109 *LQR* 329; J Keown, 'Restoring Moral and Intellectual Shape to the Law after Bland' (1997) 113 *LQR*, 481.

³⁴³ J Keown, 'Restoring Moral and Intellectual Shape to the Law after Bland' (1997) 113 *Law Quarterly Review*, 481.

³⁴⁴ [2000] 4 All ER 961 at 1010.

Notably, this dictum seems to contradict what Keown says above and this is a point that Huxtable has made - that sometimes, judges misinterpret the academic literature.³⁴⁵

There is, therefore, no doubt that the field of HCL has its own academic discipline which has come of age. However, as I will now discuss, the boundaries of the subject matter of HCL are still unsettled.

C. DELINEATING THE SUBJECT MATTER AND THE DOCTRINAL ORIENTATIONS OF HEALTH CARE LAW

The general view on the status of HCL as a field of law does not necessarily translate into unanimity among scholars in the field regarding its subject matter and methodology. As I have pointed out, the topics treated in the pioneering textbooks increased with each successive edition and the number of pages also grew significantly. It was therefore not surprising that in 2000, Kennedy and Grubb noted that the corpus of medical law was almost unrecognisable from its form at the time of their first edition in 1989 because it had metamorphosed from being exclusively concerned with medical negligence to encompassing family law and public law cases of real legal significance.³⁴⁶ The significance of these observations is that HCL has now gained a large territory, making it sufficiently mature to give birth to sub-disciplines, such as mental health law and public health law.³⁴⁷ However, it is clear that delineating the subject matter of HCL and its conceptual basis is not straightforward. In this regard, I recall Cane's observation that the boundaries of a legal subject are not set by divine prescript but by the customs of lawyers.³⁴⁸ He noted that the emergence of a separate legal subject is largely a product of the systematising activities of

³⁴⁵ See: R Huxtable, 'Separation of conjoined twins: Where next for English law?' (2002) *Criminal Law Review*, 459-70.

³⁴⁶ I Kennedy and A Grubb, *Medical law: Text and Materials* (3rd edn, London: Butterworths 2000) v.

³⁴⁷ J Coggon, *What Makes Health Public? A Critical Evaluation of Moral, Legal, and Political Claims in Public Health* (Cambridge, Cambridge University Press 2012) ch 5.

³⁴⁸ P Cane, *Atiyah's Accidents, Compensation and the Law* (6th edn, Cambridge: Cambridge University Press 2004) 25-26.

academic lawyers.³⁴⁹ In order to understand the boundaries of the subject, I will now consider the doctrinal orientation and research approaches that explicitly or implicitly inform the works of some of the leading scholars in the field.

I submit that four different approaches concerning HCL scholarship can be discerned from the literature. These are medical ethics, human rights, and multi-disciplinary and philosophical approaches. Each of them is underpinned by a different conceptualisation of medicine.

I. THE MEDICAL ETHICS APPROACH

The medical ethics approach conceptualises modern medicine as a ‘social sphere’ with competing ethical claims.³⁵⁰ Accordingly, it defines HCL as the law’s interaction with medical ethics.³⁵¹ Similarly, Davies has stated that the link between medical ethics and its practical expression in law is the essence of defining medical law.³⁵² In 1987, Grubb underscored the medical ethics approach when he suggested that in many of the areas of HCL, it is an understanding of ethical principles which may help to map out much of the uncharted waters in the field.³⁵³ It should be noted, however, that this may not be so uncharted today. Medical ethics ‘looks at distinct case constellations from biomedical practice and seeks to make a normative statement about how one should behave in such cases.’³⁵⁴ Thus, Hoppe and Miola note that ‘while both law and morals [ethics], are frameworks of norms of

³⁴⁹ Ibid.

³⁵⁰ See generally: HM Evans, ‘Philosophy and the Medical Humanities’ in HM Evans and I Finlay (eds), *Medical Humanities* (London: BMJ Books 2001) 250-256.

³⁵¹ Ibid.

³⁵² M Davies, *Textbook on Medical Law* (2nd edn, London: Blackstone Press Ltd 1998) 3.

³⁵³ A Grubb, ‘The Emergence and Rise of Medical Law and Ethics (1987) 50 *Modern Law Review*, 241-267.

³⁵⁴ N Hoppe and J Miola, *Medical Law and Medical Ethics* (Cambridge, Cambridge University Press 2014) 1.

differing binding quality and pedigree, 'ethics' can be the process which is used to reflect what course of action is appropriate in terms of moral obligations.³⁵⁵

The medical ethics approach has inspired the work of many academics, including Kennedy and Grubb,³⁵⁶ Morgan,³⁵⁷ McLean,³⁵⁸ Herring,³⁵⁹ Davies,³⁶⁰ Hoppe and Miola.³⁶¹ These scholars have a two-prong argument informing their methodologies or theories of HCL. First, they contend that there is a power imbalance between doctors and patients due to a multiplicity of factors, including information asymmetry and the basic vulnerability of patients.³⁶² Secondly, they maintain that the ethical dilemmas in healthcare, generated by medical advances, ought to be externally regulated through the instrumentality of law.³⁶³ It needs to be emphasised that the medical ethics approach to HCL appears to take the relationship between ethics (or morality generally) and law as self-evident but that is not necessarily the case in legal theory.³⁶⁴

Medical ethics manifests in HCL in two ways: first, it operates as a regulatory framework through guidance by the General Medical Council and such non-statutory professional bodies as the British Medical Association and the Royal Colleges; second, there is 'the overwhelming variety of opinion and debate contributed by philosophers, lawyers, sociologists and others, which seek not to regulate, but rather to discuss.'³⁶⁵ Hoppe and

³⁵⁵ Ibid 3.

³⁵⁶ I Kennedy and A Grubb, *Medical law: Text and Materials* (3rd edn, London: Butterworths 2000) v.; I. Kennedy, *Treat Me Right: Essays in Medical Law and Ethics* (Oxford: Clarendon Press 1988) 175-212.

³⁵⁷ D Morgan, *Issues in Medical law and Ethics* (London: Cavendish 2001).

³⁵⁸ S McLean *Old Law: New Medicine: Medical Ethics and Human Rights* (London: Pandora, 1999).

³⁵⁹ J Herring, *Medical Law and Ethics* (Oxford: Oxford University Press, 2008).

³⁶⁰ n 352 above, 3.

³⁶¹ N Hoppe and J Miola, n. 354 above, 1.

³⁶² I Kennedy and A Grubb, n. 356 above, 679.

³⁶³ I Kennedy, *The Unmasking of Medicine* (2nd rev edn, St Albans: Granada, 1983), 78, where Kennedy sought to "de-medicalise" medical ethics. I have borrowed the term "de-medicalise" from J Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship* (Oxford: Hart Publishing 2007) 41.

³⁶⁴ J Montgomery, 'The Legitimacy of Medical Law' in S McLean (ed), *First Do No Harm: Law, Ethics and Healthcare* (Aldershot: Ashgate Publishing 2006) 4.

³⁶⁵ n354 above,8.

Miola have noted that the latter statement ('unofficial sector of ethical discourse')³⁶⁶ is of limited utility as it does not seek to provide answers, given that it has no way of choosing between competing answers to questions.³⁶⁷ Thus, its utility in situations requiring normative statement is limited.³⁶⁸ However, it may be used by judges to justify decisions that they have already come to - most notably if there is no settled law in the area or the judges wish to reshape the existing legal rules. In *Chester v Afshar*,³⁶⁹ the House of Lords sought to change the law so as to prioritise patient autonomy (and thus make the decision 'legal' in nature). They cited a philosophical piece by Ronald Dworkin³⁷⁰ to justify this.

There are many approaches to reasoning deployed in the unofficial sector concerning how to resolve complex ethical dilemmas. The popular approaches in the literature include deontology, consequentialism, principlism and feminism. A detailed exposition of these approaches is avoided here due to its adequate elaboration in the textbooks and monographs alluded to earlier in this section. For my present purpose, it suffices to briefly explain them. Consequentialism (also known as utilitarianism)³⁷¹ judges whether an action is ethically right or wrong by its outcomes or consequences. It is based upon the maximisation of the wellbeing (human welfare) or happiness of human beings. The difficulty with the consequentialist approach is how to determine what is good or predict³⁷² the consequences of all conceivable situations in healthcare.

A deontological theory, on the other hand, 'holds that certain kinds of actions are good, not because of the consequences they produce, but because they are good and right

³⁶⁶ J Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship* (Oxford: Hart Publishing 2007) 6.

³⁶⁷ n354 above,8.

³⁶⁸ Ibid.

³⁶⁹ *Chester v Afshar* [2004] UKHCL 41, para 18.

³⁷⁰ R Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and individual Freedom* (New York: Vintage Books 1993).

³⁷¹ E Jackson, *Medical law* (3rd edn, Oxford: Oxford University Press 2012) 11.

³⁷² J Herring, *Medical Law and Ethics* (4th edn, Oxford: Oxford University Press 2012) 13.

in themselves.³⁷³ A central tenet of deontological theory is that a person cannot justify the breach of a basic moral principle merely by referring to the consequences. The difficulty with the deontological approach is ‘how we decide what the principles are.’ This is exacerbated by the fact that we live in a diverse society and there is rarely any shared morality on all things. Indeed, as society increasingly becomes multi-faith and multi-cultural, it becomes harder to identify what constitutes a moral consensus before translating it into positive law. Another problem with this approach is that it follows a priori reasoning as it proceeds on ‘pre-existing abstract conceptual positions rather than illuminate[ing] the social practices that the law is regulating.’³⁷⁴

Consequentialist and deontological theories may be exciting to ethicists but their relevance to finding rapid solutions to concrete ethical dilemmas in healthcare delivery are limited. In order to obviate this limitation of the medical ethics approach, Beauchamp and Childress propound a more practical approach known as principlism.³⁷⁵ Principlism refers to the four principles of respect for autonomy, non-maleficence, beneficence and justice, which, according to Beauchamp and Childress represent a common morality for societies in general around the world.³⁷⁶ Proponents of principlism contend that the best way to approach ethical problems is to test the problem against each of these principles so that possible options of solution will emerge. Brazier and Ost note that ‘whilst there may be congruity between liberal values and the four principles, Beauchamp and Childress’ approach is not accepted by all as illuminating the *correct* principles that inform bioethics and/or as the

³⁷³ Ibid 14.

³⁷⁴ J Montgomery, ‘The Compleat Lawyer - Medical Law as Practical Reasoning: Doctrine, Empiricism, and Engagement’ (2012) 20 *Medical Law Review*, 15.

³⁷⁵ TL Beauchamp and JF Childress, *Principles of Biomedical Ethics* (7th edn, Oxford: Oxford University Press 2012) ch 1.

³⁷⁶ Ibid 6.

method by which moral dilemmas in health care can be resolved.³⁷⁷ There may not be a definite consensus on the ethical approach to adopt but ethical issues remain important consideration in judicial deliberations in controversial cases. Thus in *Bland*, Hoffman LJ stated:

[t]his is not an area in which any difference can be allowed to exist between what is legal and what is morally right. The decision of the court should be able to carry conviction with the ordinary person as being based not merely on legal precedent but also upon acceptable ethical values.³⁷⁸

II. THE HUMAN RIGHTS APPROACH

The human rights approach conceptualises medicine as a 'field of intense imbalance or disequilibrium that opens up possibilities for the abuse of patients.'³⁷⁹ For example, the doctor has the information and skill needed by the patient, but which the patient lacks. The doctor by virtue of his privileged position is able to interfere with the body of the patient. This necessitates special protection for the weak and vulnerable. Accordingly, for the proponents of this approach, the subject-matter of HCL comprises the protection of patients through the mobilisation of a shielding mechanism: human rights.³⁸⁰ Although Kennedy and Grubb do not develop their human rights perspective of HCL in detail, they have declared that HCL is, essentially, 'a sub-set of human rights law.'³⁸¹ In a similar vein, Brazier and Cave contend that the fundamental nature of the relationship between doctors and patients amply justifies the human rights approach.³⁸² Their view is persuasive since human rights emerged as a more formidable mechanism for safeguarding the individual against the

³⁷⁷ M Brazier and S Ost, *Medicine and the Criminal Law Volume III: Medicine and Bioethics in the Theatre of the Criminal Process* (Cambridge: Cambridge University Press, 2013) ch 7, 221.

³⁷⁸ *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 850.

³⁷⁹ I Kennedy, *Treat Me Right: Essays in Medical Law and Ethics* (Oxford: Clarendon Press 1988) 387.

³⁸⁰ AM McCall-Smith, 'Beyond Autonomy' (1997) 14 *Journal of Contemporary Health Law and Policy*, 23.

³⁸¹ I Kennedy and A Grubb, *Medical Law: Text and Materials* (3rd edn, London: Butterworths 2000) 3.

³⁸² M Brazier and E Cave, *Medicine, Patients and the Law* (5th edn, England: Penguin Books 2011) xxiii-xlv; JK Mason and GT Laurie, *Law and Medical Ethics* (Oxford: Oxford University Press 2011) ch 1, at 31.

sweeping powers of the state than the general protection afforded under private law.³⁸³ As seen in *Bolam*, section 2.1.1, and notwithstanding the prominence of individual autonomy in bioethics and the increased recognition of self-determination in HCL, common law still tends to give power back to the medical profession to sit in judgment over the bioethical and legal issues raised in healthcare. The human rights approach, on the other hand, would enable the court to assume direct responsibility for determining the contested bioethical and legal controversies in healthcare. The human rights prism for delimiting the subject matter of HCL enables all aspects of medical practice to be recast as the loci of potential infringement of the human rights of the patient.³⁸⁴

A different reflection on the *Human Rights Act, 1998* (HRA), which incorporated the provisions of the *European Convention on Human Rights and Fundamental Freedoms*³⁸⁵ into UK law, was undertaken in 2007 by Wicks. She explores what happens when, rather than drawing on ethical principles, the familiar range of HCL issues is unpacked and repackaged from a human rights perspective.³⁸⁶ In this regard, she argues in favour of the prioritisation of individual autonomy and rights as an underlying value in English HCL.³⁸⁷ In some instances, Wicks demonstrates that the conceptual unity of HCL could be explained through the prism of human rights. Wicks has successfully demonstrated that ‘the end-of-life decision-making, reproduction, rights in the body, consent to treatment and medical confidentiality are indeed topics best understood within a human rights framework.’³⁸⁸ Noteworthy in this regard is the fundamental distinction between human rights based

³⁸³ n380 above 25.

³⁸⁴ For example, see A Garwood-Gowers, J Tingle and T Lewis (eds), *Healthcare Law: The Impact of the Human Rights Act* (London: Cavendish Publishing 2001).

³⁸⁵ I explore the relevance of specific rights under the ECHR to HCL in Chapter Five.

³⁸⁶ E Wicks, *Human Rights and Healthcare* (Oxford: Hart Publishing 2007) 2-3.

³⁸⁷ *Ibid.*

³⁸⁸ A Bois-Pedain, ‘Book Review: Elizabeth Wicks, *Human Rights and Healthcare*’ (2009) *Human Rights Law Review*, 171-176.

analysis and analytical perspective of traditional medical ethics or bioethics. Human rights law has the advantage of relying on hard law to determine the norms that it considers more important than others but traditional bioethics rely simply on “structured analytical framework”.³⁸⁹ For example, the Four Principles: autonomy, beneficence, non-maleficence and justice, originally devised by Beauchamp and Childress,³⁹⁰ are considered by some as the standard theoretical framework from which to analyse ethical situations in medicine. A notable caveat here is the acknowledgement by Brazier and Ost that ‘principlism is not by any means the theoretical approach adopted by all bioethicists, although it is a dominant approach in the United States and the UK.’³⁹¹

The critical distinction between the work of Garwood-Gowers et al and Wicks is that the former sought to gauge the probable effect of the HRA on aspects of HCL, whereas the latter undertook a more fundamental enterprise of trying to translate HCL as being constituted into a complete human rights analysis. In my view, in a jurisdiction like England and Wales, where common law was employed in the service of HCL disputes long before the passing of the HRA, human rights thinking has gradually entered into HCL discourse either in the courts or academic circles. Thus, it is true to say that human rights have played a role in developing and shaping aspects of the law in the field. For example, human rights were important in the *Evans*³⁹² case on consent to the use of stored embryos and reliance on Article 8 in the *Purdy*³⁹³ case, leading to the DPP’s policy on assisted suicide.

³⁸⁹ Ibid

³⁹⁰ TL Beauchamp and JF Childress, *Principles of Biomedical Ethics* (7th edn, Oxford: Oxford University Press 2012) ch 1.

³⁹¹ M Brazier and S Ost, *Medicine and Bioethics in the Theatre of the Criminal Process* (Cambridge: Cambridge University Press 2013) 184 (references omitted), 219.

³⁹² *Evans v Amicus Healthcare Ltd* [2004] EWCA Civ 727.

³⁹³ *R (on the application of Purdy) v. DPP* [2009] EWCA (Civ) 92

The human rights approach is, however, prone to some limitations. Traditionally, patients' grievances were redressed through the mechanism of private law. In this regard, tort law in the form of battery and negligence is of primary significance. In contrast, an action can only be brought under the HRA against the state. However, it has been argued that the HRA 'allows the courts a unique opportunity to improve the consistency and coherence of the common law without being unduly fettered by precedent'.³⁹⁴ The courts are also public bodies, so they must act compatibly with the HRA. Some of the early rulings of the courts indicate that they would rather interpret the provisions of the HRA as being compatible with common law than allow the HRA to completely replace the former.³⁹⁵

For the human rights prism to be useful in illuminating HCL, it is submitted that rights need to be reconceptualised from the positive sense of a right to make a claim, to a negative right, so that patients can assert a right not be harmed. A negative right is a right not to be subjected to an action of another person. Thus, negative rights permit or oblige inaction on the part of a duty bearer under the Hohfeldian theory of right.³⁹⁶ On the other hand, a positive right imposes an active duty on the duty bearer; it permits or obliges an action. If HCL is to be 'patient friendly', seeking to empower patients, then patients must, amongst other things, have a negative right in relation to safe clinical interaction. In this way, a patient can directly enforce his or her negative right not be harmed, through the HRA, rather than using the route of torts of battery and negligence.

III. THE PRAGMATIST APPROACH

³⁹⁴ A Maclean, 'Crossing the Rubicon on the Human Rights Ferry' (2001) 64 *Modern Law Review*, 775, 793.

³⁹⁵ See, for example: *NHS Trust A v Mrs M; NHS Trust B v Mrs H* [2001] 2 WLR 942

³⁹⁶ WN Hohfeld, *Fundamental Legal Conceptions as Applied in Judicial Reasoning*, (USA: Yale University Press 1946).

The third doctrinal approach is the pragmatist or multi-disciplinary approach. It focuses on practical issues and avoid abstraction or general theorisation.³⁹⁷ Thus, it is an evidence-based approach to the application of the discipline of law to healthcare practice for the benefit of all stakeholders. The pragmatist approach develops its 'analysis around the practices of health care rather than principles of law or ethical theory abstracted from this context.'³⁹⁸ Brazier, Teff³⁹⁹ and Montgomery are notable examples of scholars whose writings in this field of law manifest this approach. This approach consists in 'building analysis around the practices of healthcare, rather than principles of law or ethical theory abstracted from this context.'⁴⁰⁰

Contributing to the 20th Anniversary Special Issue of the *Medical Law Review* in honour of Brazier, Montgomery⁴⁰¹ explored her approach to the role and nature of HCL in an important academic paper she wrote on informed consent.⁴⁰² He identified four key characteristics of the multi-disciplinary approach as epitomised in Brazier's academic and public work: (1) the role of law is seen as facilitating effective healthcare as well as protecting patients' rights; (2) it is empirical as it shows an interest in the realities of clinical practice; (3) it engages in healthy cynicism about the consequences of legal intervention in medical practice, and (4) it is conscious of the need to develop tailored responses required to 'break the shackles of the traditional forms of action (negligence and battery) and also look more broadly to soft law to 'supplement the stark legal rules'.⁴⁰³ In seeking to propound a solution to a problem in the field of HCL, the multi-disciplinary approach 'begins

³⁹⁷ J Montgomery, 'The Compleat Lawyer - Medical Law as Practical Reasoning: Doctrine, Empiricism, and Engagement' 20 *Medical Law Review*, 9.

³⁹⁸ Ibid 10.

³⁹⁹ H Teff, 'Clinical Guidelines, Negligence and Medical Practice' in M Freeman and A Lewis (eds), *Law and Medicine Current Legal Issues Volume 3* (Oxford University Press 2000) 432,

⁴⁰⁰ n. 397 above, 10.

⁴⁰¹ Ibid 11-12.

⁴⁰² M Brazier, 'Patient autonomy and consent to treatment: the role of the law?' (1987) 7 *Legal Studies*, 169.

⁴⁰³n 397 above, 12.

from what life is like from the patient's perspective, and is open to the contributions from a wide range of disciplines to make sense of the law's role in their experiences.⁴⁰⁴ This approach always keeps in focus the notion that 'If the purpose of the law is, in part, to facilitate effective health care, then it is important to understand what might happen as a consequence of the legal rules being discussed.'⁴⁰⁵ In this way, the social and institutional context of the doctor-patient relationship becomes important in analysing issues in HCL.⁴⁰⁶ The principal audience to be considered in evaluating the legal rules is the doctor rather than the judge, or the realities of the clinic rather than the norms of litigation in the court room.⁴⁰⁷ For example, Brazier, in suggesting the setting up of a commission to start afresh and a study to fine tune the principles of informed consent and medical practice, advocated the establishment of norms in healthcare practice in such a way that 'would make recourse to the law largely unnecessary.'⁴⁰⁸

The pragmatic approach is intrinsically appealing for two reasons. To begin with, by emphasising empiricism in developing an understanding of the relationship between law and medicine, the approach has the capacity to produce a body of rules in HCL which substantially mirror the realities in the healthcare field. The resultant law will not appear to have been imposed from above on some kind of ad hoc basis as in judge-made law or rushed legislation. Moreover, the approach ensures that the body of rules in HCL is accessible to the intended audience, who are predominantly doctors and patients. As Montgomery notes in his tribute:

⁴⁰⁴ Ibid 14.

⁴⁰⁵ Ibid.

⁴⁰⁶ Ibid 15.

⁴⁰⁷ Ibid 16.

⁴⁰⁸ M Brazier, 'Patient autonomy and consent to treatment: the role of the law?' (1987) 7 *Legal Studies*, 193.

For Brazier, the law needs to be comprehensible to doctors. It is the way in which they interpret it which will make the biggest difference to patients.⁴⁰⁹

Indeed, in view of the importance of making HCL comprehensible to doctors, Teff, for example argues that 'it seems unlikely that the introduction of informed consent into English law would have much effect on medical practice without effective strategies to alter attitudes among practitioners.'⁴¹⁰

The challenge which the pragmatist approach presents to legal scholarship is that it creates the impression that a well-grounded knowledge of the nuances of healthcare is required before legal scholars can critique the interface between law and medicine. Although this is not necessarily bad, it dislodges traditional HCL scholars from the comfort zone of black-letter or doctrinal scholarship towards socio-legal approaches, which often require multi-disciplinary efforts. Indeed, this approach envisages a broadening of the researcher's jurisprudential horizon beyond strict, positive or hard rules to embrace the regulatory efficacy of other types of regulation. In this regard, it is apposite to recall Montgomery's admonition that 'a full range of legal tools needs to be brought to bear; processes and soft law as well as strict rules.'⁴¹¹

IV. SOCIO-LEGAL APPROACHES

Socio-legal approaches consist in the use of, for example, post-modernist theories, rhetorical analysis, literary criticism and the feminist perspective to critique the legal regulation of medical practice and the organisation of healthcare delivery. In his discussion of HCL, Harrington, for example, often adopts some of the 'postmodernist postulates of consumerism and anti-utopian idealism from Harvey and Bauman' as his theoretical

⁴⁰⁹ n 397 above,17.

⁴¹⁰ H Teff, 'Clinical Guidelines, Negligence and Medical Practice' in M Freeman and A Lewis (eds), *Law and Medicine Current Legal Issues Volume 3* (Oxford University Press 2000) 453.

⁴¹¹ n. 397 above, 27.

premise.⁴¹² Similarly, Veitch often draws upon social critiques of medicine, such as those of Bauman, Foucault and Illich as the prism for his exploration of HCL themes.⁴¹³ The feminist aspect of socio-legal approaches is more pervasive in the literature and consequently warrants a nuanced elaboration here.

In order to be able to explore feminism in relation to healthcare, it is apposite to explain briefly what feminist approaches to law entail. The contention of the various feminist approaches to law, reduced to their barest core is that ‘throughout history and even today, public discourse has been almost exclusively conducted by men from the perspective of men.’⁴¹⁴ Thus, the nature of women, their interests, lived experiences and perspectives in law and other spheres have been constructed by men from men’s own perspective and interpretation of the world. To counter this state of affairs, feminists analyse and criticise law as a patriarchal institution which subjugates women to men.⁴¹⁵

It may be an overstatement to assert that the feminist critique of law significantly accelerated the *emergence* of HCL in this jurisdiction. The feminist movement extended their crusading zeal into the sphere of HCL and later medical ethics in the evolution of HCL in England and Wales (more prominently post-1990s). However, in the North Americas, the deployment of a feminist critique of medicine had been going for some time until this

⁴¹² J Harrington, ‘Visions of Utopia markets, medicine and the National Health Service’ (2009) 29 *Legal Studies*, 376; J Harrington, ‘Regulating Clinical Practice: Epistemological and Cognitive Perspectives’ (2003) 22 *Medicine and Law*, 221; J Harrington, ‘Art or Science? Understanding Medicine and the Common Law’ (2001) 9 *Health Law Journal*, 129; J Harrington, ‘Migration and Access to Health Care in English Law: A Rhetorical Critique’ (2008) 4 *International Journal of Law in Context*, 315; J Harrington, ‘Time as a Dimension of Medical Law’ (2012) 20 *Medical Law Review*, 491.

⁴¹³ K Veitch, ‘The Government of Health Care and the Politics of Patient Empowerment: New Labour and the NHS Reform Agenda in England’ (2010) 32 *Law and Policy*, 313; K Veitch, ‘Juridification, Medicalisation, and the Impact of EU Law: Patient Mobility and the Allocation of Scarce NHS Resources’ (2012) 20 *Medical Law Review*, 362; K Veitch, *The Jurisdiction of Medical Law*, (Aldershot: Ashgate Publishing Ltd. 2007).

⁴¹⁴ P Smith, *Feminist Jurisprudence* (Oxford: Oxford University Press 1993) 1.

⁴¹⁵ *Ibid.*

period. Sheldon and Thomson lament the apparent neglect of feminism in mainstream HCL, noting that:

a review of the existing medical law textbooks gives the impression that feminist perspectives have had no serious impact on this part of the legal academy. A brief perusal of how these books deal with abortion might serve to illustrate this point. Only in McHale and Fox's own book is any serious attempt made to draw upon the substantial feminist literature in this area. Mason and McCall Smith's *Medical Ethics and Law* is more typical of the norm. Their chapter on abortion is broken down into the following sections: the evolution of the law, the Abortion Act 1967, the rights of the fetus and other people's rights, abortion and the incompetent, reduction of multiple pregnancies and selective reduction. The only mention of the significance of abortion services to women is in the introduction to the chapter, where the authors note in passing that attitude to abortion depend on one's views on the fetal right to life versus the woman's right to control her own body.⁴¹⁶

There are various strands of feminism as an ideological construct.⁴¹⁷ Consequently, the approaches of feminist critiques of HCL and ethics are not necessarily uniform. Nevertheless, it can reasonably be surmised from the literature that certain basic tenets run through the aims which the seemingly disparate feminist approaches seek to achieve in the context of HCL and ethics. In the first place, they contend that the dominant analytical frameworks of 'utilitarianism/consequentialism' and 'deontology/Kantianism' are traditionally masculine ethical models which never challenge the patriarchal context in which medicine is practised.⁴¹⁸ Feminist healthcare ethics criticise 'the institution of medicine for contributing to the oppression and continuing disempowerment of women.'⁴¹⁹ In England and Wales, the mantra of feminism in HCL discourse was manifested to a degree when HCL was still in its nascent form as a discipline and continues to shape scholarship and policy discourse in the

⁴¹⁶ S Sheldon and M Thomson, 'Health Care Law and Feminism: A Developing Relationship' in S Sheldon and M Thomson (eds), *Feminist Perspectives on Health Care Law* (London: Cavendish Publishing 1998) 7-8.

⁴¹⁷ Helen B Homes and Laura M Purdy (eds), *Feminist Perspectives in Medical Ethics* (Indiana: Indiana University Press 1992); Susan Sherwin, *No Longer Patient: Feminist Ethics & Health Care* (Temple: Temple University Press 1992).

⁴¹⁸ L Bender, 'Teaching Feminist Perspectives on Health Care Ethics and Law: A Review Essay' (1993) 61 *University of Cincinnati Law Review*, 1251, 1253.

⁴¹⁹ *Ibid.*

field. For example, reflecting on the competing rights of women and fetuses, McLean remarks that:

Showing respect for the embryo/fetuses at the expense of women's rights is a monumental misunderstanding of the concept of respect and a perverse interpretation of the value of human rights. It is to the law's shame that it has in the past colluded in this to the detriment of women.⁴²⁰

It may be useful in illuminating our appreciation of the entry of feminism into HCL discourse to explore some of the sites in which feminist critique has been most persuasive.

One typical site of contestation between feminist approaches and the traditional non-feminist paradigms of HCL has been the criminalisation of abortion. The Abortion Act, 1967 and its subsequent amendments in the Human Fertilisation and Embryology Act, 1990 have attracted rigorous and scholarly illuminating critique from feminist perspectives.⁴²¹ The critical issues concern the moral status of the foetus and the right rights of the pregnant woman. Feminist commentators tend to argue that a woman's right to choose whether she intends to carry the foetus to full term is what is most important because 'it reflects the self-determination of the woman.'⁴²² Commenting on the debate which preceded the introduction of the Abortion Act, Sheldon decried the perceived task of the law as 'responsibilisation' which reduces to this: 'if the woman seeks to evade the consequences of her carelessness, the law should stand as a barrier.'⁴²³ Similarly, Jackson has added that the

⁴²⁰ S McLean, *Old Law, New Medicine: Medical Ethics and Human Rights* (London: Pandora 1999) 69.

⁴²¹ For example, see: S Fovargue and J Miola, 'Policing Pregnancy: Implications of the Attorney-General's Reference (No. 3 of 1994)' (1998) 6(3) *Medical Law Review*, 265-273; S Sheldon, *Beyond Control: Medical Power and Abortion Law* (Pluto Press 1997); E Jackson, 'Abortion, Autonomy and Prenatal Diagnosis' (2000) 9 *Social and legal Studies*, 467-94.

⁴²² E Jackson, 'Abortion, Autonomy and Prenatal Diagnosis' (2000) 9 *Social and legal Studies*, 467-94; S Sheldon, 'The Abortion Act 1967: A Critical Perspective' in E Lee (ed), *Abortion Law and Politics Today* (London: Macmillan 1998) 43- 58.

⁴²³ S Sheldon, 'The Abortion Act 1967: A Critical Perspective' in E Lee (ed), *Abortion Law and Politics Today* (London: Macmillan 1998) 43- 58.

legalisation of abortion in 1967 was not intended to enhance women's reproductive autonomy, but rather to 'enable doctors [to] act lawfully in assisting women who were driven to distraction by the prospect of yet another mouth to feed.'⁴²⁴ The significance of the implications of abortion law for the disempowerment of women has made the topic of abortion assume prominence, not only in purely feminist scholarship, but even in the HCL curriculum in many law schools in England and Wales. As was seen from the empirical data in Table D above, eight law schools, which offer HCL modules, treat 'abortion' as a whole topic.

Another issue, which has attracted feminist critique, albeit subtle, relates to compulsory caesarean operations.⁴²⁵ The agonising conundrum which once again arises here is whether the bodily integrity of a pregnant woman can be sidestepped in favour of protecting the foetus by a compulsory caesarean operation. Hewson has observed that the trend towards caesarean cases suggest that the courts were unfairly pushing women to save themselves, whereas men in comparable healthcare situations are not similarly treated. She notes that:

[T]he assumption in the most recent cases seems to be that pregnant women are not really autonomous individuals entitled to equal protection, but merely a subdivision of what courts once called infants and lunatics, incapable of making decisions for themselves, for whom doctors and courts should be surrogate decision-makers.⁴²⁶

⁴²⁴ E Jackson, *Medical Law: Text, Cases and Materials* (2nd edn, Oxford: Oxford University Press 2010) 667.

⁴²⁵ H Draper, 'Women, Forced Caesareans and Antenatal Responsibilities' (1996) 22 *Journal of Medical Ethics*, 337; B Hewson, 'Women's Rights and Legal Wrongs' (1996) 146 *New Law Journal*, 1385.

⁴²⁶ *Ibid.*

Clearly, the patriarchy accusation made by feminists against HCL is substantiated by Hewson's foregoing remarks. Apart from abortion and forced caesarean sections, other aspects of human reproduction have also attracted the attention of the feminist movement.

Furthermore, feminist discourse has identified the privileged status of medicine over nursing and midwifery as another fertile site of patriarchy in which women are subordinated.⁴²⁷ The premise of this argument is that historically, and in fact until recently, the medical profession is virtually monopolised by men. Consequently, when it comes to the working out the standard of care in negligence cases, the Bolam test facilitates the perpetuations of domination and oppression of women.

These diverse doctrinal orientations reinforce the maturation of HCL as a distinct academic discipline since, as noted in section 3.1 above, scholarship provides crucial evidence of the emergence of a field of law. There does not appear to be an immediately discernible coherence in these doctrinal approaches that could imbue HCL with a conceptual unity. But Morgan has rightly noted that HCL transcends the traditional legal requirement for a clear and settled framework because he considers HCL as 'not just a subject but a responsibility.'⁴²⁸ The responsibility which Morgan alludes to entails four elements, namely a process of naming, blaming, claiming and declaiming. Each of these elements has important philosophical dimensions which Morgan explains:

Naming - is this person ill, unwell, chronic, acute etc.; blaming - exploring the role of caring for oneself and one's responsibilities for health care, particularly whether we are responsible for our own health, but also the State's responsibility for provision of health care; claiming - what are our entitlements to health care, of access to services?; and declaiming - about saying who we are and who we want to become, giving a moral and symbolic emphasis to law.⁴²⁹

⁴²⁷ J Montgomery, 'Doctors' Handmaidens: The Legal Contribution' in S McVeigh and S Wheeler (eds), *Law, Health and Medical Regulation* (Aldershot: Dartmouth 1992) 141-168.

⁴²⁸ D Morgan, *Issues in Medical law and Ethics* (London: Cavendish 2001) 3.

⁴²⁹ *Ibid.*

Clearly, these elements distribute responsibilities for various stakeholders in healthcare. Nevertheless, HCL scholars and practitioners bear the initial responsibility for developing a body of law that will fairly apportion these responsibilities. To accomplish this does not really depend upon the niceties of disciplinary categorisation in the strict sense, but being attuned to the dynamic dimension of this field of law and responding appropriately. Thus, I agree with Veitch that:

[i]f medical law has any definable feature at all, it might be thought to reside in the nature of the problems it seeks to address (problems arising from developments in medicine and biomedical science that engage questions of human values), rather than in the construction of clearly delineated legal boundaries.⁴³⁰

3.3. CONCLUSION

Defining a legal field has functional importance and a legitimising usefulness for the field. There is no doubt that HCL has emerged as a field of law and a discrete academic discipline in England and Wales with indicators that gradually became identifiable post-1980. Increasingly, patients aggrieved by their clinical experiences have sought redress in the courts. Doctors have also resorted to the courts for declarations as to the legality of proposed procedures that are ethically sensitive. The burgeoning litigation in healthcare has not only generated an avalanche of case law for academic study, but has also exposed the inadequacy of the common law in resolving the specific bioethical and legal challenges raised by healthcare. Specific legislation was enacted for the first time to address issues raised by medical advances. Even in areas where no direct solution could be provided for in

⁴³⁰ n 41 above, 16.

the statutory law due to a lack of compromise in a morally pluralistic society, bodies such as the HEFA have been established by the law to provide a forum for debating contentious ethical issues and providing guidance for medical professionals.⁴³¹

Also, concomitant with the evolution of this field of law was the emergence of its academic discipline. It entered the curriculum of legal education as many universities began to teach HCL. This eventually triggered a proliferation of textbooks and journals. The proliferation of literature was accompanied by the creation of academic research centres. Active scholarship in this field has manifested itself in four different doctrinal orientations, namely medical ethics, human rights, and multidisciplinary and socio-legal approaches. Despite the diversity in these theoretical approaches, the conceptual unity of the field lies in the commonality of the problems of healthcare practice that are addressed by HCL. The trajectory of HCL can be illuminated by an appreciation of its historical development.

That said, the ultimate validity of HCL as a discrete field depends largely on its acceptability by scholars, the legal community and, more importantly, its utility. It must empower patients and provide guidance in resolving novel challenges attendant upon ever-increasing medical advances. In the next Chapter, I shall explore the existence of a functionally equivalent field of HCL in Ghana through the lens of the characteristics of a discrete body of HCL identified in the present Chapter and pertaining to England and Wales. As already noted in Chapter Two the focus of functional comparative law is not exploring the presence of exact replica of legal arrangements or frameworks in the jurisdictions being compared. Consequently, the exploration in the next chapter is simply to identify the extent to which Ghana's legal system can be said to be responding to the conundrum of patient

⁴³¹ J Montgomery, 'Rights, Restraints and Pragmatism: The Human Fertilisation and Embryology Act 1990' (1991) 54 *Modern Law Review*, 524, 525.

disempowerment and regulations of ethical issues in healthcare particularly medical advances.

CHAPTER FOUR

EXPLORING WHETHER A DISTINCT BODY OF HEALTH CARE LAW EXISTS IN GHANA

4.0. INTRODUCTION

As discussed in Chapter Three, the need to empower patients against long-standing excessive medical power, as well as to regulate medical advances within acceptable margins, contributed to the emergence of a distinct body of HCL in England and Wales. In this chapter, I shall explore the extent to which a distinct body of HCL exists in Ghana. The exploration here is largely driven by a functional comparative law compass. Thus, my objective is not to locate an exact replica of the body of HCL identified earlier in relation to England and Wales in Ghana's legal system. On the contrary, the chapter explores the existence or absence of a functional equivalent of the English and Welsh body of HCL in Ghana and the extent to which a distinct body of HCL could interact with other factors to promote patient empowerment. In order to achieve the goals of this chapter, I shall first explore the existence of each of the defining characteristics in relation to Ghana; then find out whether the other factors that interacted with evolution of HCL to advance patient empowerment are present or absent in Ghana and finally, I shall critically compare and contrast the legal approach in England and Wales with the Ghanaian approach to patient empowerment and the regulation of advances in medicine.

4.1. EXAMINING THE EXISTENCE OF HEALTH CARE LAW IN GHANA THROUGH THE PRISM OF THE CHARACTERISTICS OF A DISTINCT FIELD OF HEALTH CARE LAW IDENTIFIED IN ENGLAND AND WALES

The quest for the empowerment of patients and the increasing interest of academics in the regulation of medical advances were noted in the previous chapter to have been pivotal to the emergence of HCL in England and Wales. In examining how these issues are addressed in Ghana, it will be helpful to adopt the defining characteristics of a distinct field of HCL in England and Wales as the framework for assessing the legal situation in Ghana. The defining characteristics of a field of HCL, as discussed in Chapter Three, may be succinctly restated here, as follows: the existence of a significant volume of case law and dedicated legislation, the teaching of courses relating to the field, and the verifiable interest in the field of legal academics. It is necessary to find out whether these features are present or absent in Ghana.

4.1.1. HEALTHCARE-RELATED LITIGATION IN GHANA

Generally, the relationship between the increasing volume of litigation in healthcare matters and patient empowerment is significant. Indeed, it has been rightly noted that ‘increasing litigation will ensure a notional shift in the balance of power within the doctor-patient relationship and in particular, the coercive paternalism of medical practice may be replaced with the patients’ assertion of rights.’⁴³² Significantly, there was not a great deal of reported litigation in Ghana from the colonial era to post-independence.⁴³³ Indeed, there is a dearth of litigation in this area of the law in Ghana. A search I conducted in the law reports⁴³⁴ in Ghana revealed only six reported cases concerning healthcare.⁴³⁵ The very few

⁴³² JA Harrington, ‘Medical Law and Health Care Reform in Tanzania’ (2004) 6 *Medical Law International*, 207, 220.

⁴³³ Ghana gained independence in 1957.

⁴³⁴ The law reports in Ghana are the *Ghana Law Report*, the *Supreme Court of Ghana Law Report*, the *Ghana Bar Report*, *West Africa Law Reports* and the *Monthly Law Report of Ghana*.

⁴³⁵ These are: *Asafo v Catholic Hospital of Apam* [1973] 1GLR 282; *Asantekramo alias Kumah v. Attorney-General* [1975] GLR 319; *Gyan v. Ashanti Goldfields Corporation* [1991] 1 GLR 466; *Darko v Korle-bu Teaching Hospital; Frank Darko (Minor) (Suing Per Next Friend Gladys Darko, Mother)*, Suit No. AHR 44/06, Judgment by Accra Fast Track High Court dated 24/06/2008; unreported (copy obtained from the Registry is available in my

decided cases relate mainly to medical negligence and access to medical records. Unlike England and Wales, where there are over two hundred reported cases⁴³⁶ relevant to HCL, the few cases in Ghana to be explored were not all decided by the courts; some were decided by quasi-judicial bodies.⁴³⁷

Beginning with the court decisions, it is worth noting that the first reported case of relevance is the leading case of *Asantekramo alias Kumah v. Attorney-General*⁴³⁸ in 1975. In this case, a patient's hand became swollen and gangrenous following the wrongful administration of a blood transfusion after an operation induced by a ruptured ectopic pregnancy.⁴³⁹ The doctor later amputated the patient's hand to save her life. In a negligence suit, the court accepted the expert medical evidence that, 'in all the contingencies, the bacteria which caused the gangrene could only have entered the plaintiff's body if the defendant's servants, namely, the nurses or those in charge of the infusion apparatus, the needle and the drip stand, were prima facie negligent.'⁴⁴⁰ Contrary to the accusation that is often levelled against English courts in handling medical negligence cases (that they defer excessively to the medical profession), the judge in this case weighed the evidence fully and even rejected a portion of the evidence provided by the defendant's witness (a doctor) and entered a judgement for the patient.⁴⁴¹

folder); *Elizabeth Vaah v Lister Hospital and Fertility Centre* (Suit No. HRCM 69/10); *Republic v The Registrar, Medical and Dental Board; Ex parte Christian* [1973] 2GLR 323 2010, Fast Track Court, High Street, Accra, Ghana (unreported).

⁴³⁶ Section 3.2.1. A of Chapter Three

⁴³⁷ These are the Disciplinary Committee of the Medical and Dental Council and the Commission on Human Rights and Administrative Justice.

⁴³⁸ [1975] GLR 319.

⁴³⁹ *Ibid* 324-326.

⁴⁴⁰ *Ibid* 339.

⁴⁴¹ *Ibid* 338.

It took almost four decades before the Bolam test,⁴⁴² which has largely dictated the direction of HCL in England and Wales,⁴⁴³ was fully discussed and applied by the Ghanaian Court of Appeal in *Gyan v Ashanti Goldfields Corporation*.⁴⁴⁴ Here, a senior nurse working in the defendant's hospital mistook polio fever for malarial fever in a one year old child patient and rushed to administer a chloroquin injection without carrying out tests or referring to the doctor on duty. This was established by the court during the trial as being in tandem with the general practice at the time.⁴⁴⁵ The injection caused paralysis in the right leg of the infant and a claim was vicariously brought against the defendant for negligence. The court upheld the dismissal of the plaintiff's claim by the trial judge. The holding of the court was founded upon two main reasons grounds: first, the evidence on record showed that the nurse did what most, if not all, healthcare professionals would have done in the circumstances on that occasion.⁴⁴⁶ Secondly, the plaintiff failed to prove that the paralysis was attributable to any omission or negligent act of the defendants as he failed to lead any evidence to substantiate his allegation that the nurse had failed to follow the medical regulations in place.⁴⁴⁷ It is instructive to note that the court appeared willing to consider clinical guidelines in determining the standard of care expected of the nurse if the claimant had been able to adduce evidence to prove the existence of the relevant clinical guidelines or medical regulations.

However, Justice Ofori-Boateng dissented from the majority and contended that a defendant in a medical negligence suit could still be held liable, despite acting in accordance

⁴⁴² See: Chapter Three.

⁴⁴³ P Byrne, *Medicine in Contemporary Society* (London: King Edwards 1987) 134.

⁴⁴⁴ *Gyan v Ashanti Goldfields Corporation* [1991] 1 GLR 466, 482.

⁴⁴⁵ *ibid*, 467.

⁴⁴⁶ *ibid* 474.

⁴⁴⁷ *ibid*.

with common practice.⁴⁴⁸ Indeed, the dissenting judge was prepared to think through the medical procedures when an emergency case was presented without confining himself to the testimony of what other doctors thought they would have done. He posed profound probing questions, remarking:

To my mind, however, the charge by the first plaintiff witness that the first defendant witness did not follow the laid down routine of the hospital to give the injection need not be confined to what happened in the treatment room where the injection was administered because the injection alone cannot be taken in isolation in a case like this. It includes all the accepted procedures and practice of treating people suffering from fever, like the plaintiff, culminating in the giving of an injection. For example, when a child is suffering from fever, what kinds of illness should be suspected? Should such illnesses be identified after diagnosis before treatment can start? When can a nurse decide to treat, on his own, an unidentified illness without any reference to a doctor? Under what circumstances can the most risky method of treating suspected malaria by injection without any test be adopted for speeding up results, as opposed to other methods of administering drugs orally which are not so risky?⁴⁴⁹

The dissenting view gives a better assurance for the protection of patients' interests in healthcare because it recognises that the scope of duty of care owed to patients goes beyond actual treatment or therapy to encapsulate all procedures undertaken on the patient, right from the moment that he or she enters the healthcare facility. It therefore questions what should constitute good medical practice. On the contrary, the majority view, based upon *Bolam*, implicitly assumes that medical paternalism will safeguard the welfare of patients. In my view, such an assumption is quite risky for patient safety and empowerment, even as the experience from England and Wales, where there is arguably a more effective regulatory healthcare regime, suggests that it is unsafe for the law to simply trust medical paternalism without external accountability.⁴⁵⁰ Indeed, the dissenting judge qualified the

⁴⁴⁸ Ibid.

⁴⁴⁹ *Gyan v Ashanti Goldfields Corporation* [1991] 1 GLR 466, 474-478.

⁴⁵⁰ For example see, I Kennedy, 'Learning from Bristol - Are We?'

<http://www.stateclaims.ie/ClinicalIndemnityScheme/publications/LearningfromBristol.pdf> (accessed: 15/5/2013).

principle in *Bolam* to the effect that ‘if a hospital practice is negligent and breaches the duty hospitals owe to patients, the extensiveness of that negligence, because it is committed by many hospitals in general, cannot cure the practice of its negligent nature.’⁴⁵¹ Since the Supreme Court of Ghana has not so far decided any other medical negligence or HCL cases, the majority decision in *Gyan* remains the current law in Ghana.

In 2008 the *Bolam* approach to medical negligence resurfaced in the unreported case of *Darko v Korle-bu Teaching Hospital*.⁴⁵² The brief facts were that a fourteen year old boy hoping to become a professional footballer complained of pain in the right knee at the defendant’s hospital for treatment.⁴⁵³ Although clinical investigations revealed that ‘the left knee was also lax, it was the right knee which was diagnosed as having a torn patella ligament.’⁴⁵⁴ He was requested to sign a consent form for surgery to repair the torn patella tendon in the right knee. The consent form indicated as follows:

I ...hereby consent to undergo the operation of the repair of right patella tendon the effect and nature of which has been explained to me. I also consent to such further or alternative operative measures as may be found to be necessary during the course of such operation and to the administration of a local or other anaesthetic for the purpose of the same. I understand an assurance has not been given that the operation will be performed by a particular surgeon.⁴⁵⁵

However, instead of the right knee being operated on, the team of surgeons operated on the left knee. The plaintiff sued for medical negligence and whilst the suit was pending, ‘the hospital refused to further attend to him during his review and physiotherapy appointments as a protest against his suit.’⁴⁵⁶ The court did not find the doctors or hospital liable for

⁴⁵¹ *Gyan v Ashanti Goldfields Corporation* [1991] 1 GLR 466, 474.

⁴⁵² *Frank Darko (Minor) (Suing Per Next Friend Gladys Darko, Mother)*, Suit No. AHR 44/06, Judgment by Accra Fast Track High Court dated 24/06/2008; unreported (the copy obtained from the Registry is available in my folder).

⁴⁵³ *Ibid* 1-4.

⁴⁵⁴ *Ibid*.

⁴⁵⁵ *Ibid* 7-8.

⁴⁵⁶ *Ibid*.

negligence in operating on the left knee instead of the right, but did find that the hospital was liable for refusing the claimant further treatment after the legal action had been initiated. In dismissing the negligence claim against the doctors, the court based its decision on two pillars. First, the court relied on *Bolam* and contended that insofar as the consultant surgeon 'acted in accordance with the practice accepted as proper by a responsible body of medical men in that particular art, although a body of adverse opinion also existed among medical men,' they could not be guilty of negligence.⁴⁵⁷ Secondly, the court justified its decision by arguing that the patient had signed 'a broad consent form' which empowered the surgical team 'to undertake any necessary measures for the purpose of the operation.'⁴⁵⁸ Indeed, Ayebi JA remarked:

From Exhibit 6, plaintiff's mother gave consent for operation on the right patella tendon. But then the consent further gave the surgeon the discretion to carry out other operative measures which may be found to be necessary during the course of the operation. Unfortunately, neither counsel for the parties addressed the import of this consent form.⁴⁵⁹

In finding the defendant hospital liable for negligence in refusing to further treat the claimant after the legal action had been initiated, the court generally relied on the Hippocratic Oath and maintained that 'since it was implicit in the Hippocratic Oath to save life, it was incumbent upon the defendant not to refuse further treatment,' despite their discomfort with the suit.⁴⁶⁰

Although, the decision in *Darko* demonstrates some degree of sensitivity to patient autonomy, it does not adequately advance patient empowerment. To begin with, the court applied the *Bolam* test without evaluating its adequacy in the light of the exigencies of the

⁴⁵⁷ *Frank Darko (Minor) (Suing Per Next Friend Gladys Darko, Mother)* Suit No. AHR 44/06, 9. Judgment by Accra Fast Track High Court dated 24/06/2008; unreported (the copy obtained from the Registry is available in my folder).

⁴⁵⁸ *Ibid* 8.

⁴⁵⁹ *Ibid*.

⁴⁶⁰ *Ibid* 13.

case before it. This is an important omission given that the issues at stake were not about the actual surgical operation, but concerned the carrying out of the operation on the left, instead of the right knee. It was not sufficient to rely on the concurring opinion of other doctors to justify the position that the operation on the left knee did not amount to negligence. Thus, it can be inferred that the judge was labouring under the illusion that medical paternalism always ensured beneficial outcomes for the patient. The judge's obsession with medical paternalism manifested itself clearly when he alluded to the Hippocratic Oath, as noted above. It would have been better had the court directed its inquiry towards the extent of the information disclosed to the patient regarding the planned surgery on the right knee and any potential risk that could have necessitated an emergency operation on the left knee. It is submitted that the court failed to attach weight to the patient's autonomy in determining the breach of duty of care by the surgical team in operating on the left knee. The lawyer for the claimant also deserves a share in the blame since he did not make an issue out of the inadequate disclosure of information to the patient. Thus, the court could not have substituted a new case for the claimant. As the judge pointed out,⁴⁶¹ the lawyers who conducted the case never bothered to comment on the wording of the consent form which the patient had signed prior to the operation.

The most recent case of considerable significance to HCL in Ghana relates to access to medical records. The Human Rights Division of the Ghana High Court has affirmed a patient's right of access to her medical records in *Elizabeth Vaah v Lister Hospital and Fertility*

⁴⁶¹ *Frank Darko (Minor) (Suing Per Next Friend Gladys Darko, Mother)* Suit No. AHR 44/06, 12. Judgment by Accra Fast Track High Court dated 24/06/2008; unreported (the copy obtained from the Registry is available in my folder).

Centre.⁴⁶² In 2010, Vaah, brought an application to the court on the basis of Article 21(1)(f) of the 1992 Constitution, which guarantees freedom of information, for two main sources of relief.⁴⁶³ First, the applicant sought a declaration that ‘a patient is entitled as a matter of right to her medical records within the custody of a health care institution subject only to the payment of reasonable fees for the production of copies of the record and any other limitations as recognized by law.’⁴⁶⁴ Secondly, the applicant also requested ‘an order compelling the respondent, Lister Hospital, to furnish her with her medical records in its custody.’⁴⁶⁵ The factual matrix that precipitated this suit was that the applicant, who was an expectant mother, began receiving antenatal services from the respondent with a view to delivery at the respondent hospital. Several tests and scans were run on the applicant and baby and proved that she was carrying a normal healthy foetus. In the course of time, the applicant’s membranes ruptured and she was rushed to the respondent hospital without delay. The next day, the applicant delivered a still-born baby. A post mortem examination revealed that ‘the baby died of “multiple organ haemorrhages” most probably due to a bleeding diathesis/coagulation defect with bleeding precipitated by the ‘trauma’ of labour.’⁴⁶⁶ The applicant deposed in the affidavit accompanying the application that she needed access to her medical records so that she could put them at the disposal of any doctor who would subsequently attend to her (whether within or outside Ghana). The respondent refused the written request of the applicant’s solicitors for the medical records. The applicant thus invoked the assistance of the court, complaining that her fundamental right to information, as guaranteed under the Constitution, had been and was still being

⁴⁶² Unreported, but the suit number is HRCM 69/10 Fast Track Court, High Street, Accra, Ghana. I went to the Court’s Registry to collect copies of unreported judgements and rulings.

⁴⁶³ *Ibid.*

⁴⁶⁴ *Ibid.*

⁴⁶⁵ *Ibid.*

⁴⁶⁶ *Ibid.*

violated by the respondent. The respondent argued that it was justified in refusing the applicant's request for medical records because by speaking to the press about the circumstances in which she gave birth at the respondent hospital, she had evinced an intention to abuse the records. The court analysed the constitutional provision on freedom of information and held that the excuse provided by the respondent in denying access to the applicant was not covered by the qualifications contemplated by the Constitution for limiting freedom of information.⁴⁶⁷ Due to the lack of Ghanaian precedent, the judge cited and discussed the American cases of *Emmet v Eastern Dispensary and Casualty Hospital*⁴⁶⁸ and *Julian Cannel v The Medical and Surgical Clinic*.⁴⁶⁹ Although *Vaah* is a High Court decision, until a higher court issues another precedent or specific legislation is passed to govern access to medical records in Ghana, *Vaah* is likely to be followed in future litigation.

Vaah raises issues of urgent concern. First, the resort to the general legal provision on freedom of information in seeking redress for access to medical records exposes a gap in Ghanaian law. There is a need for a dedicated enactment which provides a clear framework for accessing health records. Statutory intervention in this area may help address specific and distinctive issues relating to ownership of health records, access to information in health records and so on. Secondly, the case has also revealed a lack of awareness on the part of the legal community about healthcare practice and delivery in Ghana. This observation is justified by the lack of any attempt made by the court or the lawyers in the case to derive any assistance from soft law in the field. In this regard, the Medical and Dental Council's Guiding Rules on Disclosure, or the Ghana Health Service's Patient Charter

⁴⁶⁷ Unreported, but the suit number is HRCM 69/10 Fast Track Court, High Street, Accra, Ghana. I went to the Court's Registry to collect copies of unreported judgements and rulings.

⁴⁶⁸ *Emmet v Eastern Dispensary and Casualty Hospital* 130 US App D.C. 50 ,396 F 2d 931 [1967]

⁴⁶⁹ *Julian Cannel v The Medical and Surgical Clinic* 21 I 11 App. 3d 383,315 NE2d 278 [1974]

of 2010,⁴⁷⁰ or the Professional Ethics of medical doctors within Ghana could have been considered since they have some relevance to the subject before the court.⁴⁷¹

Apart from court decisions, other quasi-judicial bodies in Ghana sometimes render decisions that have some relevance for patient empowerment. The most important quasi-bodies for this purpose are the Commission for Human Rights and Administrative Justice (CHRAJ) and the Disciplinary Committee of the Medical and Dental Council (MDC). The CHRAJ has a mandate to serve as a forum for the protection and enforcement of human rights in general. It is able to apply the human rights provisions of the Constitution in an expansive way that accommodates grievances from patients against healthcare professionals.⁴⁷² For example, in *Somi v Tema General Hospital*, the CHRAJ held that the failure of a public hospital to ensure that an emergency caesarean section operation was carried out on a patient, thus leading to her death, constituted a violation of her human right to life.⁴⁷³ The fact that in 2000, CHRAJ could invoke the constitutional right to life in finding a health institution liable for the negligent handling of an emergency case leading to death suggests that CHRAJ has the potential to serve as an effective forum for the ventilation of patients' grievances against healthcare professionals and institutions. Indeed, in the CHRAJ annual reports, the Commission has consistently reported a growing awareness of the public about their rights as patients.⁴⁷⁴ In Section 4.1.3 below, I elaborate on the extent of public awareness of the Patient Charter in a more nuanced way.

⁴⁷⁰ Note that the Patients Charter has now been embodied in section 167 of the recently passed *Public Health Act, 2012* (Act 851).

⁴⁷¹ ID Norman, MSK Aikins, FN Binka, DN Banyubala and AK Edwin, 'The Constitutional Mandate for Judge-Made-Law and Judicial Activism: A Case Study of the Matter of Elizabeth Vaah v. Lister Hospital and Fertility Centre' (2012) 6 *The Open Ethics Journal*, 1, 5.

⁴⁷² 1992 Constitution of the Fourth Republic of Ghana, Art. 218.

⁴⁷³ *Somi v Tema General Hospital* [1994-2000] CHRAJ 196, 213.

⁴⁷⁴ CHRAJ, 'The 2011 State of Human Rights Report' (2011)

http://lib.ohchr.org/HRBodies/UPR/Documents/Session14/GH/JS1_UPR_GHA_S14_2012_JointSubmission%201_Annex2_E.pdf (accessed: 18/5/2013).

Furthermore, the MDC serves as a platform for aggrieved patients to petition against the conduct of doctors and dentists.⁴⁷⁵ A brief report obtained⁴⁷⁶ from their secretariat in 2012 indicates that between 2002 and 2011, six cases relating to patient empowerment had been concluded.⁴⁷⁷ The most recent decision of the MDC is *MDC v Dr Sandys Abraham Arthur* (Complainant: Amarkai Amarteifio).⁴⁷⁸ On 1st January, 2007, the complainant, Miss Amarteifio, accompanied her fiancé Johnson (deceased patient) to a private health facility where Dr Arthur was employed.⁴⁷⁹ The patient reported pain in the upper calf, which was diagnosed by the respondent as a torn ligament.⁴⁸⁰ The complainant informed the practitioner that the patient had rested in bed for some days as a result of a chest infection and so could not have torn a ligament, but possibly had a deep vein thrombosis (DVT).⁴⁸¹ The respondent ignored the complainant's suggestion and prescribed aspirin tablets for the patient. The respondent advised the patient to see him the following day, but he did. The pain in the calf worsened, yet the respondent insisted the deceased had a torn ligament.⁴⁸² Even though the complainant repeated her suspicion of DVT, the respondent stood his ground and repeated the treatment for a torn ligament. The patient died the following morning (the 3rd day) in his own home.⁴⁸³ A post mortem examination result indicated that 'the patient died of a pulmonary embolism resulting from DVT.'⁴⁸⁴ A complaint was therefore lodged with the MDC, which found negligence in the treatment of the patient,

⁴⁷⁵ Health Professionals Regulatory Bodies Act, 2012 (Act 857), ss. 27(e), 54. Section 54 actually saves Part IV of the repealed Medical and Dental Council Act, 1972 (NRCD 91), relating to disciplinary matters.

⁴⁷⁶ I visited the secretariat and met the legal representative on the MDC, Dr SY Bimpong- Buta, January 2012.

⁴⁷⁷ The cases were disciplinary charges against (1) Dr Sandys Abraham Arthur; (2) Dr JF Tetteh; (3) Dr Sacky Sathayavathi; (4) Dr Dominic Obeng Andoh and Dr James Clarke; (5) Dr Ebenezer Nii Yemoh, and (6) Dr Eric Ntiamoah Mensah.

⁴⁷⁸ Decision of MDC, 2008 (available in the folder).

⁴⁷⁹ Ibid 2-3.

⁴⁸⁰ Ibid.

⁴⁸¹ Ibid.

⁴⁸² Ibid.

⁴⁸³ Decision of MDC, 2008 (available in the folder).

⁴⁸⁴ Ibid 4.

resulting in his death and pronounced the respondent guilty of infamous conduct in a professional respect. The MDC ordered removal of the respondent's name from the register of medical practitioners in Ghana.⁴⁸⁵

Although the MDC found the doctor liable, it is difficult to suggest that the MDC's handling of disciplinary cases is mainly geared towards patient empowerment. On the contrary, it appears that the MDC is primarily interested in upholding the reputation of the healthcare profession. This can be inferred from the interpretation which the MDC in this case gave to what constitutes infamous conduct. The MDC interpreted infamous conduct to mean 'any conduct which detracts from the duty imposed by regulation 1 or simply put any conduct which tends to bring the medical profession into disrepute or disgrace or dishonour.'⁴⁸⁶ Regulation 1 stipulates that: 'A medical practitioner must be a man of integrity and good faith. It is his duty at all times to uphold the dignity and high standard of his profession and his own dignity and high standing as a member of it.'⁴⁸⁷ The MDC sought to test the correctness of its interpretation by drawing inspiration from the way in which the same phrase 'infamous conduct' used in equivalent English legislation in the nineteenth century, had been construed in the *Allinson's* case in which the English Court of Appeal held that:

if it is shown that a medical man, in the pursuit of his profession, has done something with regard to it which would be reasonably regarded as disgraceful and dishonourable by his professional brethren of good repute and competency, it is open to the Council to find that he has been guilty of infamous conduct in a professional respect.⁴⁸⁸

⁴⁸⁵ Decision of MDC, 2008 (available in the folder), 17.

⁴⁸⁶ *Ibid* 15.

⁴⁸⁷ Medical Profession (Professional Conduct and Ethics) Regulations, 1975.

⁴⁸⁸ *Allinson v General Council of Medical Education and Registration* [1894] 1 QB 750, 751.

The MDC has fully endorsed the definition of ‘infamous conduct’ given above. Despite the clarification of the meaning of ‘infamous conduct’ by the MDC in Dr Arthur’s case, there still remains a pertinent question for future cases and law reform. It is uncertain whether the same interpretation of ‘infamous conduct’ will be adopted in future disciplinary cases, since the MDC is not a court of law in the strict sense but a quasi-judicial body. Consequently, the doctrine of judicial precedent as it is utilised in Ghanaian courts does not necessarily apply to operations of the MDC. Due to the absence of a full compilation of the disciplinary cases decided by the MDC since its inception over 30 years ago, I could not gain access to all the disciplinary cases decided during the period. This would have enabled me to ascertain whether in previous cases, different interpretations of ‘infamous conduct’ were provided by the DC. This absence poses a problem when one endeavours to discern the thinking of the MDC concerning ‘infamous conduct’ from its previous decisions. My research did not find any case in the law reports in Ghana concerning an appeal before the Court of Appeal in which a challenge was made to the MDC’s interpretation of infamous conduct in disciplinary proceedings, or where judicial review was sought before the High Court in relation to such proceedings. Thus, there is no guide as to whether or not the MDC has been consistent in its interpretation of infamous conduct. The only reported case concerning the MDC is *Republic v. The Registrar, Medical and Dental Board; Ex parte Christian*.⁴⁸⁹ But this case concerned the service of a disciplinary decision by the MDC on an affected doctor who had left the shores of Ghana immediately following the full proceedings of the MDC, but before the final decision had been issued and this offers no assistance.

Furthermore, it is not likely that there will be a clarification of the provision by Parliament in the foreseeable future, because the MDC, which could possibly recommend

⁴⁸⁹ [1973] 2 GLR 323

an amendment of the law, has openly declared its approval of the law in the Dr Arthur case. It is therefore not surprising that in the newly passed Health Professions Regulatory Bodies Act, 2013 (Act 857), the part of the present legislation (i.e. NRCD 91) concerning disciplinary provisions, including infamous conduct, has been left intact with no hope for amendment that could have clarified the law. I submit that there is an urgent necessity for an amendment to provide for a clear interpretation of ‘infamous conduct,’ particularly when Article 19(11) of the 1992 Constitution is critically assessed. According to this constitutional provision, ‘no person shall be convicted of a criminal offence unless the offence is defined and the penalty for it is prescribed in a written law.’ The procedure for trying the allegation of infamous conduct in a professional respect is materially the same as for an ordinary criminal trial in a court of law. It is therefore crucial for a clear statement of the offence in the law so that the determination of the commission, or otherwise, of infamous conduct does not lie largely in the realm of the MDC’s subjective consideration.

In my view, the lack of certainty in some aspects of the MDC Act (now replaced substantially by Act 857), particularly infamous conduct, coupled with the absence of clear legislative attempts or judicial decisions to clarify the law, could possibly be explicated by the absence of a distinct body of HCL in Ghana. Indeed, if a field of HCL succoured by legal scholarship were in existence, the infelicities associated with the provision relating to infamous conduct would surely have been explored and necessary recommendations made for law and policy makers.

4.1.2. HEALTHCARE-RELATED LEGISLATION IN GHANA SINCE INDEPENDENCE

As noted in Chapter 3, a critical component of the field of HCL is the existence of dedicated legislation that seeks to empower patients or mediate the ethical dilemmas generated by advances in medicine. In this section, I proceed to explore the extent to which

this feature of a distinct field of HCL exists in Ghana. To some extent, there are many statutes that have been enacted in Ghana to govern various aspects of health in general and healthcare in particular. In Table 3 below, I outline these statutes and note their implications for healthcare in terms of patient empowerment.

TABLE 2: Healthcare-Related Legislation in Ghana

SHORT TITLE OF STATUTE/DELEGATED LEGISLATION/ GUIDELINES	RELEVANCE TO THE EMPOWERMENT OF THE PATIENT AND THE REGULATION OF MEDICAL ADVANCES
Health Professions Regulatory Bodies Act 2013 (Act 857)	<ul style="list-style-type: none"> • Consolidates the existing statutes on the Medical and Dental Council, Pharmacy Council, and Nursing and Midwifery Council into one statute • Creates two new regulatory bodies- the Allied Health Professions Council and the Psychology Council.
Public Health Act 2012 (Act 851)	<ul style="list-style-type: none"> • Provides for a comprehensive legal framework for public health • Incorporates the GHS Patient’s Charter as a compendium of patient rights • Repeals the old disparate statutes on public health – the Infectious Diseases Act, 1908 (Cap 78); the Mosquitoes Act, 1911 (Cap 75); (c) the Quarantine Act, 1915 (Cap 77); (d) the Food and Drugs Act, 1992 (PNDCL 305B). and (2) Sections 285-288 of the Criminal Offences Act, 1960 (Act 29).
Mental Health Act 2012 (Act 846)	<ul style="list-style-type: none"> • Provides an elaborate statement of patients’ rights in the context of mental health.
Data Protection Act 2012 (Act 843)	<ul style="list-style-type: none"> • Provides that a person shall not process personal data which relates to the health of an individual unless stated exceptions apply.⁴⁹⁰
National Health Insurance Act 2003 (Act 650)	<ul style="list-style-type: none"> • Establishes the National Health Insurance Authority (NHIA) with the mandate to ‘secure the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents’ (s. 2(1)). • The NHIA ‘ensures that healthcare services rendered to beneficiaries of schemes by accredited healthcare providers are of good quality’ (s. 2(2)). • the NHIA is required to ‘devise a mechanism for ensuring that the basic healthcare needs of indigents are

⁴⁹⁰ Data Protection Act 2012 (Act 843), s. 21(1)(b).

	<p>adequately provided for' (s. 2(2)).</p> <ul style="list-style-type: none"> The NHIA has the additional responsibility towards quality assurance and in particular: <ul style="list-style-type: none"> '(a) the quality of healthcare services delivered are of reasonably good quality and high standard; (b) the basic healthcare services are of standards that are uniform, throughout the country; (c) the use of medical technology and equipment are consistent with the actual needs and standards of medical practice; (d) medical procedures and the administration of drugs are appropriate, necessary and comply with accepted medical practice and ethics, and (e) drugs and medication used for the provision of healthcare in the country are those included in the National Health Insurance Drug List of the Ministry of Health' (s. 68).
Ghana AIDS Commission Act 2002 (Act 613)	<ul style="list-style-type: none"> Is not directly relevant to patient empowerment, but creates a broad-based commission to co-ordinate the national fight against HIV/AIDs.
Traditional Medicine Practice Act 2000 (Act 572)	<ul style="list-style-type: none"> Regulates traditional medical practice for the first time and provides a monitoring scheme, which can protect patients against exploitation by unscrupulous herbalists.
Ghana Health Service and Teaching Hospitals Act 1996 (Act 525)	<ul style="list-style-type: none"> Mainly sets up the institutional framework for the delivery of healthcare through state-owned health institutions. Remotely touches on patient safety by providing that the monitoring of the quality of care provided in health institutions is part of the responsibilities of the Boards established by the Act (s. 35(2)).
The Fourth Republic Constitution of Ghana, 1992	<ul style="list-style-type: none"> Guarantees various human rights which can be adapted to the healthcare context.
Medical and Dental Council Act 1972 (NRCD 72)	<ul style="list-style-type: none"> Deals exclusively with the regulation of the medical profession. Establishes a council which 'is concerned with medical and dental practitioners and is responsible for securing, in the public interest, the highest standards in the practice of medicine and dentistry' (s. 4).
World Health Organisation (Protection) Act 1958 (No. 41)	<ul style="list-style-type: none"> Makes it unlawful to misuse or abuse the name and emblem of the WHO.
Vaccinations Act 1919 (Cap. 76) [recently repealed by Act 851]	<ul style="list-style-type: none"> Provides for free and compulsory vaccination against certain diseases.

Infectious Diseases Act 1908 (Cap. 78) [recently repealed by Act 851]	<ul style="list-style-type: none"> • Deals with how to contain the spread of infectious diseases.
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From the above table, it is clear that there is no specific or dedicated legislation dealing with the various issues arising from medical advances, such as IVF-assisted reproduction, organ transplantation, etc. which have gradually been imported into healthcare in Ghana. Apart from this obvious gap in Ghanaian law, neither has the theme of patient empowerment been featured prominently in healthcare legislation enacted in Ghana from the colonial era to the post-independence era. Having said that, this situation which has existed since the inception of this research in 2011, has now improved with the recent enactment of the Mental Health Act, 2012 ('MHA') and the Public Health Act, 2012 ('PHA'). Admittedly, the MHA has made a significant shift in putting the issue of patient empowerment or patients' rights at the centre of the legal and policy framework for mental health. Specifically, the Act provides a compendium of rights for mental patients. To begin with, it affirms the importance of the self-determination of voluntary mental patients: '(2) [t]he consent of a voluntary patient shall be obtained before treatment is given. (3) [a] voluntary patient reserves the right to refuse treatment.'⁴⁹¹ These provisions are important indicators of the modest progress being made in Ghana towards the empowerment of patients. There is no reported case concerning these provisions of section 41 (consent and refusal of treatment), so their true effects are yet to be realised.

Looking at the MHA, apart from general mental healthcare, a higher level of consent is required where special treatments are to be administered to mental health patients. In this regard, four aspects of the MHA are worth considering. First, 'a person with mental disorder shall not undergo sterilization, a major medical or surgical procedure without informed

⁴⁹¹ Mental Health Act 2012 (Act 846), s. 40.

consent or the informed consent of a personal representative if that person is incapable of giving the consent.⁴⁹² The MHA expressly mentions electro-convulsive therapy as one procedure which cannot be administered without informed consent.⁴⁹³ It is interesting to note how the Ghanaian lawmakers have reserved informed consent for these high risk invasive procedures. Unlike England and Wales, where no statute has specifically incorporated the doctrine of informed consent, for the first time this has been expressly incorporated in Ghanaian law. The MHA did not merely incorporate informed consent and leave the courts to work out its interpretation but went a step further to unequivocally spell out its meaning. Thus, according to s. 97 of the MHA, informed consent means ‘an agreement or consent for a procedure given freely without coercion by a person with capacity when the person has been made fully aware of the nature of the procedure, its implications and available alternatives.’ A person has capacity where he or she possesses ‘the functional ability to understand or form an intention with regard to an act.’⁴⁹⁴ A striking feature of this statutory definition of informed consent is the requirement for full disclosure to the patient or their representative. However, the benefits of this provision are limited as informed consent is stipulated here only in relation to mental, rather than general healthcare. Secondly, a healthcare facility can ignore the absence of informed consent and proceed with the requisite procedure where the life of the patient with a mental disorder is endangered as a result of the delay caused while obtaining consent.⁴⁹⁵ Thirdly, in all cases of serious medical procedures for a mentally ill person, where informed consent cannot be given or is delayed, the relevant healthcare facility is required to apply to the Mental Health

⁴⁹² Mental Health Act 2012 (Act 846), s. 71.

⁴⁹³ *Ibid*, s. 71(5).

⁴⁹⁴ *Ibid*, s. 97.

⁴⁹⁵ *Mental Health Act*, 2012 (Act 846), at s. 71(2).

Review Tribunal for consent.⁴⁹⁶ Finally, the MHA has made the breach of the rights of a patient with a mental disorder a criminal offence, punishable with a fine and imprisonment.⁴⁹⁷ Thus, a doctor or any healthcare professional that treats such patients without obtaining appropriate consent risks facing criminal prosecution. It appears from these provisions that as far as mental healthcare is concerned, the issue of patient empowerment is addressed in Ghanaian law. Nevertheless, it is difficult to meaningfully assess whether there are rough edges in the law which need to be reviewed since the provisions of the MHA are yet to be tested in the courts or the tribunal. It also needs to be emphasised that merely passing a legislation with elaborate provisions on patient rights will not by itself be an effective solution to the conundrum of patient disempowerment. There would have to be socio-cultural changes as well (as discussed in Chapter Six).

Another way in which the MHA potentially advances patient empowerment is the guaranteeing of 'free and full access to information about mental disorder and the treatment plan of [the mental] patient.'⁴⁹⁸ This is a remarkable improvement in Ghanaian law, especially when one considers the situation in *Vaah* where the court had to invoke generic provisions on freedom of information as grounds for holding that the claimant was entitled access to medical records. Since there is no specific legislation on access to medical records in Ghana, except the general *Data Protection Act, 2012 (Act 843)* (hereafter, DPA), it is my submission that a court may now draw inspiration from the MHA when interpreting freedom of information under the 1992 Constitution in relation to medical or health records in a similar situation to *Vaah*. In a country where there has been excessive medical paternalism and patients tend to lack the confidence to ask doctors questions concerning

⁴⁹⁶ *Ibid*, s. 71(2) and (3).

⁴⁹⁷ *Mental Health Act 2012 (Act 846)*, s. 94.

⁴⁹⁸ *Ibid*, s. 62(1).

their clinical experience, the MHA has ushered in an era of a brave new world. The conundrum inherent in the MHA's approach towards access to medical records is that it permits the health facility to deny access to information about the patient's medical disorder and treatment plan 'if the information is harmful to the well-being of the patient.'⁴⁹⁹ The question which immediately comes to the fore is how we determine what constitutes 'harmful information'? This provision is yet to be tested in litigation, so not much can be said beyond this observation.

Similarly, the DPA as a general rule exempts the processing of personal data relating to the health of an individual.⁵⁰⁰ However, this presumption may be rebutted by necessity of medical purpose where the 'processing is undertaken by a health professional; and pursuant to a duty of confidentiality between patient and health professional.'⁵⁰¹ Furthermore, there is a general prohibition of the disclosure of personal data relating 'to the physical, mental health or mental condition of the data subject.'⁵⁰² This prohibition is relaxed where there is another law that requires disclosure. Unlike the MHA, which has already entered into force, the operation of the DPA is yet to commence from a date to be specified in a statutory instrument.⁵⁰³ Consequently, the real effect of the DPA in relation to health data or records cannot be assessed at present.

The PHA has also introduced new initiatives that can potentially advance the empowerment of patient. For the first time, the GHS Patient's Charter has been given statutory basis through its incorporation into section 167 of the PHA. The Charter embodies the rights and responsibilities of patients. The PHA has also established a maiden framework

⁴⁹⁹ Ibid 62(3).

⁵⁰⁰ *Data Protection Act 2012* (Act 843), s. 37(1)(b).

⁵⁰¹ Ibid s. 37(6)(e).

⁵⁰² Ibid 62(a).

⁵⁰³ Ibid s.99.

for conducting clinical trials.⁵⁰⁴ The explicit endorsement of the doctrine of informed consent is noticeable in this framework.⁵⁰⁵

In addition to the new statutory provisions described above in relation to patient empowerment, Chapter Five of the Constitution of Ghana embodies a bill of rights which can be relied upon to draw inspiration for patient empowerment in Ghana. Article 12(2) unambiguously stipulates that '[e]very person in Ghana, whatever his race, place of origin, political opinion, colour, religion, creed or gender shall be entitled to the fundamental human rights and freedoms of the individual contained in this Chapter but subject to respect for the rights and freedoms of others and for the public interest.'⁵⁰⁶ Article 34(2) of the 1992 Constitution of Ghana imposes an obligation on a sitting President to ensure 'the realization of basic human rights; *the right to good health care* of every citizen.'⁵⁰⁷ However, Article 34 forms part of Chapter Six (Directive Principles of State Policy) of the Constitution and the rights contained therein are of an aspirational character. Consequently, the status of the right to healthcare under Ghana's Constitution appears to be somewhat doubtful when juxtaposed with other rights. For example, the right to education, which follows the right to health in the enumeration of rights contained in Article 34(2), noted above, is elaborately repeated in Article 25. Since Article 25 is located in Chapter Five of the Constitution (Fundamental Human Rights and Freedoms) it can be considered as having more prominence than the right to healthcare. This is particularly worrying when account is taken of the fact that, until recently, the directive principles of state policy under which the right

⁵⁰⁴ See: Part 8 of the Public Health Act, 2012 (Act 851); see: further details re informed consent in Ghana in Section 6.3.2 of the thesis.

⁵⁰⁵ Public Health Act 2012 (Act 851), 158-159.

⁵⁰⁶ 1992 Constitution of the Republic of Ghana.

⁵⁰⁷ Article 34(2) stipulates: 'The President shall report to Parliament at least once a year all the steps taken to ensure the realization of the policy objectives contained in this Chapter and, in particular, the realization of basic human rights, a healthy economy, the right to work, the right to good health care and the right to education'.

to healthcare is subsumed, were all held to be non-justiciable⁵⁰⁸ ('An issue is justiciable if it is capable of being settled by a court').⁵⁰⁹ In the *Lotto case*, the Supreme Court emphatically declared that there is a rebuttable presumption for the justiciability of rights and other provisions contained in the Directive Principles.⁵¹⁰ Thus, it can be contended that 'the right to health care' mentioned in Article 34(2) forms part of the enforceable rights under the Constitution. A survey of law reports in Ghana which I undertook did not reveal any reported cases concerning the direct or implicit enforcement of the right to healthcare. The paucity of case law could be explained by the obscurity which the right to health is accorded in the Constitution. Unlike other rights, which have prominently been enshrined in a dedicated chapter on fundamental human rights and freedoms in the Constitution, the right to healthcare is just briefly mentioned in a chapter on directive principles of state policy.

Perhaps if there had been an adequate appreciation of the right to healthcare among the citizenry and within the legal community in Ghana, Ghana's obligations under international law could have been relied upon in litigation. Ghana ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 2000,⁵¹¹ the International Covenant on Civil and Political Rights (ICCPR),⁵¹² the Convention on the Rights of the Child (CRC) in 1990,⁵¹³ the African Charter on Human and Peoples' Rights (ACHPR) in 1989,⁵¹⁴ and many other international instruments which either directly or indirectly protect the right to

⁵⁰⁸ *New Patriotic Party v Attorney- General (31st December Case)* [1993-94] 2GLR 35

⁵⁰⁹ *Ghana Lotto Operators Association v National Lottery Authority* [2007-2008] SCGLR 1088, 1099 (hereinafter 'the Lotto case').

⁵¹⁰ *ibid* 1106.

⁵¹¹ Available at: https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en (accessed: 6/5/2014).

⁵¹² Available at: https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-4&chapter=4&lang=en (accessed: 6/5/2014).

⁵¹³ Available at: http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?Treaty=CRC&Lang=en (accessed: 6/5/2014).

⁵¹⁴ Available at: <http://www.achpr.org/states/> (accessed: 6/5/2014)

health.⁵¹⁵ In terms of Article 40 of the Constitution, Ghana is obligated to fulfil her commitments to international organisations. However, being a dualist country, Article 75 requires the domestication of international instruments before their content can have any effect within its legal system. It follows that if a suit seeking to enforce the right to health, however defined, were to be pegged onto Ghana's general obligations under international law, it may be an uphill task, taking into account the unambiguous provisions of Article 75. Nevertheless, the dualist status of Ghana should not, in principle, be a challenge to the protection of rights since those who framed the Constitution purposefully made the Bill of Human Rights expandable. In this regard, Article 33(5)⁵¹⁶ of the Constitution stipulates that the human rights and freedoms spelt out in Chapter 5 of the Constitution are not exhaustive but, more importantly, all rights considered to be inherent in a democracy and intended to secure the freedom and dignity of man are also guaranteed. This constitutional provision has an important implication for HCL in Ghana. It is submitted that by virtue of this, any right relating to healthcare and recognised in other democratic countries as necessary for ensuring the dignity of man may be enforced in a Ghanaian court, despite the absence of explicit domestic legislation.

It is apposite at this stage to survey the relevant provisions and explore the extent to which they can be utilised to advance the empowerment of patients. As noted earlier, there is no explicit recognition of the right to healthcare in the Constitution,⁵¹⁷ it only stipulates that a person acting on behalf of a sick person cannot deny that person the right to medical

⁵¹⁵ J.C. Mubangizi, 'The Constitutional Protection of Socio-Economic Rights in Selected African Countries: A Comparative Evaluation' (2006) 2 *African Journal of Legal Studies*, 1, 15.

⁵¹⁶ The full text of Article 33(5) states: 'The rights, duties, declarations and guarantees relating to the fundamental human rights and freedoms specifically mentioned in this Chapter shall not be regarded as excluding others not specifically mentioned which are considered to be inherent in a democracy and intended to secure the freedom and dignity of man'.

⁵¹⁷ See: Chapter Six for further discussion of this point.

treatment, education or any other social or economic benefit on the grounds of religion or other beliefs.⁵¹⁸ The provision tacitly requires consent to be given in all other cases prior to medical procedures. However, the Constitution does not give an indication of the nature of consent required of a patient. There is no decided case based upon this provision, so there is no guidance from the courts concerning the nature of consent that satisfies this constitutional provision. Therefore, neither is it clear as to whether the informed consent principle, as recently incorporated in the MHA, may be extended to an interpretation of this constitutional provision.

Furthermore, patients' rights to access medical records, which is an aspect of the right to health, can be enforced through the combined effect of freedom of information and the right to privacy. Article 21(1)(f) of the Constitution guarantees 'the right to information, subject to such qualifications and laws as are necessary in a democratic society.' The right to privacy guaranteed under the Constitution could arguably be interpreted to encapsulate the privacy of health records and protection from the arbitrary disclosure of medical records of patients by healthcare workers.⁵¹⁹ The viability of utilising some of these generic human rights provisions to aid patient empowerment was seen earlier in the *Vaah* case.

It has been demonstrated in this section that although Ghana has legislative provisions of relevance to healthcare, it was not until post-2012 that it enacted statutes to directly address patient rights in a clinical and research setting. Since these statutes are relatively new and there are no cases based upon them, it is not realistic to gauge their true impact on patient empowerment. This reinforces the earlier point made in this thesis that having

⁵¹⁸ The 1992 Constitution, Art. 30.

⁵¹⁹ See: Article 18(2) of the 1992 Constitution which stipulates: 'No person shall be subjected to interference with the privacy of his home, property, correspondence or communication except in accordance with law and as may be necessary in a free and democratic society for public safety or the economic well-being of the country, for the protection of health or morals, for the prevention of disorder or crime or for the protection of the rights or freedoms of others.'

statutory provisions on patient rights are not automatic guarantee of patient empowerment. Moreover, it is significant to note that despite the increasing use of IVF and other medical advances, none of the new statutes provide a regulatory framework to govern them.

4.1.3. HEALTHCARE-RELATED QUASI-LAW IN GHANA (SOFT LAW)

There are other forms of quasi-law or 'soft law'⁵²⁰ in Ghana which have significance for patient empowerment. The prominent example of quasi-law that I will explore first is the Ghana Health Service Patients Charter and the Code of Ethics.⁵²¹ The Patient's Charter and Code of Ethics were introduced in 2002 'with the main aim of promoting an open and positive relationship between and amongst health workers and patients.'⁵²² The Code of Ethics particularly defines the general moral principles and rules of behaviour for all service personnel in the GHS.⁵²³ The Patient's Charter addresses three thematic areas:

- (i) respect for the patient as an individual with a right of choice in the decision of his/her health care plans;
- (ii) the right to protection from discrimination based on culture, ethnicity, language, religion, gender, age and type of illness or disability;
- (iii) the responsibility of patients/clients and health personnel towards the full enjoyment of the right to health.⁵²⁴

⁵²⁰ As indicated in Chapter Three above, the term 'soft' or 'quasi-law' was first introduced into the discussion of sources of HCL by J Montgomery.

⁵²¹ Other examples of quasi-law are guidelines, including the Ministry of Health, 'Ghana Health Service Guidelines for Case Management of Malaria in Ghana' (Accra 2004); Ministry of Health; 'Ghana Health Service, National Guidelines for Laboratory Diagnosis of Malaria' (Accra 2009).

⁵²² GHS, 'Patient Charter' <http://www.ghanahealthservice.org/aboutus.php?inf=Patients%20Charter> (accessed: 8/12/2011).

⁵²³ GHS, 'Code of Ethics' <http://www.ghanahealthservice.org/aboutus.php?inf=Code%20of%20Ethics> (accessed: 10/5/2013).

⁵²⁴ GHS, 'Patient Charter' <http://www.ghanahealthservice.org/aboutus.php?inf=Patients%20Charter> (accessed: 8/12/2011).

The thematic areas addressed by the Patient's Charter are in line with General Comment number 14⁵²⁵ of the International Covenant on Economic Social and Cultural Rights (ICESCR). The Patients' Charter embodies fourteen rights and nine responsibilities for patients which all healthcare providers and patients are enjoined to observe. Examples of rights in the Patients' Charter are: 'the right to be informed about alternative treatment, the right to privacy during consultation; the right to consent or decline to participate in a proposed research study involving him or her after a full explanation has been given; the right to full information on his/her condition and management and the possible risks involved, except in emergency situations when the patient is unable to make a decision and the need for treatment is urgent.'⁵²⁶ The Patient's Charter not only recognises rights but also imposes responsibilities on the patient. Thus, according to the Charter, a patient is responsible for many things, including '(i) providing full and accurate medical history for his/her diagnosis, treatment, counselling and rehabilitation purposes; (ii) Requesting additional information and or clarification regarding his/her health or treatment, which may not have been well understood; (iii) complying with prescribed treatment, reporting adverse effects and adhering, to follow up requests.'⁵²⁷ This has parallels with the NHS Constitution in England, as the former envisages similar responsibilities within the context of the partnership contemplated between patients and the NHS.⁵²⁸ It can be discerned from the approach used in the Charter that the Ghana Health Service (GHS) envisages the building of a partnership between healthcare professionals and patients in the healthcare process. Clearly, such an

⁵²⁵ Committee on Economic, Social and Cultural Rights, 'General Comment 14, The right to the highest attainable standard of health' (twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000), paras 12(d) and 36

⁵²⁶ Committee on Economic, Social and Cultural Rights, 'General Comment 14, the right to the highest attainable standard of health' (twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000), paras 12(d) and 36.

⁵²⁷ Ibid.

⁵²⁸ See: NHS, 'NHS Constitution' <https://www.gov.uk/government/publications/the-nhs-constitution-for-england> (accessed: 5/5/2014).

initiative is a positive step towards patient empowerment, since the rights-based approach to healthcare, depending upon the manner of its implementation and general effectiveness, could diminish the disequilibrium of power in the patient-doctor relationship in Ghana.

However, until 2012 when the PHA was enacted, the legal status of the Patient's Charter was doubtful, since it was neither created as an Act of Parliament, nor delegated as legislation. It is important to note that the PHA does not create any new right as far as patients' interests in healthcare are concerned; it basically invests the extant Patient's Charter with unequivocal legal status by repeating the content of the Patient's Charter verbatim as the Sixth Schedule to the PHA.⁵²⁹ The Charter constitutes an operational guideline for health providers which the GHS is mandated to regulate. It is important to point out that the teaching hospitals are not subject to the regulation of the GHS and so may not follow the prescriptions of the Charter.⁵³⁰ Despite not being an Act or a formal delegated legislation, the Patients' Charter has become a de facto framework for patients' rights discourse in Ghana's health sector.⁵³¹ Indeed, empirical research seeking to determine the extent of public awareness of the Charter and individuals' readiness to assert their rights as patients was conducted by Abekah-Nkrumah, Manu and Atinga in 2010.⁵³² Their findings show that 'the majority of patients (53.4 per cent) are not aware of the existence of the Charter; of those that know about it, a sizeable minority (33.7 per cent) are not knowledgeable about its contents.'⁵³³ Unlike the patients, the providers of healthcare exhibit better awareness (61.8 per cent) and content knowledge (61.8 per cent) of the Patients'

⁵²⁹ Public Health Act 2012 (Act 851), s. 167.

⁵³⁰ Ghana Health Service and Teaching Hospitals Act 1996 (Act 525).

⁵³¹ For example see: G Abekah-Nkrumah, A Manu and RA Atinga, 'Assessing the implementation of Ghana's Patient Charter' (2010) 110 *Health Education*, 169 – 185.

⁵³² *Ibid.*

⁵³³ *Ibid* 182.

Charter, but on the whole are not yet carrying out their responsibilities under it.⁵³⁴ From the empirical findings, it emerges that patients who are supposed to be beneficiaries of rights in the Charter are not sufficiently aware of its existence or its content.⁵³⁵ It is even more worrying when one considers the socio-demographic matrix of the research. The paper indicates that 'this is an initial exploratory research with a limited sample, which was biased towards the educated.'⁵³⁶ It is thus likely that the degree of awareness among the illiterate population would be shockingly low. According to statistics from the 2000 Census, only 57.9% of Ghana's population is literate.⁵³⁷ The lack of awareness of the Patients' Charter will impede litigation for the ventilation of these rights. Careful research involving a search through all the available law reports from Ghana indicate that there is no reported case relating to the Patients' Charter.⁵³⁸ It is therefore fair to conclude that most Ghanaians continue to be ignorant of the Charter and the rights stipulated in it.

The empirical findings above are also corroborated by the annual report on the state of human rights in Ghana published by the CHRAJ. Field work undertaken by the CHRAJ and reflected in its 2010 annual report confirms this massive lack of awareness among the population.⁵³⁹ The report further revealed that there were no clear governmental or

⁵³⁴ Ibid.

⁵³⁵ A similar survey in respect of the NHS Constitution has been conducted by the Patients Association in the UK: The Patients Association, 'NHS Constitution- Fact or Fiction' (London 2012) http://www.patientsassociation.com/Portals/0/Public/Files/Research%20Publications/NHS%20Constitution%20Report_Fact%20or%20Fiction.pdf (accessed: 5/5/2014).

⁵³⁶ The Patients Association, 'NHS Constitution - Fact or Fiction' (London 2012) http://www.patientsassociation.com/Portals/0/Public/Files/Research%20Publications/NHS%20Constitution%20Report_Fact%20or%20Fiction.pdf (accessed: 5/5/2014), 169.

⁵³⁷ CIA World Factbook, 'Ghana Demographics Profile 2013' http://www.indexmundi.com/ghana/demographics_profile.html (accessed: 10/1/2013).

⁵³⁸ The law reports in Ghana are 'Ghana Law Report', 'Supreme Court of Ghana Law Report', 'Ghana Bar Law Report' and 'Ghana Monthly Law Report'.

⁵³⁹ CHRAJ, 'The 2010 State of Human Rights Report' (Accra 2010) http://lib.ohchr.org/HRBodies/UPR/Documents/Session14/GH/JS1_UPR_GHA_S14_2012_JointSubmission%201_Annex2_E.pdf (accessed: 18/5/2013).

institutional plans towards creating awareness or enforcing the Patients' Charter.⁵⁴⁰ The only significant mode of accessing information on the Charter is through posters and fliers in health institutions.⁵⁴¹ However, these are not even to be present in every health institution, or in a language⁵⁴² that can be read nor understood by the masses.⁵⁴³ In most cases, health personnel who are supposed to inform patients on their admission to hospital of their rights under the Charter do not do so. In sum, 'Inadequate staff strength in view of increasing workload (hospital attendance), inadequate funds to carry out education programmes, and insufficient rooms for clients' privacy and confidentiality are the major challenges in achieving the objectives of the Charter.'⁵⁴⁴ It is instructive to note that the need to actively create awareness of the existence and content of the Charter in Ghana is imperative, since even in England,⁵⁴⁵ with a high literacy rate and easily accessible information, a large segment of the patient population remains ignorant of the NHS Constitution, which serves the equivalent function as the Charter in Ghana.

4.1.4. WHAT IS THE PLACE OF LEGAL ISSUES AFFECTING HEALTHCARE IN GHANA'S LEGAL EDUCATION?

To date, there is no University or other tertiary education institution in Ghana that offers a course in HCL. There are five major public universities and over twenty private universities in Ghana. Only the University of Ghana and Kwame Nkrumah University of Science and Technology have law faculties.⁵⁴⁶ Since the inception of the University of Ghana over half a century ago, HCL has never been offered as a discrete academic discipline to

⁵⁴⁰ Ibid.

⁵⁴¹ Ibid.

⁵⁴² That is English.

⁵⁴³ CHRAJ, n. 539 above.

⁵⁴⁴ Ibid, 539..

⁵⁴⁵ The Patients Association, 'NHS Constitution- Fact or Fiction' (London 2012)

http://www.patientsassociation.com/Portals/0/Public/Files/Research%20Publications/NHS%20Constitution%20Report_Fact%20or%20Fiction.pdf (accessed: 6/5/2014).

⁵⁴⁶ <http://www.ghanauniversities.org/universities.aspx> (last visited: 20/8/2012).

undergraduates, or even to postgraduate students.⁵⁴⁷ It is surprising that such academic disciplines as Environmental Law, Comparative Law, International Human Rights Law and Criminology, which are relatively new to Ghana - like HCL - are offered, but HCL is not.⁵⁴⁸ Indeed the fact that the subject has never been introduced in this university is quite inexplicable because in the 1970s it had one lecturer who had been a former staff member of the legal unit of the WHO and was also actively researching in HCL.⁵⁴⁹ The Law Faculty at Kwame Nkrumah University of Science and Technology (KNUST), on the other hand, was established a decade ago. Although HCL is not offered to students yet, the KNUST law faculty has mentioned HCL in the list of its courses available on its website.⁵⁵⁰ 'Medical Law and Ethics 1 & 2' are the names of the modules listed there. It is positive that a law faculty established a decade ago has evinced an intention to offer HCL as an academic discipline. This move is indicative of the increasing relevance of issues of HCL in Ghanaian society. The repercussions of the failure to offer HCL as an academic discipline in any of the Ghanaian universities has recently been noted by Doku et al:

The law faculties of the University of Ghana and Kwame Nkrumah University of Science and Technology, do not offer elective courses of study in health law hence lawyers trained in Ghana qualify without exposure to health law training, let alone mental health law. Without lawyers who are trained in health law to help interpret, advocate and enforce the Mental Health Act, to protect patients' rights and implementation of the Act the risk of non-fulfilment or breach of patients' rights will be real.⁵⁵¹

⁵⁴⁷ Faculty of Law, 'Course Handbook' <http://www.ug.edu.gh/index1.php?linkid=876> (last accessed: 20/8/2012).

⁵⁴⁸ Ibid.

⁵⁴⁹ He was called R Simmonds and he wrote the article 'The Law and Human Experimentation' (see: n. 528 below).

⁵⁵⁰ <http://knust.edu.gh/pages/sections.php?siteid=law&mid=258&sid=846> (accessed: 20/8/2012). I personally interviewed the Dean of this Faculty on 10/8/2012 and he confirmed that it is not yet being offered, but they are waiting until they get experts in to teach it.

⁵⁵¹ VCK Doku, A Wusu-Takyi and J Awakame, 'Implementing the Mental Health Act in Ghana: Any Challenges Ahead?' (2012) 34 *Ghana Medical Journal*, 241, 244.

From the foregoing it is increasingly clear that there is a real and urgent need for the teaching and learning of HCL in Ghana. Again, the teaching of HCL as a discipline per se will not immediately empower patient, it rather has the prospect of building capacity of personnel that may play important role in helping patients to ventilate their grievances once the necessary awareness has been created. Some commentators who are not necessarily HCL lawyers or academics occasionally explore HCL themes in their writings, as will be seen in the subsection below.

4.1.5. COVERAGE OF HEALTHCARE LAW IN ACADEMIC WRITING ON GHANA

Despite the fact that HCL is not taught in any of the Ghanaian universities, Ghanaian scholars are not completely uninterested in the subject. There has been some academic writing relevant to HCL in Ghana. The leading law journals in which these writings might be found are the *Review of Ghana Law (RGL)* published by the Council for Law Reporting, the *University of Ghana Law Journal (UGLJ)*, the *KNUST Law Journal*, the *Journal of African Law*, and the *African Journal of International and Comparative Law*. I did a manual and electronic review of all the editions of *RGL* from its maiden edition in 1969 to 2005 (the most recent edition). For the electronic search, I entered the search words 'Health Care Law,' 'Medical law,' 'Health Law,' 'Medical Negligence,' and 'Patient Autonomy,' but none of these yielded any relevant articles. Using the same methodology for the *UGLJ*, two articles exploring certain HCL topics were identified. These were 'The Law and Human Experimentation' by Simmonds,⁵⁵² and 'The law of Abortion in Ghana' by Poole-Griffiths.⁵⁵³ Simmonds (who, as previously mentioned, was formerly a member of the legal staff of the WHO before joining the University of Ghana Law Faculty), discussed the necessity for human experimentation

⁵⁵² R Simmonds, 'The Law and Human Experimentation' (1973) 10 *University of Ghana Law Journal*, 81.

⁵⁵³ FL Poole-Griffiths, 'The Law of Abortion in Ghana' (1973) 10 *University of Ghana Law Journal*, 103.

and the overriding obligation to comply with the acceptable ethical standards embodied in the *World Medical Association Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects*.⁵⁵⁴ He suggested the incorporation of these ethical standards into the international declaration within domestic legislation in order to avert the repetition of the Nazi experimentation scandal.⁵⁵⁵ Simmonds' recommendation advances the cause of patient empowerment, at least in the context of medical research and clinical trials for new drugs.⁵⁵⁶ Poole-Griffiths, on the other hand, contended in his paper that the vast number of illegal abortions undertaken by patients did not call for a scaling up of punishment for the offence; rather, it warranted expansion in the country's medical facilities.⁵⁵⁷

Apart from the mainstream law journals, it is apposite to look at the *Ghana Medical Journal* (GMJ) by virtue of its strategic focus, in order to identify HCL-related articles that might have been published in it since its inception in 1962 by the Ghana Medical Association. However, within the first two decades of the founding of the *GMJ*, none of the articles published in it could be considered as directly relevant to HCL. Although during the late 1970s scholars from fields other than medicine began to contribute articles to the journal, no lawyer or legal academic contributed any article relevant to HCL until 2006. For example, Twumasi, the medical sociologist, contributed an article entitled 'Social Aspects of Health and Illness with Particular Reference to Ghana.'⁵⁵⁸ Strangely, for over three decades

⁵⁵⁴ World Medical Association, 'WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects' [http://www.wma.net/en/30publications/10policies/b3/index.html.pdf?print-media-type&footer-right=\[page\]/\[toPage\]](http://www.wma.net/en/30publications/10policies/b3/index.html.pdf?print-media-type&footer-right=[page]/[toPage]) (last accessed: 6/9/2012).

⁵⁵⁵ n. 552 above, 102.

⁵⁵⁶ This is now reflected in the regulatory framework under the PHA.

⁵⁵⁷ FL Poole-Griffiths, 'The Law of Abortion in Ghana' (1973) 10 *University of Ghana Law Journal*, 110.

⁵⁵⁸ PA Twumasi, 'Social Aspects of Health and Illness with Particular Reference to Ghana' (1976) *Ghana Medical Journal*, 63.

following the inception of the *GMJ*, not one single article by a scholar from the field of law exploring any legal issue relevant to health and healthcare has appeared in it.⁵⁵⁹

It was only three decades after the journal's inception that articles of significant relevance to HCL appeared. In 1996, Appiah-Poku, an ethicist, contributed an article on justice in healthcare.⁵⁶⁰ The author discussed the problem of resource allocation in healthcare delivery in the context of the 'cash and carry' health-funding policy, which was then in operation in Ghana's health sector. He drew upon Rawls' *Theory of Justice* and Beauchamp and Childress' *Principles of Bioethics* and advocated 'access to healthcare which was not dictated by market principles,' but by 'the communal responsibility to be fair to patients who lacked the financial ability to pay.'⁵⁶¹ The same author wrote another article on informed consent in 1999.⁵⁶² In this paper, he used his empirical findings to reinforce the point that informed consent not only enhances patient autonomy, but also advances clinical goals, as there was a positive correlation between a patient with full disclosure of their condition and their attendance and participation in treatment programmes. A similar point was made in 2005 by Clegg-Lampatey and Hodasi in their article which audits aspects of informed consent.⁵⁶³ They concluded that:

Patient information with regard to their diagnosis and operation at the Korle Bu Teaching Hospital is very unsatisfactory. Informed consent is poorly administered. There is the need for surgeons to train doctors to administer informed consent or administer the consent themselves. The consent form in use currently needs modification.⁵⁶⁴

⁵⁵⁹ I examined the content of all the editions of the Journal from the maiden issue in 1962, to 2011.

⁵⁶⁰ J Appiah-Poku, 'Justice in Health Care - A Study at Komfo Anokye Teaching Hospital, Kumasi' (1996) 33 *Ghana Medical Journal*, 826.

⁵⁶¹ *ibid*, 828.

⁵⁶² *Ibid* 62.

⁵⁶³ H Clegg-Lampatey and WM Hodasi, 'An Audit of Aspects of Informed Consent and Pain Relief in General Surgical Units of Korle Bu Teaching Hospital' (2005) 39 *Ghana Medical Journal*, 63.

⁵⁶⁴ *Ibid* 67.

Four decades after the founding of the Journal, the first article co-authored by a legal academic was published in 2005 on abortion services in Ghana.⁵⁶⁵ The authors noted that the law in Ghana appears to allow therapeutic abortion and therefore sets no limit to the gestational age at which pregnancy may be lawfully terminated. They therefore recommend law reform to set a limit of gestational age at which safe abortion may be permitted. This article is one of the academic papers published in the *GMJ* in which a thorough analysis of a statute (i.e. the Criminal Code) relating to HCL is undertaken. The justification for this approach may well be that one of the co-authors is a legal academic. This article is quite significant as it has been cited in 24 papers, according to Google.

Another article of relevance to the field of HCL published in 2008 is Edwin's paper on therapeutic privilege.⁵⁶⁶ The author advocates for full disclosure to be made to competent patients since this upholds the ethical principles of autonomy, beneficence and non-maleficence. In 2009, the same author discussed the necessity for the disclosure of medical errors within the context of the doctor-patient relationship.⁵⁶⁷ Two years later, Norman et al contributed another article to the *GMJ*, in which they discussed the legal framework for dealing with public health emergencies in Ghanaian hospitals.⁵⁶⁸ This paper provides suggestions for hospital administrators and medical personnel on how to develop administrative templates in compliance with the law while managing public health

⁵⁶⁵ RAS Morhe and ESK Morhe, 'An Overview of the Law and Availability of Abortion Services in Ghana' (2005) 40 *Ghana Medical Journal*, 80.

⁵⁶⁶ A Edwin, 'Don't Lie but Don't Tell the Whole Truth: The Therapeutic Privilege - Is it Ever Justified?' (2008) 42 *Ghana Medical Journal*, 156.

⁵⁶⁷ A.K. Edwin, 'Non-Disclosure of Medical Errors – An Egregious Violation of Ethical Principles' (2009) 43 *Ghana Medical Journal*, 34.

⁵⁶⁸ ID Norman and M Aikins et al, 'The Medico-Legal Prerequisite for Initiating Quarantine and Isolation Practices in Public Health Emergency Management in Hospitals in Ghana' (2011) 45 *Ghana Medical Journal*, 167.

emergencies. It also provides examples of such templates for possible adoption by hospitals and other health administrators.

There are a few other academic writings published outside Ghana that explore some aspects of HCL there. In order to identify these, I undertook an internet search using major search engines, including Google, Ixquick, Heinonline, the Social Science Research Network, Lexis and Westlaw. The search phrases I entered included 'medical law (Ghana),' 'health care law (Ghana),' 'medical ethics (Ghana),' 'right to health care (Ghana),' and 'patient empowerment (Ghana).' These general and directed online searches yielded only two refereed articles other than those from the *GMJ* mentioned above. Again, one of the two academic papers of some relevance to this field was written by non-legal scholars. Newton and Appiah-Poku, collaborators from the Kintampo Health Research Centre in Ghana, have authored a number of papers of some relevance to questions of patient empowerment. In 2007, their article entitled '*Opinions of Researchers Based in the UK on Recruiting Subjects from Developing Countries into Randomized Controlled Trials*' was published.⁵⁶⁹ The paper emerged from an empirical investigation undertaken by the authors to explore the challenges of effectively explaining the content of consent forms administered to research subjects before their informed consent could be said to have been properly elicited. The paper dwelt on the Declaration of Helsinki on Ethical Principles for Medical Research Involving Human Subjects as the legal basis for obtaining informed consent prior to biomedical research. However, the authors failed to demonstrate the extent to which the Declaration has a legal effect in developing countries, including Ghana. Clearly, such an omission in the paper could reasonably be attributed to the fact that the authors were not lawyers or did not have the requisite legal background. Nevertheless, the fact that the

⁵⁶⁹ SK Newton and J Appiah-Poku '*Opinions of Researchers Based in the UK on Recruiting Subjects from Developing Countries into Randomized Controlled Trials*' 2007) 7 *Developing World Bioethics*, 149-156.

authors explored this topical issue of informed consent suggests that patient disempowerment is not fanciful but real phenomenon.

Similarly, in 2010, an international journal called *Health Education* published the result of empirical research carried out by Abekah-Nkrumah et al seeking to gauge public awareness of the Ghana's Patients' Charter and individuals' readiness to assert their rights as patients.⁵⁷⁰ The study findings of Abeka-Nkrumah et al have already been discussed above so no further comment needs to be made, except that it is one of the few available academic writings on HCL in Ghana. The other paper relevant to Ghana HCL which was revealed through the web search was jointly authored and related to the *Vaah* case.⁵⁷¹ In exploring the decision in the case, the paper examined the issues of the physician-patient relationship, the ownership of health records and the duties of the physician to the patient. The authors concluded that the court ought not to have grounded its decision to grant access to medical records on the basis of a provision of Ghana's Constitution, which provided generally for the right to information. Unlike the previous papers, one of the four joint authors is a medical doctor and lawyer. Thus, a legal analysis of medico-legal cases needed for academic HCL was pursued. However, although the paper engaged in extensive legal analysis, it is submitted that the authors ought to have explored the prospects of a human rights-based approach to resolve the conundrum of lack of access to medical records, rather than criticising the Judge for choosing the human rights route to resolve the dispute. Moreover, rather than seeking to superimpose medico-legal analysis extant in US and Canadian jurisdictions on the situation in Ghana, the paper could have been more

⁵⁷⁰ G Abekah-Nkrumah, A Manu and RA Atinga, 'Assessing the implementation of Ghana's Patient Charter' (2010) 110 *Health Education*, 169 – 185.

⁵⁷¹ ID Norman, MSK Aikins, FN Binka, DN Banyubala and AK Edwin, 'The Constitutional Mandate for Judge-Made-Law and Judicial Activism: A Case Study of the Matter of Elizabeth Vaah v. Lister Hospital and Fertility Centre' (2012) 6 *The Open Ethics Journal*, 1.

original by seizing the opportunity presented by the Judge to explore and advance a human rights-based approach to HCL that would better fit the particular situation in Ghana, as I will clarify further in Chapter Six.

4.2. SIMILARITIES AND DIFFERENCES IN THE FEATURES OF A DISTINCT BODY OF HEALTH CARE LAW IN ENGLAND AND WALES, AND GHANA

The two jurisdictions being studied do not uniformly manifest the characteristics of a distinct body of HCL identified earlier in Chapter 3. I will outline the key points of convergence and divergence between the two jurisdictions and analyse the potential rationale. This will later serve as a launch pad for discussing the way forward for Ghana in Chapter Six.

In the first place, England and Wales has a higher frequency of HCL litigation compared to Ghana. Such a great volume of HCL litigation provides indication of a certain degree of patient empowerment. The disparity between the two jurisdictions can be accounted for. It is clear that there is a highly informed population in England and Wales who are more disposed to assert their rights. Also, it is plausible to attribute the inflation of HCL litigation in England and Wales to the frequent media prominence given to HCL issues, particularly medical scandals and medical advances, coupled with vibrant scholarship amongst legal academics. By contrast, in Ghana, there is no active scholarship in HCL topics, probably due to there being too few legal scholars researching the area. Perhaps the significant quantitative increase in HCL cases in England and Wales, as compared with Ghana, may be also partially explained by the frequent public inquiries into healthcare quality and scandals, which are given sufficient prominence in the media. The public who watch or observe these proceedings are likely to become more emboldened to assert their rights as patients. Thus, the fact that the well-publicised findings of these inquiries in England and Wales are made freely available online so that the public have easy access to them, as well as the extensive

media coverage of HCL cases in the areas concerned, enhance the public demand for accountability from healthcare professionals. However, there is no record of a public inquiry in Ghana ever being held over the operation of any health facility or in the healthcare system in general. Surprisingly, there have been a number of public inquiries commissioned in respect of various political issues.⁵⁷²

Moreover, it is easier to identify certain core principles or threads which run through the majority of cases decided in England and Wales. Thus, the principles of patient autonomy, self-determination and the sanctity of life can be discerned as being engaged in most HCL cases in England and Wales. The same cannot be said for Ghana, due to the paucity of cases litigated in relation to healthcare. Indeed, the few Ghanaian cases available mainly relate to medical negligence and do not manifest any consistent principle. It is only *Vaah* which has considered the issue of patient autonomy directly in relation to access to medical records. Nevertheless, it is pretty tenuous to rely on a single case to generalise or hypothesise about HCL in Ghana. The smaller number of HCL cases in Ghana compared to England and Wales is not necessarily indicative of poor attitude of Ghanaian doctors but more importantly, for purposes of the present thesis, it demonstrates that the test for existence of a distinct discipline of law alluded to in Chapter Three that I used to locate a distinct discipline of HCL in England and Wales could not be fully satisfied in the case of Ghana. The reason is that some of the ingredients of the test (such as quantitative increase in case law with peculiar factual characteristics) could not be satisfied by evidence assembled through my research.

Moreover, there are many more dedicated HCL statutes in England and Wales than there are in Ghana. Whereas the HCL statutes in Ghana until 2012 mainly created an institutional framework and remain completely silent on substantive norms that should

⁵⁷² RK Ameh, 'Doing Justice After Conflict: The Case for Ghana's National Reconciliation Commission' (2006) 21 *Canadian Journal of Law and Society*, 81.

guide healthcare delivery, most of the HCL statutes in England and Wales accomplish both purposes. The relative insensitivity of the pre-2012 Ghanaian healthcare-related statutes to patient empowerment may be attributed to poverty, illiteracy and lack of access to justice.

4.3. CONCLUSION

The discussion in this chapter has underscored some significant points which I propose to recapitulate. Firstly, there has not been much litigation in relation to healthcare in Ghana. The few cases decided by the courts and quasi-judicial bodies predominantly concern medical negligence, with only a tangential connection to patient autonomy or self-determination. Secondly, until 2012, there was no legislation or delegated legislation which provisions that could potentially be utilised to advance patient empowerment in healthcare. Until dedicated legislation is enacted on patients' rights, it will take a court which is determined to advance patient empowerment to exploit and manipulate principles of statutory interpretation in order to apply the extensive patients' rights provided in the MHA to other, more general healthcare matters. The conspicuous vacuum which existed in Ghanaian law in relation to patient rights has been evidenced by the increasing popularity of the Patients' Charter in healthcare discourse.. Thirdly, specific or general treatment of legal aspects of healthcare and its relationship with patient empowerment and medical advances has not been given any place in Ghana's legal education. The absence of HCL modules in the curricula of law schools has led some non-legal scholars who write on HCL matters in Ghana to raise concerns about lawyers' lack of appropriate technical capacity to attend to legal tasks created by the MHA as a means of advancing patients'

empowerment.⁵⁷³ Fourthly, the exploration in this chapter has demonstrated that while there is a paucity of proper legal academic writing on HCL topics in Ghana, there has been a gradual increase in publications on some aspects of HCL in Ghana by scholars who do not have the requisite legal background to properly undertake a rigorous and critical analysis of the relevant issues which could potentially advance patient empowerment. Thus, there has been a discernible disconnect between the healthcare-related statutes and themes addressed in academic writing on HCL in Ghana by non-legal scholars. Finally, the discussion here has illuminated an understanding of differences in how patient empowerment and the mediation of dilemmas generated by medical advances are addressed by the law in the two jurisdictions under study.

In the next chapter, I shall proceed to chart the historical trajectory along which a distinct body of HCL emerged in England and Wales. This may yield powerful lessons for Ghana when I embark upon an exploration of the question of whether there is a need for a distinct body of HCL to be developed in Ghana.

⁵⁷³ VCK Doku, A Wusu-Takyi and J Awakame, 'Implementing the Mental Health Act in Ghana: Any Challenges Ahead?' (2012) 34 *Ghana Medical Journal*, 244.

CHAPTER FIVE

WHAT FACTORS HAVE ACCELERATED THE EMERGENCE OF A DISTINCT BODY OF HEALTH CARE LAW IN ENGLAND AND WALES?

5.0. INTRODUCTION

The exploration undertaken in Chapter Three not only unpacked the defining characteristics of a distinct body of healthcare law (HCL), but also crucially demonstrated that HCL in England and Wales is a distinct field of law as it satisfies those defining criteria. Thus, the above chapter essentially explored HCL as it is currently constituted in England and Wales as a legal field. However, the explanation of *how* and *why* HCL has acquired those characteristics, rendering it a distinct body was not proffered. In this chapter, I seek to fill this gap by charting the historical trajectories and contours along which the distinct body of HCL in England and Wales came to be what it is; and in particular how evolution of this distinct body of law interacted with other factors to contribute towards patient empowerment

5.1. AN OVERVIEW OF THE CONTRIBUTORY FACTORS

While it is generally incontestable in the first part of the 21st century that HCL has emerged as a field of law that can potentially promote patient empowerment and assist in resolution of ethical dilemmas associated with medical advances, the circumstances which precipitated its development have received little attention in the literature. In order to fully

map out the field of HCL in England and Wales and explore the potential lessons that can be drawn in relation to Ghana, it is apposite to consider the factors that have assisted or accelerated this development. Five key factors are worth exploring here. These are (1) the revival of autonomy-oriented liberalism and human rights thinking, (2) the popularisation of bioethical discourse; (3) the feminist movement; (4) the role of the media, and (5) the advocacy role played by pioneering scholars. It must be emphasised that none of these factors can be considered as the most important trigger or accelerator in the emergence of HCL. Rather, it is more plausible to contend that the five key factors worked in concert in various ways to influence the development of this field of law.

5.1.1. THE REVIVAL OF LIBERALISM AND HUMAN RIGHTS THINKING: THE INCREASING POPULARITY OF AUTONOMY

The projection of patient empowerment, particularly through the advancement of autonomy as an important ethical value in regulating healthcare via law, has benefitted from the reawakening of society's interest⁵⁷⁴ in the notions of liberalism and human rights. As Brazier and Ost have noted that the influence of 'liberalism on bioethics and criminal law' (and for that matter HCL) cannot be whittled down because it 'remains the predominant system of political normativity in Anglo-American and other Western societies.'⁵⁷⁵ The notions of liberty were embedded in social thought long before the war. However the universal adoption of human rights as basis of new world order that would guarantee peace gave new impetus to political liberalism.

Liberalism is increasingly less amenable to straightforward definition. This is particularly so since 'the concept has changed significantly over time... and is riddled with

⁵⁷⁴ J Coggon, *What Makes Health Public? A Critical Evaluation of Moral, Legal, and Political Claims in Public Health* (Cambridge, Cambridge University Press 2012) ch 5.

⁵⁷⁵ M Brazier and S Ost, *Bioethics, Medicine and the Criminal Law Volume III: Medicine and Bioethics in the Theatre of the Criminal Process* (Cambridge: Cambridge University Press, 2013) ch 7, 182.

contradictions and ambiguities because of historical, social and political singularities and interactions.⁵⁷⁶ Nevertheless, for the purposes of the present discussion I use the term “liberalism” to denote ‘an ideological construct which perceives the promotion and enhancement of the freedom or liberty of the individual as the most cherished goal of political and social arrangements.’⁵⁷⁷ Autonomy, which is often expressed as self-determination, lies at the heart of the concept of liberalism.⁵⁷⁸ The influence of liberalism in the development of HCL can be assessed from two perspectives: general norms of human rights under international law, and autonomy via Mill’s harm principle. The only justification for circumscribing the liberty of a person, according to Mill’s harm principle, is necessity to prevent injury or pain to another autonomous person.⁵⁷⁹ In the context of healthcare, patients ought to have their autonomy respected, including their self-determination regarding what should happen to their body, unless in certain cases this causes harm to others. For example, public health considerations may be a legitimate ground to interfere with a patient’s autonomy. A typical illustration may be the *Rampton Smokers’* case in which the court upheld a prison regulation banning inmates from going out to smoke as legitimate as it sought to safeguard the health others.⁵⁸⁰

Turning to the general norms of human rights under international law, the formal recognition of ‘human rights’ for individuals was left unspecified until the 1948 Universal Declaration of Human Rights following revelation of atrocities during the Nuremberg trial.

⁵⁷⁶ TW Smith, ‘General Liberalism and Social Change in Post-World War II America: A Summary of Trends’ (1981) 10 *Social Indicators Research*, 2.

⁵⁷⁷ P. Kelly, *Liberalism* (Cambridge, MA: Polity Press 2005) ch 1; P Alston and R Goodman, *International Human Rights* (Oxford: Oxford University Press 2013) 139.

⁵⁷⁸ n. 576 above, ch 7.

⁵⁷⁹ JS Mill, ‘On Liberty’ in *On Liberty and Other Essays* (Oxford: Oxford University Press 2008), 13-14, 83-84.

⁵⁸⁰ *R (G and B) v Nottinghamshire Healthcare NHS Trust; R (N) v Secretary of State for Health* [2008] EWHC 1096

The significance of human rights in the context of the evolution of a field of HCL can readily be appreciated. To begin with, since health and healthcare are components of the well-being of human beings, it is contended that any efforts to protect the rights or entitlement of individuals to issues relating to their well-being should similarly apply to healthcare. Accordingly, human rights norms which relate to well-being in general and healthcare in particular under international conventions and declarations can be said to have impacted the quest for the empowerment of patients, however remotely or tangentially. In the United Kingdom, international instruments must be incorporated into domestic law by Parliament before they can have direct effect. Nevertheless at the time⁵⁸¹ when the UK had not yet incorporated some of these international instruments relevant to HCL, their provisions to some extent indirectly influenced the writings of some pioneer HCL academics⁵⁸² and judicial deliberations in HCL cases.⁵⁸³ McLean, for example, points out that there was a dearth of national case law in this field which necessitated that an analysis of developments in the field be approached from the perspective of norms embodied in the plethora of international instruments extant at the time.⁵⁸⁴ In one of her maiden co-authored monographs in the field published in 1983, she cited provisions from the *European Convention on Human Rights*⁵⁸⁵ to bolster her explanation of the right to reproduction and also cited the *Proceedings of the 5th World Congress on Medical Law, 1979* to reinforce her remark that 'sterilisation had become one of the most popular ways of controlling

⁵⁸¹ It is important to note that the United Kingdom has ratified the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights and indeed the European Convention on Human Rights

⁵⁸² M Brazier, 'Rights and Health Care' in R Blackburn, *Rights of Citizenship* (London: Mansell 1994) 56-74.

⁵⁸³ For its influence in judicial deliberations see: *Sidaway v Bethlem Royal Hospital Governors* [1985]1 All ER 643, 649, wherein Lord Scarman used rights-based argument.

⁵⁸⁴ Extracted from the 'Transcript of Personal Interview with Professor Sheila McLean on 16/10/2013'. A copy is available on file with the author.

⁵⁸⁵ The UK incorporated ECHR into its domestic law via the Human Rights Act 1998.

reproduction because of its relative certainty.⁵⁸⁶ Moving forward to today, the UK still has not incorporated most of these instruments, notably the ICESCR and more specialised relevant treaties, such as the CRC. Only the ECHR has been incorporated. Articles under the ECHR have increasingly appeared and been applied in HCL case law.

With the rapid adoption of various international human rights instruments, some scholars have actively explored the degree to which human rights may be seen serving as the fulcrum upon which to hinge patients' rights in HCL.⁵⁸⁷ This is perhaps unsurprising as one commentator has noted that patients' rights more likely to be breached in healthcare not necessarily 'because health care providers are more inclined than others to do so, but because the individual in health care is easily reduced to a case and the patient's position is weak because of the illness and the insecurity and fear it produces.'⁵⁸⁸ In such a situation, the individual needs to be protected. This has always been the role of law. Thus, Kennedy has postulated that human rights can appropriately be the basis for protection of patients' interest in healthcare because that is in keeping with how society has had to adopt 'some sort of social system' for safeguarding vulnerable persons against privileged ones.⁵⁸⁹

As far as human rights norms derived from international human rights are concerned, a patient's right to bodily integrity and autonomy in relation to medical procedures is reflected not only in customary international law (as established by the Nuremburg Trials), but also in various treaties or conventions. Examples of relevant International human rights

⁵⁸⁶ S McLean and G Maher, *Medicine, Morals and the Law* (Aldershot: Gower Publishing Company Ltd 1983) 125-126.

⁵⁸⁷ See for example collection of essays in: A Garwood-Gowers, AJ Tingle, AJ and T Lewis (eds), *Healthcare Law: The Impact of the Human Rights Act* (London: Cavendish Publishing 2001) 1.

⁵⁸⁸ HJJ. Leenen, 'The Rights of Patients in Europe' (1994) *European Journal of Health Care Law*, 5. See also: Paul Sieghart, *The international law of human rights* (Clarendon Press Oxford 1983); Thomas Risse-Kappen, Stephen C Ropp and Kathryn Sikkink, *The power of human rights: International norms and domestic change, Vol. 66* (Cambridge University Press 1999); I Kennedy, 'Emerging Problems of Medicine, Technology and the Law' in I Kennedy (ed), *Treat Me Right: Essays in Medical Law and Ethics* (Oxford: Clarendon Press 1988) 12.

⁵⁸⁹ I Kennedy, 'Patients, Doctors and Human Rights' in I Kennedy (ed), *Treat Me Right: Essays in Medical Law and Ethics* (Oxford: Clarendon Press 1988) 386.

instruments are those already mentioned: ICCPR, ICESCR, and ECHR. As I have noted in Chapter Three, the incorporation of the ECHR into UK law via the *Human Rights Act, 1998* (HRA) has expanded the scope of protection that patients can enjoy in their clinical experience. Indeed soon after the passing of HRA, it was noted by Lord Irvine, the Lord Chancellor at the time, that the number of Convention rights which are relevant in the medical field is ‘more than you might guess.’⁵⁹⁰ He further remarked that the principles of the ECHR ‘will gradually reshape the climate in which the courts view any case concerned with human rights.’⁵⁹¹ Wicks has interpreted Lord Irvine’s remarks to mean that the scope of influence of the HRA could not be gauged at the time, largely because ‘the medical field is itself so diverse – from issues of duties of care to doctor-patient confidentiality; from assisted conception to end of life decisions – that the nature of rights which apply varies accordingly.’⁵⁹²

The potential impact of the HRA on HCL has been explored in monographs specifically dedicated to the subject.⁵⁹³ The anticipated impact of human rights on the development of HCL is a reflection of the views of some the pioneers of HCL in England and Wales. Indeed, as noted in Chapter Three, Kennedy and Grubb in the late 1980s went as far as to categorically define HCL (what they prefer to call medical law) as ‘a subset of human rights.’⁵⁹⁴ It is apposite at this juncture to explore some of the specific instances in which the liberal agenda of human rights has been relevant in the evolution of HCL. As a prelude to this exploration, it is important to underscore here that it is not only the usual formulaic

⁵⁹⁰ Lord Irvine of Lairg, ‘The Patient, the Doctor, their Lawyers and the Judge: Rights and Duties’ (1998) 7 *Medical Law Review*, 261.

⁵⁹¹ *Ibid.*

⁵⁹² E Wicks, *Human Rights and Healthcare* (Oxford: Hart Publishing 2007) 12.

⁵⁹³ A Garwood-Gowers, AJ Tingle and T Lewis (eds), *Healthcare Law: The Impact of the Human Rights Act* (London: Cavendish Publishing 2001) 1; T Murphy, *Health and Human Rights* (Oxford: Hart Publishing 2013); R Horton, ‘Health and the UK Human Rights Act 1998’ (2000) 356 *The Lancet*, 1186-1188; S McLean and JK Mason, *Legal and ethical aspects of healthcare* (UK: Greenwich Medical Media 2003).

⁵⁹⁴ I Kennedy and A Grubb, *Medical Law*, (London: Butterworths 1989) 3.

right to health or right to healthcare that marks the point of intercession between liberalism and human rights on the one hand and HCL on the other, although the right to healthcare may feature prominently in considering the thorny issue of allocating scarce healthcare resources, or whether there should be a right to demand medical treatment.⁵⁹⁵ To use Shue's lexicon of human rights, the right to healthcare relates to subsistence rights and is therefore a positive right.⁵⁹⁶ A positive right is one that requires that something is done for the realisation of the subject-matter of that right. Thus, the right to healthcare per se has not been the fulcrum around which human rights has advanced patient empowerment in HCL. It is those rights usually classified as civil and political rights which have proven to be most influential in the course of the evolution of HCL. Some of these categories of human rights are worth exploring for their relevance in the quest to empower patients in their clinical experience.

First, the right to life is enshrined in Article 2 of the ECHR under the following terms: 'everyone's right to life shall be protected by law.' It is a fundamental right in the sense that it provides the basis for enjoyment of all other rights. Consequently, the right to life has important implications for HCL, particularly having regard to the sensitive and delicate decisions made at both the beginning and end of life.⁵⁹⁷ Indeed, both law⁵⁹⁸ and bioethics are yet to provide definitive answer to the enduring question of 'when the right to life begins at conception; implantation; viability; birth, or at some other stage in the process of life's commencement?'⁵⁹⁹ The resolution of these puzzles would profoundly assist in

⁵⁹⁵ *Burke v GMC* [2005] EWCA Civ 1003

⁵⁹⁶ H Shue, *Basic Rights - Subsistence, Affluence and US Foreign Policy* (2nd edn, Princeton: Princeton University Press 1996) ch 2.

⁵⁹⁷ Wicks, n 593 above, 13.

⁵⁹⁸ The English High Court, in *Paton v Trustees of British Pregnancy Advisory Service* [1978] 987, 989, established that the foetus cannot, in English law, have any right of its own at least until it is born and has a separate existence from the mother.

⁵⁹⁹ Wicks, n 593 above, 13.

determining 'the treatment which is available to a pregnant woman, both in terms of the legality of a termination of pregnancy and in terms of the woman's right to refuse necessary medical treatment during pregnancy and labour.'⁶⁰⁰ For example, in the case of *Paton v UK*,⁶⁰¹ the European Commission categorically refuse to recognise the foetus having absolute right to life but left open whether the foetus did have some right to life. Moreover, it is still not clear whether the right to life necessarily encapsulates the sanctity of life as an overarching value to be upheld at all times, or whether the quality⁶⁰² of a person's life releases the state from its obligations to sustain that life.⁶⁰³ In this regard, the question arises whether a 'right to life not only protects the value of life but also incorporates an element of self-determination about issues of life and death.'⁶⁰⁴ In the landmark *Pretty*⁶⁰⁵ case, the applicant, a motor neurone disease patient, sought to rely on the right to life under Article 2 ECHR to derive a right to die, but the UK and European Courts rejected her submission. The court held, inter alia, that such an interpretation would be contrary to the very right to life the provision was crafted to protect. Commenting on the *Pretty* case, Ost contended that deriving a right to die from the right to life and other rights on the basis of an individual's perception of a lack of quality of life was discouraged by the UK courts due to 'fears that vulnerable members of society would be at risk.'⁶⁰⁶ The UK Supreme Court has

⁶⁰⁰ *ibid.*

⁶⁰¹ For (1980) 19 D.R. 244 (E.Com.H.R.)

⁶⁰² See: Chapter Three for a discussion of the *Bland* case in which the court answered this question, albeit in the specific context of a patient in the persistent vegetative state.

⁶⁰³ Lord Irvine of Lairg, 'The Patient, the Doctor, their Lawyers and the Judge: Rights and Duties' (1998) 7 *Medical Law Review*, 261

⁶⁰⁴ E Wicks, n. 593 above, 14.

⁶⁰⁵ *R (on application of Pretty) v Director of Public Prosecutions* [2002] 1 All ER 1; *Pretty v United Kingdom* (2002) 35 EHRR 1

⁶⁰⁶ S Ost, *An Analytical Study of the Legal, Moral, and Ethical Aspects of the Living Phenomenon of Euthanasia* (Wales: Edwin Mellen Press 2003) 164.

given indications in a recent decision that a blanket ban on assisted dying is a violation of the right to life in Article 8 of the ECHR.⁶⁰⁷

Wicks has noted that ‘one other aspect of the right to life which has huge significance in the healthcare context is the issue of a positive obligation upon the state to preserve life and the possibility that this may be the basis for a *right to treatment*.’⁶⁰⁸ Thus, in England and Wales, where there is a publicly-funded healthcare system, it is the possibility of a recognition of a right to receive necessary or beneficial medical treatment which may appeal to the general public,⁶⁰⁹ although the UK courts are reluctant to recognise any right to demand medical treatment.⁶¹⁰ The illustrations and examples of relationship of specific human rights to healthcare cannot be exhausted, but how do all these bring about patient empowerment.

It has been demonstrated that the culture of political liberalism that gathered momentum in the post-World War II era facilitated adoption of a plethora of human rights instruments. The aftermath of the war increasingly revealed that a strong state under the control of over powerful politicians could not be trusted to safeguard liberty of the individual; this set the scene for political and legal order that should gravitate more towards autonomy of the individual. Undoubtedly, this did not happen overnight, and did not also automatically translate into empowerment of patient in the context of healthcare. Nevertheless, political liberalism and the increasing adoption of various human rights frameworks sowed seeds that would gradually develop into projecting the need for empowering patient against excessive medical paternalism. Indeed, some of findings from

⁶⁰⁷ *R (on the application of AM) (AP) (Respondent) v Director of Public Prosecution (Appellant); R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice (Respondent)* [2013] EWCA Civ 961

⁶⁰⁸ Wicks, n 593 above, Chs 1 and 2.

⁶⁰⁹ *Ibid.*

⁶¹⁰ *Burke v GMC* [2005] EWCA Civ 1003

the Pioneering HCL Scholars considered below lend credence to the fact HCL discourse in the early stages benefitted from the concept of political liberalism and human rights as they added to the repertoire of criteria available at the time for commenting on the then evolving body of HCL. Much as it is conceded that an emergence of a distinct body of HCL per se could not be an instant solution to patient disempowerment, it is my submission that the crystallisation of liberalism through human rights certainly gave some hope to patients. Indeed, public conversation and academic discourse on matters affecting patient empowerment would have been most likely not forthcoming in a situation where liberalism was not valued or the field of HCL was virtually none existent.

5.1.2 THE POPULARISATION OF BIOETHICAL DISCOURSE

The upsurge in bioethical discourse in the 1970s crucially set the scene for academic interest to extend to a relatively new area of law known, inter alia, as HCL in the post-1980.⁶¹¹ 'Before exploring those particular aspects of the development of bioethics which impacted on the then evolving HCL, it will be illuminating to unpack the meaning of bioethics. In seeking to explicate bioethics, it is important to note that although bioethics and medical ethics are sometimes used interchangeably, the two are not necessarily uniform in meaning.'⁶¹² 'The term *bioethics* was first used in print in 1970 in an article'⁶¹³⁶¹⁴ by Potter, an oncologist from the University of Wisconsin.⁶¹⁵ The Encyclopaedia of Bioethics explains the origins of bioethics as follows:

⁶¹¹ E. Owusu-Dapaa, 'Historical Development of Health Care Law and Bioethics in England and Wales: A Symbiotic Relationship?' (2014) 33 (1) *Medicine and Law* 22, 30-32.

⁶¹² Ibid.

⁶¹³ Ibid.

⁶¹⁴ VR Potter, 'Bioethics, the Science of Survival' (1970) 14 *Perspectives in Biology and Medicine*, 127-53.

⁶¹⁵ MA Rothstein, 'The Role of Law in the Development of American Bioethics' (2009) 20(4) *Journal of International Bioethique*, 73, 74.

The word *bioethics* was coined in the early 1970s by biologists in order to encourage public and professional reflection on two topics of urgency: (1) the responsibility to maintain the generative ecology of the planet, upon which life and human life depends; and (2) the future implications of rapid advances in the life sciences with regard to potential modifications of a malleable human nature. Bioethics, then, emerged from biologists who felt obliged to address the moral meaning of the biosphere, and to reflect on the remarkable implications of their discoveries and technological innovations.⁶¹⁶

Bioethics mark a 'critical departure' from the prior tradition of *medical ethics*, where doctors governed their own conduct through professional codes.⁶¹⁷ Medical ethics, in a technical sense, connects to the medical (i.e. physician's) profession; it 'governs how a physician as a professional should practice - and has traditionally been seen as within the province of physicians only.'⁶¹⁸ On the other hand, whilst bioethics encompasses medical ethics within its orbit, it also 'expands the scope of ethical inquiry to include not only clinical issues but also many more beyond the 'bedside'⁶¹⁹ concerns'; for example what happens at institutional, research, public health and policy levels.'⁶²⁰ Despite the two fields having some kind of distinct identity as a field of inquiry, it is obvious that medical ethics preceded bioethics. Thus, Jonsen remarks that:

[e]ven though medical ethics, bioethics' predecessor was shaken by notable and notorious events, it was a slow accumulation of concerns about the ambiguity of scientific progress that turned the old medical ethics into the new paths [known as bioethics].⁶²¹

In this regard, it has also been noted that 'following the emergence of bioethics... many non-physicians played a critical role in developing regulatory standards for medicine and the life

⁶¹⁶ SG Post (ed), *Encyclopaedia of Bioethics* (3rd edn, USA: Thomson Learning Inc. 2004) xi.

⁶¹⁷ D Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision-Making* (New York: Basic Books 1991) 189.

⁶¹⁸ AT Campbell, J Sicklick, P Galowitz, R Randye and SB Fleishman, 'How Bioethics Can Enrich Medical-Legal Collaborations' (2010) 38 *Journal of Legal Medicine and Ethics*, 847, 852.

⁶¹⁹ The phrase 'bedside' was used initially in the context of bioethics by DJ Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision-Making* (New York: Basic Books, 1991) 189.

⁶²⁰ AT Campbell, J Sicklick, P Galowitz, R Randye and SB Fleishman, n. 609 above, 847, 852.

⁶²¹ AR Jonsen, *The Birth of Bioethics* (New York: Oxford University Press 1998) 3.

sciences, and took the lead in publicly defining the ethical issues raised by clinical practice and research.⁶²² In fact, bioethics can be taken to incorporate interdisciplinary perspectives, including philosophy, sociology, law and theology in debating or addressing not only traditional issues of medical ethics, but also the ethical dilemmas generated by advances in medicine, science and biotechnologies.⁶²³ Within the context of the present historical discussion, my focus shall then be on the extent to which the upsurge in interdisciplinary perspectives of ethical dilemmas in healthcare have influenced the emergence of a distinct body of HCL. In this regard, it also becomes important to explore the viability of the hypothesis that patient empowerment and academic interest in medical advances have accelerated the development of HCL as a field of law.

At the outset, it is pertinent to note that the origins of bioethics in England and Wales and any influence these might have had on HCL are inextricably linked to the history of bioethics across the Atlantic. The exact origins of bioethics in the USA remain a contested issue, but for the purposes of charting a symbolic commencement of bioethics as a discipline, a useful insight may be drawn from Rothstein's narrative.⁶²⁴ According to Rothstein, five events in the USA during the 1970s directly affected the emergence of bioethics there:

- (1) development of safer and more successful solid organ transplantation techniques, thereby raising the issue of how to allocate the supply of scarce organs;
- (2) establishment of hospital ethics committees to deal with organ transplant allocation, end-of-life issues, and other matters;
- (3) the deinstitutionalization of many individuals with mental illness, often as a result of litigation;
- (4) debates

⁶²² D Wilson, 'Who Guards the Guardians? Ian Kennedy, Bioethics and the 'Ideology of Accountability' in British Medicine' (2012) 25 *Social History of Medicine*, 193.

⁶²³ M Brazier and S Ost, *Bioethics, Medicine and the Criminal Law Volume III: Medicine and Bioethics in the Theatre of the Criminal Process* (Cambridge: Cambridge University Press 2013) ch 7, 180-189.

⁶²⁴ MA Rothstein, 'The Role of Law in the Development of American Bioethics' (2009) 20(4) *Journal of International Bioethique*, 73, 74.

See also: AR Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998) 3; S Toulmin, 'How Medicine Saved the Life of Ethics' (1982) *Perspectives in Biology and Medicine*, 25, 736-50.

about the safety of new recombinant DNA technology, including the Asilomar Conference in 1975⁶²⁵; and (5) the beginning of medical ethics classes at American medical schools.⁶²⁶

These events had been preceded by some scandals involving healthcare and biomedical science, which aroused public interest and generated calls for the public to have a voice in deliberations relating to healthcare and biomedical research. For example, as a result of controversies over the withholding of syphilis drugs from African Americans in Alabama, and non-consented experiments on institutionalised children in New York, Katz argued that fundamental questions needed to be asked about the nature of the authority assigned to physicians.⁶²⁷ He argued for the more active involvement of lay people in research decisions, since doctors were not better placed than the rest of society to be commissioned as the sole arbiters of medical ethics. In 1974, President Nixon responded to these controversies by setting up a National Commission for the Protection of Human Subjects in Biomedical and Behavioural Research, which was required to have at least six lay people amongst its eleven members, drawn from philosophy, sociology, or the general public.⁶²⁸ The growing influence of bioethics in the USA was confirmed in 1978 when President Carter formed a permanent Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research.⁶²⁹

These developments in the USA had a snowball effect in England and Wales, which was going through social and political change that emphasised accountability and

⁶²⁵ The main goal of the conference was to address the biohazards presented by recombinant DNA technology. According to Paul Berg and Maxine Singer in 1995, the conference marked the beginning of an exceptional era for both science and the public discussion of science policy. See: http://www.biotech-info.net/asilomar_revisited.html (accessed: 18/6/ 2013).

⁶²⁶ MA Rothstein, n. 615 (above), 74; see also: D Wilson, 'Who Guards the Guardians? Ian Kennedy, Bioethics and the 'Ideology of Accountability' in British Medicine' (2012) 25 *Social History of Medicine*, 193.

⁶²⁷ J Katz, 'Who is to Keep Guard Over the Guardians Themselves?' (1972) 23 *Fertility and Sterility*, 604.

⁶²⁸ D Wilson, 'Who Guards the Guardians? Ian Kennedy, Bioethics and the 'Ideology of Accountability' in British Medicine' (2012) 25 *Social History of Medicine*, 199.

⁶²⁹ Ibid 200.

transparency. Politically speaking, Margret Thatcher's government in the late 1970s had argued that professions should be exposed to outside scrutiny in order to render them accountable to their end-users.⁶³⁰ It was against the backdrop of this crusade for an 'audit society' that Ian Kennedy, who had been trained in the USA and had followed all the developments in medical ethics and later, bioethics, called for the external oversight of medicine during his series of lectures and publications between 1973 and 1981.⁶³¹ Indeed, there was a general crusade for an *audit society* in the UK at various levels.⁶³² In the social realm, there was a combination of factors that had generated a growing discussion of medical ethics. These included uncertainty over death and transplants, the exposure of birth defects caused by the 'miracle' morning sickness drug, Thalidomide, and the publication of Maurice Pappworth's *Human Guinea Pigs*.⁶³³ In this publication, Pappworth sought to expose unethical medical and scientific research which was being performed contrary to the Nuremberg Code. He cited experiments on children and on inmates of mental and penal institutions, and included actual examples of research that had been conducted on patients who were at NHS hospitals for routine surgery. 'One notable example was cardiac catheterization, performed on patients who had been admitted for routine surgery and had given permission for blood specimens to be taken while they were under the anaesthetic.'⁶³⁴ Pappworth believed the reasons for the experiments to be purely for the advancement of the careers of those involved rather than for the therapeutic benefit of the patients.⁶³⁵ Pappworth was advised by the medical establishment to keep quiet on the issue, but he

⁶³⁰ Ibid 197.

⁶³¹ Ibid.

⁶³² Ibid.

⁶³³ M Pappworth, *Human Guinea Pigs* (London: Routledge and Keegan 1967); M Whong-Barr, 'Clinical Ethics Education in Britain: A History of the London Medical Group', 2003 *New Review of Bioethics*, 73; Wilson, n. 629 above, 198.

⁶³⁴ S Lock, 'Pappworth, Maurice Henry (1910–1994)' in B Harrison (ed), *Oxford Dictionary of National Biography* (Oxford University Press 2004) <http://www.oxforddnb.com/view/article/55242> (accessed: 1/12/2013).

⁶³⁵ Ibid.

refused.⁶³⁶ According to Pappworth's biographer, the publication of the book spontaneously provoked a huge storm in British society; its debate attracted massive newspaper and television coverage, as well as questions in Parliament.⁶³⁷ It has been noted that eventually, Pappworth's work ultimately accelerated the introduction of stricter codes of practice for human experimentation and the establishment of research ethics committees, which would have come much later, had it not been for his whistleblowing.⁶³⁸ In the wake of these developments, the London Medical Group (LMG) was formed by medical students in 1963 as a forum for discussing the ethical implications of medical advances and scientific research. The LMG sponsored 'the extracurricular study of issues raised by the practice of medicine which concern other disciplines, such as the law, moral philosophy, moral theology and the social sciences, in programmes of lectures and symposia on topics identified by students of medicine, nursing and allied disciplines.'⁶³⁹

Also, in the 1970s, a small group of academics from law and other disciplines began to discuss the ethical implications of new technologies and clinical practices.⁶⁴⁰ These included the academic lawyer, Ian Kennedy; the theologians, Alastair Campbell and Gordon Dunstan, and the philosopher, Robin Downie. The growth of those ethical discourses around the 1970s culminated in the publication of the *Journal of Medical Ethics* in 1975. This journal served as a platform for readers and authors who were interested in the rich debates on bioethics taking place in the late 1960s and 1970s and enabled lawyers to contribute legal perspectives.

⁶³⁶ Ibid.

⁶³⁷ Ibid.

⁶³⁸ See the history the Institute of Medical Ethics has put on its website: http://www.instituteofmedicalethics.org/website/index.php?option=com_content&view=category&id=1&layout=blog&Itemid=12 (accessed: 20/6/2013); Also see, M Whong-Barr, 'Clinical Ethics Education in Britain: A History of the London Medical Group' (2003) *New Review of Bioethics*, 73.

⁶³⁹ Ibid.

⁶⁴⁰ D Wilson, 'Who Guards the Guardians? Ian Kennedy, Bioethics and the 'Ideology of Accountability' in British Medicine' (2012) 25 *Social History of Medicine*, 199.

5.1.3. MEDICAL ADVANCES

The history of improvements in medicine can be seen as a sort of 'continuum so that at every point in time a new approach or technology in medicine may be discovered.'⁶⁴¹ However, the medical advances witnessed during the past four decades have radically altered the nature of medical practice by making doctors assume more power over life and death than ever before. Medical technology has allowed doctors to prolong life. This in turn has 'signalled that there is no longer any general consensus on the sanctity of life, when it begins, or when it ends, or should end.'⁶⁴² Similarly, medical advances in the field of human reproduction have significantly ameliorated the conundrum of infertility. These medical advances have provoked public anxiety about the acceptable boundaries for scientific progress in human health. I explore these further now with a closer scrutiny of some of the prominent medical advances of the time.

5.1.2.1. ORGAN TRANSPLANTATION

The breakthrough⁶⁴³ made in the transplantation of human organs during the 1960s had become well consolidated by the 1970s, with organ transplantation being seen as a medical therapy and with consequent excess demand for organs over supply.⁶⁴⁴ In 1968, the legal, bioethical and social uncertainties that attended these novel medical procedures were succinctly captured by Donald Longmore:

This is a new area of medical endeavour; its consequences are still so speculative that nobody can claim an Olympian detachment from them. Those who work outside the field do not yet know enough about it to form rational and objective conclusions. Paradoxically, those who work in the thick of it [...] know too much and

⁶⁴¹ I Kennedy, 'Emerging Problems of Medicine, Technology and the Law' in I Kennedy (ed), *Treat Me Right: Essays in Medical Law and Ethics* (Oxford: Clarendon Press 1988) 6.

⁶⁴² M Brazier, *Medicine, Patients and the Law* (1st edn, Middlesex: Penguin Books 1987) 8.

⁶⁴³ http://www.organdonation.nhs.uk/ukt/about_transplants/transplantation_milestones/transplantation_milestones.asp (last visited: 02/4/2012).

⁶⁴⁴ <http://www.nhsbt.nhs.uk/> (accessed: 23/11/2012).

are too committed to their own projects to offer impartial counsel to the public, who are the ultimate judges of the value of spare-part surgery.⁶⁴⁵

Two important bioethical challenges were raised by the recognition of organ transplantation as a regular part of medical practice. First, how could patients in need of organs obtain them when needed? For example, a patient could benefit from a donation from a live donor if available. This raised the issue of whether a human organ could and should be treated as a commercial commodity.⁶⁴⁶ Furthermore, organs from cadavers raised an issue as to consent, which also depended on 'the property status of the organ.'⁶⁴⁷ This prompted academic legal debate. For instance, in order to address the problem of shortage of kidneys for transplantation, coupled with 'the dangers inherent in the commercialisation'⁶⁴⁸ of kidneys, Kennedy argued in various articles for 'an amendment of the *Human Tissue Act, 1961* to allow an opt-out scheme for harvesting kidneys from dying patients.'⁶⁴⁹ As discussed later in this section, a particular scandal associated with the sale of kidneys in 1985 attracted public attention due to its coverage in the media.

The second significant bioethical issue regarding organ transplantation is the definition of death. This is crucial for determining the best time to harvest organs. For a long time it was thought that the vital functions of a human body were respiration, pulse and the capacity for consciousness or sentience; thus, death was understood as the absence of these

⁶⁴⁵ D Longmore, *Spare-Part Surgery*, (Michigan: Doubleday 1968) 169, cited in G Dworkin, 'The Law Relating to Organ Transplantation in England' (1970) 33 *Modern Law Review*, 13.

⁶⁴⁶ The Human Tissue Act 2004, which repealed The Human Organ Transplant Act 1989, creates a number of offences related to human organs, including the selling of organs. For an overview of the Act, see M Brazier and S Fovargue, 'A Brief Guide to the Human Tissue Act 2004' (2006) 1 *Clinical Ethics*, 26.

⁶⁴⁷ G Dworkin and I Kennedy, 'Human Tissue Rights in the Body and its Parts' (1993) 1(3) *Medical Law Review*, 291, 319.

⁶⁴⁸ JK Mason and RA McCall Smith, *Mason & McCall Smith Law and Medical Ethics* (2nd edn, London: Butterworths 1987) 229.

⁶⁴⁹ I Kennedy, 'The donation and transplantation of kidneys: should the law be changed?' (1979) 5 *Journal of Medical Ethics*, 13, 18; I Kennedy, 'Kidney transplants: a reply to Sells' (1980) 6 *Journal of Medical Ethics*, 29-32.

vital functions.⁶⁵⁰ In 1976, the Royal Colleges of Medicine in England and Wales adopted 'brain-stem death' as the new 'medical definition of death'.⁶⁵¹ *R v Malcherek*⁶⁵² endorsed the definition of 'brain-stem death', which was subsequently included in the Department of Health's Code of Practice.⁶⁵³ This criterion for declaring a person dead meant that it was possible for high quality organs to be harvested for transplantation.⁶⁵⁴ Despite the apparent judicial approval of the brain-stem death test for confirmation of death, it has no statutory foundation in England and Wales. Mason and McCall Smith have rightly opined that legislative intervention in prescribing a definitive test for death is unnecessary. According to these commentators, 'medical facilities and expertise alter and do so faster than can the law; it is therefore essential that the evaluation of diagnostic techniques remains in the hands of the medical profession.'⁶⁵⁵ Indeed, the new challenge presented to the law by organ transplantation and the determination of an exact point in time at which death can be considered to have taken place has engaged the attention of certain pioneers in HCL for a good period of time.⁶⁵⁶ Therefore, it reinforces one of the hypotheses of this thesis that the legal academic interest in medical advances has accelerated the emergence of HCL as a distinct body of law in England and Wales.

⁶⁵⁰ I Kennedy, *The Unmasking of Medicine* (London: George Allen & Unwin 1981) 162-164.

⁶⁵¹ Conference of Medical Royal Colleges and their Faculties in the United Kingdom, 'Diagnosis of brain death', (1976) 11 *British Medical Journal*, 1187-8.

⁶⁵² *R v Malcherek* [1981] 2 ALL ER 422

⁶⁵³ Department of Health, 'Cadaveric organs for transplantation: A code of practice including the diagnosis of brain death' (London: HMSO 1983).

⁶⁵⁴ JK Mason and RA McCall Smith, n. 657 above, 214.

⁶⁵⁵ JK Mason and RA McCall Smith, *Mason & McCall Smith Law and Medical Ethics* (2nd edn, London: Butterworths 1987) 214.

⁶⁵⁶ For example see PGD Skegg: 'Irreversibly Comatose Individuals: "Alive" or "Dead"?' (1974) 33 *Cambridge Law Journal*, 130-144; PGD Skegg, 'Liability for the Unauthorized Removal of Cadaveric Transplant Material' (1974) 14 *Medicine, Science and the Law*, 53-57; PGD Skegg, 'The Case for a Statutory "Definition of Death"' (1976) 2 *Journal of Medical Ethics*, 190-192; PGD Skegg, 'The Interpretation of the Human Tissue Act 1961' (1976) 16 *Medicine, Science and the Law*, 193-199; PGD Skegg, 'Authorization of the Removal of Cadaveric Transplant Material at Common Law' (1978) 18 *Medicine, Science and the Law*, 90-92; PGD Skegg, 'The Termination of Life-Support Measures and the Law of Murder' (1978) 41 *Modern Law Review*, 423-436.

5.1.2.2. ASSISTED REPRODUCTIVE TECHNOLOGIES (ART)

Developments in human reproduction have also presented unprecedented legal and ethical dilemmas. The 'delivery of Louise Brown, the first 'test tube' baby, through in vitro fertilisation at Oldham Hospital, Manchester in 1978'⁶⁵⁷ gave rise to public concerns over the apparently uncontrolled advance of science, bringing with it new possibilities for manipulating the early stages of human development.⁶⁵⁸ Fertility treatment also depended upon gametes and embryos provided by third parties. This raised sensitive bioethical and legal issues concerning how to regulate the involvement of such third parties. First, should they be entitled to payment for making their gametes/embryos available to others? Secondly, should there be screening of those third parties and should the prospective parents be allowed to choose whose gametes and embryos to accept? Thirdly, what legal relationship should exist between the resultant child and the third party? Related to this, should the law prohibit disclosure of information about the donor? Fourthly, must the consent of the donor be obtained before any further medical procedures or scientific research could be carried out on the embryos? There was also the issue over the destruction of embryos after their use. This impinged upon the question of when human life actually 'began' in the reproduction process. Lastly, the potential of IVF technology to develop further was another source of concern, as it was uncertain whether scientists should be prohibited from further research on human reproduction or whether the potentially beneficial outcome was sufficient justification for giving unfettered research freedom to doctors and scientists. Against this backdrop of cautious public excitement and concern, the Warnock Committee was established in July 1982 'to consider what policies and safeguards

⁶⁵⁷ M Brazier, *Medicine, Patients and the Law* (1st edn, Middlesex: Penguin Books Ltd 1987) 179.

⁶⁵⁸ M Warnock, *The Report of the Committee of Inquiry into Human Fertilisation and Embryology*, Cmnd. 9314, para 1.2.

should be applied, including consideration of the social, ethical and legal implications of ARTs, and to make recommendations.⁶⁵⁹ The Committee's Report was influential in the development of HCL, at least in the context of the regulation of ART.

First and foremost, despite some of its controversial recommendations (as discussed below) on highly ethically sensitive matters, the Report informed the enactment of the *Human Fertilisation and Embryology Act, 1990*. It recommended the establishment of an independent statutory body to monitor, regulate and license infertility services and embryo experiments. This was a critical outcome of the deliberations of the Committee as a balance needed to be struck between public anxiety about the moral dimensions of reproductive technologies and the need to facilitate advancement in treatment and medical knowledge by continuing research on embryos. The issue of researching on embryos was particularly contentious as it defied the usual harm-benefit calibration of the ethical dimension of medical advances. Indeed, Warnock herself later noted that:

The question is not whether individuals should be allowed to do what they like, as long as it does not harm people, but whether the experiments at present carried out, which undoubtedly do harm to the embryo, should be permitted at all. If they are not permitted, it will be because of this harm. If they are permitted, it must be because the embryo, at a certain early stage of its development, is not yet morally significant; and because, on the other side, the benefits to other humans in society which will flow from such research are so great as to outweigh the insignificant damage.⁶⁶⁰

Thus, a licensing authority consisting not only of scientists and medical professionals but also 'lay' people without any financial interest in the proposed research, was recommended by the Report. These prescriptions were substantially enacted into law through the creation

⁶⁵⁹ M Warnock, *The Report of the Committee of Inquiry into Human Fertilisation and Embryology*, Cmnd. 9314, para 1.2.

⁶⁶⁰ M Warnock, 'Moral thinking and government policy: the Warnock Committee on Human Embryology' (1985) *The Milibank Memorial Fund Quarterly Health and Society*, 504, 514.

of the Human Fertilisation and Embryology Authority.⁶⁶¹ The phenomenon of in vitro fertilisation and the Warnock Report generated public discourse and stimulated much academic interest. Various aspects of the ethical and legal dimensions of the technology were explored in the academic literature. The *Journal of Medical Ethics* published many articles touching on the matter. A few examples here will enhance our appreciation of the pervasiveness of those discussions in the literature. In 1983, Singer and Wells explored the ramifications of the new reproductive technology, including the unnaturalness of the procedure, restrictions on access and the ethico-legal concerns it entailed.⁶⁶² Kirby sought to reflect legal and bioethical concerns that scholars and legal practitioners from Britain had expressed on IVF at a symposium held on the subject in 1983.⁶⁶³ In addition, Jansen critiqued the Warnock Committee's Report recommendations on the need for legislation to outlaw ownership in human embryos. He contended that although the presumption behind such a recommendation may be the prohibition of the commercial trade in embryos, the Report underestimated the stake that donors may have in the fate of their sperm, ova or embryos.⁶⁶⁴ The issue of allowing research on embryos, which had received partial approval from the Warnock Committee, was discussed by Brown in 1986.⁶⁶⁵ Brown sought to respond to an earlier paper by Kennedy,⁶⁶⁶ which called for a complete ban on human embryo research, except on embryos generated fortuitously (i.e. by chance or accident and not deliberately) and aged fourteen days or less, by contending that since 'human embryo experimentation affords future generations the likelihood of considerable medical benefits,'

⁶⁶¹ RL Cunningham, 'Legislating on Human Fertilization and Embryology in the United Kingdom' (1991) (12)3 *Statute Law Review*, 214, 220.

⁶⁶² Peter Singer and Deane Wells, 'In vitro fertilisation: the major issues' (1983) 9 *Journal of Medical Ethics*, 192

⁶⁶³ MD Kirby, 'Bioethics of IVF- the state of the debate' [1984] 1 *Journal of Medical Ethics*, 45.

⁶⁶⁴ RPS Jansen, 'Sperm and Ova as Property' (1985) 11 *Journal of Medical Ethics*, 123, 125.

⁶⁶⁵ J Brown, 'Research on human embryos - a justification' [1986] 12 *Journal of Medical Ethics*, 201.

⁶⁶⁶ I Kennedy, 'Let the law take on the test tube' (May 26, 1984) *The Times*, 6.

any prohibition or restriction on its research must be preceded by a full public debate.⁶⁶⁷

Moreover, Montgomery waded into the post-Warnock Committee debate and the ensuing legislation by offering some approval, noting that:

The Human Fertilisation and Embryology Act 1990 represents a milestone in biomedical regulation. Not only does it finally bring to fruition the long running government discussions about the proper limits of reproductive science, it also provides the first attempt in English law to provide a comprehensive framework for making medical science democratically accountable.⁶⁶⁸

Additionally, the Warnock Committee recommended a more restricted regime on surrogacy.

The Committee was aware that some sections of society did not see anything wrong with commercial surrogacy so long as there was no compulsive element and yet still took the view that commercialisation was inherently wrong due to the inevitability of exploitation associated with it. In her post-Committee reflection, Warnock aptly captured the position of the Committee:

Whatever our views about the rightness or wrongness of surrogacy, most of the Committee agreed that it was not something that, in itself, should be criminalized. Our recommendations were not designed to turn a surrogate mother herself into a criminal [...] we recognized that a law against surrogacy would, in any case, be an intolerably intrusive, and ultimately an unenforceable, law. On the other hand, we were unanimous in holding it to be offensive for anyone to act as a commercial agent, offering surrogate mothers for payment to infertile couples or single men. This was, we thought, an area where the criminal law could and should be involved; and so we recommended.⁶⁶⁹

Thus the ensuing legislation, the *Surrogacy Arrangements Act, 1985* (now amended by the *Human Fertilisation and Embryology Act, 2008*) had the primary aim of preventing any commercial involvement in the negotiation and setting up of surrogacy arrangements. This anti-autonomy stance of the Warnock Report and the 1985 Act on surrogacy attracted

⁶⁶⁷ J Brown, n. 674 above, 201, 205.

⁶⁶⁸ J Montgomery, 'Rights, Restraints and Pragmatism: The Human Fertilisation and Embryology Act 1990' (1991) 54 *Modern Law Review*, 524.

⁶⁶⁹ M Warnock, 'Moral thinking and government policy: the Warnock Committee on Human Embryology' (1985) *The Milbank Memorial Fund Quarterly Health and Society*, 504, 511.

criticism from commentators. The alleged sale of Kim Cotton's baby⁶⁷⁰ to a childless couple in 1985 and the media coverage it attracted is often cited by commentators as the trigger for the hasty criminalisation of commercial surrogacy in 1985.⁶⁷¹ Freeman criticised the Warnock Report as being increasingly incoherent and philosophically muddled and the 1985 Act as an ill-considered and largely irrelevant panic-measure.⁶⁷² Subsequently, reflecting on reforms of surrogacy law recommended by the Brazier Commission, Freeman again attacked the 1985 Act and its subsequent amendment in 1990 as not having been 'rationally constructed or properly thought through', as it was a 'response to a moral panic with the surrogate the classic "folk devil."' ⁶⁷³

The deliberations of the Warnock Committee, the ensuing report and the related legislation, stimulated debate in both academic literature and the media. The growing academic interest in the legal and bioethical concerns regarding advances in reproductive technologies culminated in the emergence of assisted reproduction as an active research area for HCL scholars, as well as its presence in the HCL syllabus in universities.⁶⁷⁴ This area has generated a multitude of articles and monographs⁶⁷⁵ and as noted in Chapter 3, all law schools in England and Wales that offer a course in HCL teach ART as part of the syllabus.

⁶⁷⁰ See: BBC, '1985: Inquiry over 'baby-for-cash' deal' http://news.bbc.co.uk/onthisday/hi/dates/stories/january/4/newsid_2495000/2495857.stm (accessed: 10/4/2012).

⁶⁷¹ C Dyer, 'Baby Cotton and the Birth of a Moral Panic' (*The Guardian*, 15 January 1985); A Hutchinson and D Morgan, 'A Bill Born From Panic' (*The Guardian*, 12 July 1985).

⁶⁷² MDA. Freeman, 'After Warnock-Whither the law?' (1986) 39 *Current Legal Problems*, 33-35.

⁶⁷³ MDA Freeman, 'Does Surrogacy have a future after Brazier?' (1993) 7 *Medical Law Review*, 20.

⁶⁷⁴ See: Chapter 3 of this thesis.

⁶⁷⁵ For example, see: M Brazier, 'Liberty, responsibility, maternity' (1999) 52 *Current Legal Problems*, 52; M Brazier, 'Regulating the Reproduction Business?' (1999) 7 *Medical Law Review*, 166-193; M Brazier, 'Embryos, Property or People' (1999) *Contemporary Reviews in Obstetrics and Gynaecology*, 50-54; H Biggs, 'The quest for a perfect child: how far should the law intervene?' (2006) in H Biggs and K Horsey (eds), *Human Fertilisation and Embryology: Reproducing Regulation* (London: Routledge Cavendish 2006) 1-15; E Jackson, 'Degendering Reproduction' (2008) 16 *Medical Law Review*, 346-368; E Jackson, *Regulating Reproduction* (Oxford: Hart Publishing 2001); E Jackson, 'Statutory regulation of PGD: unintended consequences and future challenges' in Sheila McLean, *Pre-implantation Genetic Diagnosis: A Comparative and Theoretical Analysis* (Routledge 2012) 71-88.

5.1.2.3. RESPIRATORS/LIFE SUPPORT MACHINES

The victim died on October 8, 1979, when, in view of the fact that he was virtually already dead, the breathing machine on which he had been placed on October 5 was finally switched off.⁶⁷⁶

The introduction and incorporation of respirators or life support machines into routine medical practice in some crucial respects has accelerated the evolution of the field of HCL. The machines have challenged the conventional perceived goal of medicine. Traditionally, medical practice was geared towards the treatment of diseases and not the prolongation of life beyond what the human system unaided by these new machines could endure. This led to the question of whether switching off a life support machine constituted the killing of the person, or whether the patient would be considered to have died from other (pre-existing) causes. In *Re A*, for example, a two year old boy had suffered a serious head injury and was put on a ventilator, but a subsequent test established that he was brain-stem dead. The court held that it was lawful for the doctors to switch off the ventilator.⁶⁷⁷ Was it a doctor or a court that should have decided when the life support machine ought to be switched off? Indeed, in *Bland*, where the issue arose as to whether artificial feeding and antibiotic drugs may be lawfully withheld from an insensate patient with no hope of recovery, when it was known that if that were to be done, the patient would shortly die, the court observed that until relatively recently, the question could scarcely have arisen, since the medical technology to prolong life in such cases did not exist.⁶⁷⁸ These innovations in medical technology brought to the fore the relationship between law and medicine, particularly in the context of criminal law. Most of the practical issues considered above in relation to respirators necessarily impinge on criminal law, even if not overtly so, as in the direct

⁶⁷⁶ *R v Cunningham* [1982] AC 566, 573, as per Lord Hailsham L.C. (emphasis added).

⁶⁷⁷ *Re A* [1992] Med L R 303

⁶⁷⁸ *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 837

criminal prosecution of a doctor who switches off a life support machine implicitly engaging criminal law, such as in *Bland*.⁶⁷⁹ In this regard, Brazier and Ost contend that close scrutiny of the relationship between law and medicine will confirm that the criminal stands on centre stage.⁶⁸⁰

The practical challenges inherent in the use of respirators in relation to the causation of death at law have exercised the minds of some pioneering scholars in HCL in England and Wales. The typical conundrum presented is whether a doctor who switches off a respirator could be regarded as the proximate cause of the patient's death. Writing in 1984, Skegg opined that in the 'overwhelmingly unlikely event of a doctor being prosecuted for terminating the artificial ventilation' of a patient dependent on a respirator, 'judges would be likely to develop, modify, refine, or even fudge, legal concepts rather than direct the jury that the doctor was guilty of murder.'⁶⁸¹ Thus, the introduction of life support machines, like other medical advances, has increasingly necessitated the bending of otherwise settled principles of criminal law in order to make the law sensitive to ethical dilemmas associated with these medical advances. Indeed, in explaining her choice of HCL as a career option, McLean, one of the pioneers of HCL in this England and Wales has stressed the need for a discrete field of law to govern healthcare and medical advances:

When I started it was difficult to decide on what topic to include in medical law because it had not been taught anywhere before. So it was difficult to decide on topics to include. But with advances in medicine like genetics, I think there is a distinct jurisprudence which non-medical lawyers will not know or understand; so the kind of question we are asking in medical law is quite distinct. Also we adapt topics to healthcare. There are other areas like genetics where there are no common law principles which will apply so you have to create. Certainly within the

⁶⁷⁹ *Airedale NHS Trust v Bland* [1993] A.C. 789

⁶⁸⁰ M Brazier and S Ost, *Bioethics, Medicine and the Criminal Law III: Medicine and Bioethics in the Theatre of the Criminal Process* (Cambridge, Cambridge University Press 2013) 2.

⁶⁸¹ PDG Skegg, *Law, Ethics and Medicine: Studies in Medical Law* (2nd edn, Oxford, Clarendon Press 1984), 181.

legal system; there are discrete questions which require considerable innovation on part of those who started teaching the area for the first time.⁶⁸²

The significance of these medical advances in the context of the evolution of HCL is that they generate moral and legal dilemmas, which cause lawyers, philosophers, theologians and the general public to partake in the debate and its resolution, rather than leaving them to the exclusive deliberation of members of the medical profession.

5.1.3. THE ROLE OF THE MEDIA

‘Medicine and medical science attract a degree of media coverage much greater than other professions or other branches of science.’⁶⁸³ The breakthroughs and advances in medical science and the practice of medicine have become a subject of public discourse as a result of media reporting.⁶⁸⁴ The spectacular advances that have brought about modern medicine made headlines in various parts of the media. For instance, IVF made headlines in leading newspapers in the late 1960s. *The Times* carried a report discussing the implications of the then developing ‘test tube’ baby technology.⁶⁸⁵ It posed the following question: ‘looking even further into the future, the growing of a baby in a test tube, should it prove both possible and ethically justifiable, is not at all the same thing as ‘growing life in a test tube.’’⁶⁸⁶ The uncertainty regarding the success rate of this technology must have made it an uneasy decision for putative mothers to undergo the test tube trials. According to *The Times*, in 1970, a 34 year old Lancashire woman who had agreed to participate in a trial was interviewed by her consultant gynaecologist on the BBC television programme, *Horizon*, a

⁶⁸² Extract from ‘Transcript of Interview with Professor Sheila McLean, 16/10/2013’ (a copy is available on file).

⁶⁸³ M Brazier ‘How Media Presents Medicine and Science’ (2011) 11 *Medical Law International*, 187.

⁶⁸⁴ J Coggon, A Ford and M Quigley, ‘Introduction - Medical law and ethics in the Media Spotlight’ (2011) *Medical Law International*, 177.

⁶⁸⁵ Nature-Times News Service ‘Implications of the test-tube embryo’ (London: *The Times*, 15 February 1969, accessed at: The Times Digital Archive Web, 4 May, 2012) 8.

⁶⁸⁶ *Ibid.*

day before the initial step was to be performed.⁶⁸⁷ The consultant made it clear during the programme that he had no moral qualms about any advancement in the technology that would make it possible to ‘manufacture’ babies in the biological engineering industry, provided that public opinion was in support of it.⁶⁸⁸ Similarly, organ transplantation, which had become part of regular medical practice, also came under the spotlight of the media. For example, in 1969, the *Daily Mirror* carried a headline ‘Heart-Swap Doctor Accused of Murder’ in its coverage of a case where the heart of a man who died in an accident through the crushing of his skull was removed and implanted in another patient. This caused a theologian to initiate a suit against the doctor.⁶⁸⁹

It was not only the scientific breakthroughs that made headlines but errors and scandals were also, and continue to be, given equal prominence by the media. I have discerned a pattern in the newspapers which I have examined from available digital archives: until the last four decades, medical errors were not reported with the passion evident in reporting these days. Two examples illustrate this observation. The *Daily Mirror* reported that nearly 2000 cases of mistaken diagnosis were admitted to hospitals under the Metropolitan Asylums Board during 1904.⁶⁹⁰ An examination of the way the newspaper reported this matter shows that it did not, or was not expected to generate public anger, as it was covered in a small corner of the page. However, in contrast, in 2006 the *Daily Mirror* carried the headlines ‘As my wife lay dying of cancer at 33 she handed me a devastating final letter, I’ve been killed by a medical blunder.’⁶⁹¹ The story in the paper was about a

⁶⁸⁷ P Wright, ‘Progress towards ‘test tube’ baby’, (London: *The Times*, 24 February 1970, accessed at: The Times Digital Archive Web, 4 May, 2012) 1.

⁶⁸⁸ Ibid.

⁶⁸⁹ Daily Mirror Reporter, ‘Heart-Swap Doctor Accused of Murder’ *Daily Mirror* (London, England 5 June 1969) 22-23.

⁶⁹⁰ *Daily Mirror, The Reporter* (London, 7 August 1905) 4.

⁶⁹¹ *Daily Mirror, The* (London, 14 July 2006), 25.

successful outcome in a medical negligence suit by the husband of the deceased, which resulted in a six-digit compensation award. The story was given full page coverage in the newspaper. This prominent coverage by the *Daily Mirror* reveals that society is no longer sympathetic to the perception that doctors belong to a noble profession and therefore cannot make mistakes (or should not be blamed for making mistakes) in the genuine quest to restore health.

Additionally, the media has played an influential role in stimulating public debates about ethical dilemmas which these developments generate. In 1980, under the headline 'Doctor's Secrets for Sale', the *Daily Mirror* reported that the British Medical Association was about to release its '*Handbook of Medical Ethics*' for sale to enable the public to understand the problems that doctors face in their practice and how to tackle them. The paper stated that 'It also tells how to deal with drink-drive patients; with those in police custody with pressure from the Press, radio and TV about medical matters and with child abuse patients.'⁶⁹² What is quite telling about the *Daily Mirror's* report in 1980 is that the medical profession was already feeling the pressure of the public voice concerning ethical matters and general clinical conduct. This was facilitated by the new bioethics movement which, in 1970, started engaging with the ethical dimensions of medical practice in England and Wales, as discussed earlier. However, the difficulty with the media in all these examples is the degree to which they can be objective in presenting these scientific matters, without skewing their reportage towards sensationalism (in the case of the tabloid press), and their preferred side of the ethical pendulum. It was in connection with this that Brazier posed the following question: 'Is it better for issues relating to medicine and science to attract public

⁶⁹² Reporter, 'Doctor's Secrets for Sale' *Daily Mirror* (London 18 January 1980) 6.

debate in which case they need to be presented with a degree of drama? Or are we arguing that such matters should be reserved for the intellectual elite?’⁶⁹³

I would suggest that the publicity generated by the media has actually accelerated the emergence of HCL in different ways. First, it has made the public aware of the extraordinary heights which medicine has attained for the first time in recorded civilisation, thereby stimulating the public’s enthusiasm for medical advances and anxieties about their regulation and inherent ethical challenges. Second, the media coverage of inquiries into medical scandals and malpractices has also contributed towards the development of HCL. In this regard, mention could be made of the Public Inquiry into children’s heart surgery at Bristol Royal Infirmary (1998-2001), chaired by Ian Kennedy. The Bristol Inquiry unfolded shocking revelations concerning the disempowerment of patient at the hands of doctors, particularly how organs of children were removed without the knowledge or consent of their parents after unsuccessful cardiac surgery. The general public could follow the revelations due to extensive media coverage of the proceedings and the ensuing report.⁶⁹⁴ The report recommended that the delivery of healthcare should be approached from the perspective of the patient.⁶⁹⁵

5.1.4. THE CONTRIBUTION OF PIONEERING HEALTHCARE LAW SCHOLARS

Academic lawyers, rather than legal practitioners were at the forefront of the development of HCL as a field of law and, concomitantly, as a discipline. To begin with, novel issues presented in HCL cases provided impetus for the courts to seek assistance from academic writings founded on research into thorny ethical or moral issues involving

⁶⁹³ M Brazier, ‘How Media Presents Medicine and Science’ (2011) 11 *Medical Law International*, 194. .

⁶⁹⁴ Daily Mail Reporter, ‘NHS must change after inquiry into Bristol heart baby deaths’ <http://www.dailymail.co.uk/news/article-60959/NHS-change-inquiry-Bristol-heart-baby-deaths.html> (accessed: 10/9/2013).

⁶⁹⁵ I Kennedy, ‘*The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol*’ (HMSO Cm 5207).

medicine. An example of this can be found in *Re A*, which saw the court dealing with numerous amicus curia submissions from ethicists and other moral constituencies in British society.⁶⁹⁶ Secondly, the complexity of issues presented in HCL cases required judges to mould the law to fit or reflect contemporary societal norms. For example as Lord Scarman remarked in *Gillick*, that novel factual features of the case namely ‘contraception as a subject for medical advice and treatment’; ‘the increasing independence of young people’; and ‘the altered status of women’ warranted an interpretation that would make the law accommodate the new social and medical technological changes.⁶⁹⁷ Thus in *Bland*, Lord Browne-Wilkinson highlighted the need for Parliament to address dilemmas posed by medical advances when he opined that ‘the broader issues raised by a withdrawal of artificial feeding to allow a PVS patient to die would be better dealt with by Parliament.’⁶⁹⁸

The pioneering scholars in the field have endeavoured to extend the frontiers of legal thinking to the specific bioethical and legal issues raised by healthcare in some cases to consider how to regulate and who should regulate medical advances. Consequently, any historical account of this field would not be complete without exploring their contribution. In terms of the authorship of early textbooks and leading articles on HCL, nine pioneering scholars can be identified, namely Glanville Williams, Peter Skegg, Ian Kennedy, John Kenyon Mason, Alexander McCall Smith, Sheila McLean, Margaret Brazier, Jonathan Montgomery and Graeme Laurie. I shall proceed to explore the specific contribution made by these scholars to the maturation of HCL as a field of law. The selection of these scholars for nuanced consideration here is neither arbitrary nor an underestimation of the contribution of others; they have been selected on the basis of their involvement in the evolution of the

⁶⁹⁶ *Re A (children) (conjoined twins: surgical separation)* [2000] 4 All ER 961

⁶⁹⁷ *Gillick v West Norfolk and Wisbech Area Health Authority and Another* [1985] 3 All ER 402, 419.

⁶⁹⁸ *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 878

field from a chronological perspective, in terms of authoring leading textbooks, monographs and articles in the field during the period under consideration.

A. GLANVILLE WILLIAMS

Notwithstanding Williams' fame as a criminal lawyer, his monograph, *The Sanctity of Life and the Criminal Law*,⁶⁹⁹ can be viewed as the foundation stone of HCL. His monograph considered how far human life is or ought to be protected under criminal law. He also discussed moral issues, such as abortion, infanticide and suicide. It is thus notable for tackling thorny ethical issues that continue to vex the law and bioethics. His important role in being a precursor of HCL scholarship was acknowledged by Grubb when he commented in 1998 that 'if the fathers of HCL in England and Wales were Kennedy and Skegg, then Williams was its grandfather.'⁷⁰⁰ This was why Kennedy and Grubb, as founding editors of the *Medical Law Review*, invited him to contribute the Journal's first article.⁷⁰¹ More recently, Keown and Jones have lauded William's book as 'a bold and original attempt at an interdisciplinary analysis of profoundly important questions of law and ethics', despite containing - in their view - 'some flawed theological and legal arguments'.⁷⁰² The proud position occupied by Williams in the history of HCL in England and Wales has recently been affirmed by some of the living pioneers of this field of law.⁷⁰³ Thus, when asked whether, as an academic, he had an interest in HCL prior to 1980, Skegg responded as follows:

In the 1970s Ian Kennedy and I were the two English academic lawyers whose main focus was on 'the law and health care' [...] There were, however, other academic lawyers who wrote in that field in the later 1970s and the early 1980s: from

⁶⁹⁹ (London: Faber & Faber 1958).

⁷⁰⁰ A Grubb, 'Glanville Williams: A Personal Appreciation' (1998) 6 *Medical Law Review*, 136

⁷⁰¹ G Williams, 'Controlling the Repetitive Dangerous Offender' (1993) 1 *Medical Law Review*, 1.

⁷⁰² J Keown, 'Surveying the Foundations Medical Law - a reassessment of Glanville Williams's the sanctity of life and the Criminal Law' (2008) 16 *Medical Law Review*, 85, 88.

⁷⁰³ Interviews with Professors Peter Skegg, Sheila McLean, Ken Mason, Margot Brazier, Andrew Grubb, Jonathan Montgomery and Graeme Laurie in October 2013 as part of the empirical legal research for this thesis. Copies of all transcripts are incorporated as Appendix 4.

memory, Glanville Williams, John Finnis, Graham Zellick, Joseph Jacob, John Finch, Gerald Robertson, and before long John Keown.⁷⁰⁴

Responding to the same question, Grubb remarked that:

Before the 1980s, it won't be easy to describe a development of law that systematically dealt with the relationship between doctors and patients or healthcare generally. The law came out of criminal law and it was analysed like that. The initial scholars who dealt with medical law were really criminal lawyers looking at issues like death and dying, transplantation. *Probably the greatest legal academic of all times in England and Wales, Glanville Williams, wrote about those kinds of issues; and he was actually a criminal lawyer even though he was a legal polemic since he knew most of the law. He wrote on abortion, transplantation, with [a] focus for lawyers.*⁷⁰⁵

The other respondents as captured in the Transcript of the Interview (Appendix 1) did not allude to Glanville Williams in their responses to this particular question; so it is unnecessary to state their answers at this stage. From the accounts of Skegg and Grubb, it can reasonably be maintained that although HCL did not exist in the shape of a discrete legal field as in the post-1980 era, Williams' writings foreshadowed some of the issues that later took centre stage in HCL.

B. PETER SKEGG

Skegg's book, *Law, Ethics and Medicine*, enabled him to influence the development of HCL with the author's black-letter law approach.⁷⁰⁶ His objective was to produce studies on legal aspects of some of the issues that arise in medical practice.⁷⁰⁷ Skegg made the effort to synthesise common law and how it affected healthcare practice. However, it is arguable whether he gave sufficient direction to HCL, which was then emerging as a body. As Grubb aptly noted Skegg ought to have expressed his personal views on what the new evolving

⁷⁰⁴ Extract from 'Transcript of Interview with Professor Peter Skegg on 29/10/2013'.

⁷⁰⁵ Extract from 'Transcript of Interview with Professor Andrew Grubb on 22/10/2013' (emphasis added).

⁷⁰⁶ (Oxford: Clarendon Press 1984).

⁷⁰⁷ Ibid vii.

discipline was or, better still, 'the underlying notions which supply the framework of what, at least in part, entails medical law in the 1980s.'⁷⁰⁸ Besides Skegg's book, his numerous articles⁷⁰⁹ are worthy of commendation because they were seminal in synthesising the common law. Thus, Keown appropriately notes 'the new kid on the legal block was suckled academically by Peter Skegg's excellent *Law, Ethics and Medicine* (1984).'⁷¹⁰ These comments are corroborated from the empirical findings in Section 5.1.7 below.

C. IAN KENNEDY

The high profile advocacy role played by Ian Kennedy is arguably the watershed phase in the evolution of HCL as a discrete body of law. Kennedy's basic thesis was that the excessive medicalisation of non-medical matters had made doctors extremely powerful and the only way to overcome that was to subject medicine to external accountability through the instrumentality of the law.⁷¹¹ Kennedy's contribution was unique because he purposefully advocated a variety of platforms through his writing for the recognition of a discrete body of HCL to facilitate patient empowerment.

First, he delivered the prestigious 1980 BBC Reith lectures, which were then published in his seminal monograph, *The Unmasking of Medicine*.⁷¹² Brazier has described this publication as 'a key moment in the birth of modern medical law' because the case law and

⁷⁰⁸ A Grubb, 'The Emergence and Rise of Medical Law and Ethics (1987) 50 *Modern Law Review*, 243.

⁷⁰⁹ Such as: PDG Skegg, 'Medical procedures and the Crime of Battery' (1974) *Criminal Law Review*, 693; PDG Skegg, 'The termination of life support measures and the law of murder' (1978) *Modern Law Review*, 423; PDG Skegg, 'The case for a statutory definition of death' (1976) 2 *Journal of Medical Ethics*, 190; PDG Skegg, 'Consent to Medical Procedure on Minors (1973) 36 *Modern Law Review*, 37; PDG Skegg, 'Irreversibly Comatose Individuals: "Alive" or "Dead"?' (1974) 33 *Cambridge Law Journal*, 130; PDG Skegg, 'Human Corpses, Medical Specimens and the Law of Property' (1975) 4 *Anglo-American Law Review*, 412; PDG Skegg, 'Liability for the Unauthorised Removal of Cadaveric Transplant Material' (1974) 14 *Medicine, Science and Law*, 53.

⁷¹⁰ J Keown, 'Review of 'The Principles of Medical Law' (2000) *Cambridge Law Journal*, 412.

⁷¹¹ I Kennedy, *The Unmasking of Medicine* (London: George Allen & Unwin 1981) ch 1-2.

⁷¹² *Ibid.*

the literature on the field exponentially increased thereafter.⁷¹³ The 1980 BBC Reith lectures were a broad platform which enabled Kennedy to reach a larger audience, at least if we are to gauge this by the usual popular patronage of BBC programmes. It is not surprising that the resultant publication became a popular point of reference in the community of HCL scholars and lawyers in England and Wales.⁷¹⁴

Inspired by the ideas of Illich⁷¹⁵ and Foucault,⁷¹⁶ Kennedy presented an unprecedented tirade - at least as regards an academic lawyer in England and Wales - against the dominance and paternalism of the medical profession.⁷¹⁷ The core of his message was that medical practice was oriented towards supporting the socio-economic system; it was concerned with cure rather than prevention; it placed too little emphasis on achieving health through environmental improvements; its decisions were hardly ever value-free, and doctors generally failed to understand all the foregoing.⁷¹⁸ He bemoaned the fact that citizens failed to realise the political aspect of medicine and instead, kept concentrating excessive power in the hands of doctors to decide matters which were not purely technical, but also ethical or policy-oriented.⁷¹⁹

Besides Kennedy's Reith lectures and his numerous works, Veitch has noted that Kennedy's dual status 'as professor of medical law' and 'Chairman of the Bristol Royal

⁷¹³ M Brazier, 'The Age of Deference-A Historical Anomaly' in M Freeman, *Law and Bioethics* (Oxford: Oxford University Press 2008) 464; M Brazier and E Cave, 'Why We Wrote ... Medicine, Patients and the Law' (2008) 3(3) *Clinical Ethics*, 205.

⁷¹⁴ For example: M Brazier and N Glover, 'Does Medical Law have a Future' in D Hayton (ed), *Law's Future(s)* (Oxford: Hart Publishing 2000) 371-389, 371; M Brazier and E Cave, *Medicine, Patients and the law* (London: Penguin 2011); M Jonathan, *Health Care Law* (Oxford: Oxford University Press 2003); J McHale and M Fox, *Health Care Law: Text and Materials* (London: Sweet and Maxwell 2006); I Kennedy and A Grubb, *Medical Law* (London: Butterworths 2000); RA Hope, 'The Birth of Medical Law' (1991) 11 *Oxford Journal of Legal Studies*, 247-53; L Gostin, 'Honouring Ian McColl Kennedy' (1997-1998) 14 *Journal of Contemporary Health Law and Policy*, xi.

⁷¹⁵ I Illich, *Limits to Medicine: Medical Nemesis, the Expropriation of Health* (London: Penguin 1977).

⁷¹⁶ M Foucault, *The Birth of the Clinic: Archaeology of Medical Perception* (London: Tavistock Publications Ltd 1973).

⁷¹⁷ I Kennedy, *The Unmasking of Medicine* (London: George Allen & Unwin 1981) ch 1-2.

⁷¹⁸ *Ibid.*

⁷¹⁹ *Ibid.*

Infirmity Inquiry' gave him the opportunity to further influence the development of HCL in this jurisdiction, since he used both positions as platforms to reiterate his original concerns over the seeming monopoly of the medical profession over matters which were not strictly technical.⁷²⁰ The huge impact of Kennedy's seminal book in laying the foundation of modern HCL was evident from the reactions it provoked from the medical profession. Indeed, the vigour and rigour of Kennedy's critique of medicine was unfavourably commented upon by some writers associated with the medical profession. In 1981, the *Journal of Medical Ethics* published twelve articles reacting to Kennedy's radical challenge to medical practice.⁷²¹ Unsurprisingly, Montgomery has recently acknowledged the unique pioneering role of Kennedy, remarking that:

...Professor Sir Ian Kennedy, then at the Law School of King's College London virtually invented the field in the United Kingdom. Certainly, his Reith Lectures in 1980, later published as *The Unmasking of Medicine* (1983), mark the beginning of highly visible public discussions of the issues which became increasingly matters for society to determine whereas they had previously been seen as internal matters of professional ethics.⁷²²

It is a tribute to Kennedy's contribution to development of HCL that after over three decades leading and respected modern scholars in the field have convincingly maintained that ' Kennedy was correct about the law being overly paternalistic in the 1980s, and the fact that doctors were claiming responsibility for making decisions that were outside of their field of expertise.'⁷²³

⁷²⁰ Veitch, n 41 above, 24; R Dingwall and P Hobson-West, 'Litigation and the Threat to Medicine' in D Kelleher et al (eds), *Challenging Medicine* (London: Routledge 2006) 40.

⁷²¹ The articles included: D Black, 'Agreement and Disagreement' (1981) 6 *Journal of Medical Ethics*, 173; E Wilkes, 'I am still proud to be a Doctor, Mr. Kennedy' (1981) 7 *Journal of Medical Ethics*, 177; M Thomas, 'Should the Public Decide?' (1981) 7 *Journal of Medical Ethics*, 182; RA Carson, 'Unmasking or demythologising medicine?' (1981) *Journal of Medical Ethics*, 189; A Schamroth, 'The 1980 Reith Lectures--some reactions. A medical student's response' (1981) 7 *Journal of Medical Ethics*, 191.

⁷²² J Montgomery, 'Lawyers and the Future of UK Bioethics' <http://eprints.soton.ac.uk/id/eprint/341657> (accessed: 13/6/2013).

⁷²³ C. Foster, J. Miola, 'Who's in Charge? The Relationship Between Medical Law, Medical Ethics and Medical Morality?' (2015) 23 *Medical Law Review* 505, 529.

Indeed, the towering stature of Kennedy in the evolution of the discipline is abundantly bolstered by unanimous independent views expressed by some of the pioneering scholars, as discussed in the findings of the empirical survey below.

D. MARGARET BRAZIER

Margaret Brazier is another key scholar who played a role in developing HCL into its status as a distinct discipline. Beginning her academic career as a tort law scholar,⁷²⁴ Brazier, like Kennedy, acknowledged the inadequacy of traditional common law and statutory law which existed in the 1980s. She used various platforms and publications to advance the case for medical ethics and HCL. In 1986, she collaborated with the philosopher John Harris and founded the Centre for Social Ethics and Policy at the University of Manchester.⁷²⁵ This collaboration bears testimony to Brazier's multi-disciplinary approach to HCL and ethics, which I discussed earlier in Chapter Three. Her achievements were recently celebrated in a special issue of the *Medical Law Review*⁷²⁶ and in a Foreword to that publication; Gostin noted that Brazier had been a leading exponent of respect for persons, which finds expression in the concept of personal autonomy: the first principle of modern HCL.⁷²⁷ Indeed, this ethical principle of personal autonomy has been used by scholars in HCL to analyse many pertinent issues in different contexts, including judicial decisions, proposed statutory law and professional guidelines. I argue in Chapter Three that it is the use of

⁷²⁴ Professor Brazier was responsible for the 8th, 9th and 10th editions of *'Street on Torts'*. She was an editor for *'Clerk and Lindsell on Torts'* from 1974 – 1998, becoming the General Editor in 1990 for the 17th edition. See: Staff Profile,

http://www.law.manchester.ac.uk/postgraduate/research/researchdegrees/phd_bmj/staff_profiles/index_new.html (last accessed: 5/7/2012).

⁷²⁵ M Brazier, A Dyson, J Harris and M Lobjoit, 'Teaching Medical Ethics Symposium: Medical Ethics in Manchester, (1987 13 *Journal of Medical Ethics*, 150, 151.

⁷²⁶ It was entitled; *'Across the Spectrum of Medical Law: A Special Issue in Honour of Margaret Brazier'*; LO Gostin, 'Foreword in Honour of a Pioneer of Medical Law: Professor Margaret Brazier OBE QC FMEDSCI' (2012) 20(1) *Medical Law Review*, 1; the same point is made by JK Mason, 'Autonomous Humanity? In Tribute to Margaret Brazier' (2012) 20(1) *Medical Law Review*, 150–156.

⁷²⁷ *Ibid* 2.

ethical principles, including personal autonomy as an analytical framework, which, among other things, renders HCL a discrete subject.

E. SHEILA MCLEAN

The construction of the history of HCL in becoming a discrete discipline or legal field in England and Wales cannot be completed without consideration of the scholarship of Sheila Mclean in this area of the law. Mclean has contributed towards the emergence of the discipline in two major ways which are worthy of exploration. In the first place, Mclean produced many important scholarly works in the form of articles and monographs from the early 1980s. In 1983, McLean co-authored a book entitled *Medicine, Morals and the Law* with a medical doctor, Gerry Maher.⁷²⁸ The objective of this book, as captured in its Preface, was to reinforce the external critique of medical practice which Kennedy⁷²⁹ and Illich⁷³⁰ had earlier embarked upon. The medical profession could no longer be allowed to debate ethical dilemmas of medical practice via medical ethics. Lay people needed to participate in the resolution of these through the instrumentality of law and moral evaluation.⁷³¹ The authors discussed contemporary issues, such as the sanctity of life, abortion, euthanasia, withdrawal of treatment, and decision-making in medicine, and offered their opinions as to how they should be resolved. At the end of the millennium, McLean authored a monograph entitled, *Old Law, New Medicine: Medical Ethics and Human Rights*⁷³² in which she bemoaned the excessive medicalisation of problems faced by patients and their families, which she opined, were not most of the time essentially of a medical nature.⁷³³

⁷²⁸ S McLean and G Maher, *Medicine, morals, and the law* (Aldershot, Gower 1983).

⁷²⁹ I Kennedy, *The Unmasking of Medicine* (2nd rev edn, St Albans: Granada, 1983) ch 1.

⁷³⁰ I Illich, *Limits to medicine: medical nemesis, the expropriation of health* (London: Boyars 1976).

⁷³¹ McLean, Maher n 729 above, vii-viii.

⁷³² S McLean, *Old law, New Medicine: Medical Ethics and Human Rights* (London: Pandora 1999).

⁷³³ *Ibid* xi.

Since 1983, McLean has authored over one hundred publications on almost every aspect of HCL.⁷³⁴

Apart from her extensive writing on almost all the major themes often explored in HCL, McLean has played many important public service roles, including serving on various statutory and non-statutory bodies that deal with legal and ethical issues relating to medical practice and biomedical research. For example, she is UK Adviser to WHO Europe on the revision of the *Health for All Policy*; Specialist Adviser to the House of Commons Select Committee on Science and Technology; a member of the BMA Ethics Committee, and a member of the Wellcome Trust, Biomedical Ethics Panel.⁷³⁵

F. ANDREW GRUBB

Grubb is a pioneer scholar who, like others, showed original interest in HCL at the beginning of his academic career. Grubb's contribution to the field can be explored in three main ways, namely: teaching, research and his public service role in relation to the field of HCL. It must be noted as historic fact that Grubb was the very first person to create a course in HCL at the University of Cambridge, where he graduated in the late 1970s.⁷³⁶ He has stated that as a student in the 1970s, medical law was completely unknown; it simply did not exist.⁷³⁷ Grubb recalls his experience with the introduction of the discipline of HCL into the curriculum for LLB students, as follows:

When I first started teaching in the University of Cambridge in the early 1980s in the law school, there had been for a long time an elective course for medical students started by Glanville Williams. It was popular for medical students. Because it had been started by Williams, it was run by the law faculty; so when I got there I was asked to take it on by running it. I was a criminal lawyer, a tort lawyer and an administrative law lawyer[...]So I had three main interests that might have worked.

⁷³⁴ Staff Profile, <http://www.gla.ac.uk/schools/law/staff/sheilamclean/#tabs=1> (last accessed: 13/09/2013).

⁷³⁵ Ibid.

⁷³⁶ Information based upon a 'Personal Interview with Professor Grubb, 22/10/2013'.

⁷³⁷ Ibid.

Gradually I got interested in it. The courses consisted of a few lectures from me and guest lectures by people from a medical background and lawyers including Ian Kennedy. One evening in a bar, I said to him [Kennedy] I was trying to write a book on medical law and he accepted that we should write together and so the first edition came out in 1989. The reality was that the more I got into it the more I became a medical lawyer.⁷³⁸

Apart from the development of the discipline through teaching, Grubb has also generated high quality scholarship in the field. He has co-authored a leading textbook and practitioner's book on the subject with his long-time collaborator, Ian Kennedy.⁷³⁹ Grubb alone authored the expanded volume of their book in its third edition.⁷⁴⁰ Moreover, since the early 1980s, he has authored more than fifty articles.⁷⁴¹ Grubb's scholarship covers much of the scope of the field.⁷⁴² He is one of the pioneers to focus on the purposeful development of HCL as an academic discipline. This assessment is bolstered by his rigorous review of Skegg's maiden monograph on the field, cited earlier above.⁷⁴³ As already noted, having lauded the pioneering efforts Skegg made in his *Law, Ethics and Medicine* to synthesise English common law at the time of his writing and how it affects healthcare delivery in this jurisdiction, Grubb criticised Skegg's monograph as having failed to give sufficient direction to HCL, which was then emerging as a discrete subject.⁷⁴⁴

Another dimension of Grubb's HCL scholarship is that he sees great potential in comparative law methodology in unravelling certain problems of HCL in one jurisdiction that

⁷³⁸ Information based upon a 'Personal Interview with Professor Grubb, 22/10/2013'.

⁷³⁹ I Kennedy and A Grubb, *Medical Law: Text With Materials*, (London: Butterworths 1989; 2nd edn, London: Butterworths 1993).

⁷⁴⁰ A Grubb, *Medical Law: Text With Materials*, (London: Butterworths 2000).

⁷⁴¹ Such as: A Grubb 'The Emergence and Rise of Medical Law and Ethics - A review of PDG Skegg, *Law, Ethics and Medicine: Studies in Medical Law*, Oxford University Press (1985)' (1985) 50 *Modern Law Review*, 241; A Grubb, 'Breach of Confidence: Anonymised Information' (2000) 8(1) *Medical Law Review*, 115-120; A Grubb, 'Human Rights: Right to Treatment and Article 2' (2000) 8 *Medical Law Review*, 358-359; A Grubb, 'Incompetent Patient (Adult): Bland and the Human Rights Act 1998' (2000) 8(3) *Medical Law Review*, 342-349; A Grubb 'Incompetent Patient (Child): HIV Testing and Best Interests' (2000) 8(1) *Medical Law Review*, 120-125.

⁷⁴² *Ibid.*

⁷⁴³ A Grubb, 'The Emergence and Rise of Medical Law and Ethics (1987) 50 *Modern Law Review*, 241.

⁷⁴⁴ *Ibid* 243.

might have been solved in another. Thus, when he was invited to write the inaugural editorial of the *European Journal of Health Law*, he underscored the utility of comparative law and advocated its use in HCL research:

The comparative approach may also have an additional benefit. It will facilitate the identification of problems that have yet to be faced in some countries. All too often a society is 'taken by surprise' as technological developments in medicine are introduced without regulation and, often, without thought being given by the society to their implications. Some countries may already have had to address the issue and thus study of their policy solutions can help others to formulate policy responses for the future.⁷⁴⁵

His academic interest in the systematic development of the discipline of HCL saw him become one of the founding editors of the leading and highly reputed journal in the field, the *Medical Law Review*. Between 1992 and 2004 he was editor of that Journal.⁷⁴⁶ As far as his public service contribution toward HCL is concerned, Grubb has been a member of a number of bioethics bodies, including the Human Fertilisation and Embryology Authority and the Ethics Committee of the Royal College of Physicians.⁷⁴⁷ The wealth of experience Grubb has accumulated in the field has given him pertinent insights into the antecedents and direction of HCL in England and Wales. I shall explore this further in the section on findings from my empirical survey below.

G. JONATHAN MONTGOMERY

Another academic who has made a distinct contribution to the evolution of HCL as a discrete field of law is Jonathan Montgomery, having contributed numerous articles and a textbook on the subject. In 1997, Montgomery wrote his maiden HCL textbook, departing from the traditional description of works of that nature, he chose⁷⁴⁸ to entitle his work *Health Care*

⁷⁴⁵ A. Grubb, 'Comparative European Health Law' (1995) 11 *European Journal of Health Law*, 292.

⁷⁴⁶ Staff Profile, <http://www.law.cf.ac.uk/contactsandpeople/GrubbA> (accessed: 4/1/2012)

⁷⁴⁷ *Ibid.*

⁷⁴⁸ See: Section 1.5 of Chapter One for explanation of Montgomery's title preference.

Law.⁷⁴⁹ In addition to this textbook, which was revised in 2002, Montgomery has authored several dozen articles and book chapters which critically engage with major HCL issues, including the orientation of HCL as a discrete legal field.⁷⁵⁰ It will be helpful to attempt to outline some of the key crusading arguments often deployed by Montgomery, especially in relation to the proper direction of HCL as a discrete subject.

Montgomery has consistently argued that a proper HCL methodology ought to be one which is not a priori, but steeped in the 'concrete realities of healthcare delivery', including an appreciation of the 'historical traditions of medical practice'.⁷⁵¹ In this regard, he criticises Kennedy and his 'Centre of Medical Law and Ethics at King's College, London - which more or less represents the orthodox position on the subject' - for approaching HCL from the perspective of 'rationalist consumerism', which indulges 'applied moral philosophy' in exploring controversial issues, at the expense of the 'concrete realities of medical practice'.⁷⁵² The 'orthodox approach', according to Montgomery, sees medical law as 'a species of applied ethics, implying a staged process of applying ethical principles to a problem and deriving the necessary legal rules from that application.'⁷⁵³ In a later work Montgomery notes the flaw inherent in the orthodox approach:

Few commentators have tried to understand the concrete situations in which health care is delivered. Yet without such an appreciation, criticism seems uninformed, abstract and superficial.⁷⁵⁴

To overcome this defect in the orthodox approach to HCL, Montgomery advocates a paradigm shift when he remarks:

⁷⁴⁹ J Montgomery, *Health Care Law* (Oxford: Oxford University Press 1997) 1.

⁷⁵⁰ See the list of his publications via the University of College of London website: <https://iris.ucl.ac.uk/iris/browse/profile?upi=JRMON09> (accessed: 1/7/2013).

⁷⁵¹ J Montgomery, 'The Compleat Lawyer - Medical Law as Practical Reasoning: Doctrine, Empiricism, and Engagement' (2012) 20 *Medical Law Review*, 8-28.

⁷⁵² J Montgomery, 'Medical Law in the Shadow of Hippocrates' (1989) 52 *Modern Law Review*, 566.

⁷⁵³ J Montgomery, 'Time for a paradigm shift? Medical law in transition' (2000) 53 *Current Legal Problems*, 363

⁷⁵⁴ Montgomery, *ibid* n753.

an examination of the way in which the courts, the health professions, and the NHS have regulated standards of practice shows how the idea of externally driven scrutiny has been less effective than had been hoped by many commentators. Instead, a paradigm based on the development of values within the health care communities provides a more illuminating model for explaining the subject.⁷⁵⁵

In this regard, it has been suggested that HCL should adjust its conceptualisation of law and lawmakers. Thus, legal norms for the governance of medical practice are to be derived not only from statutes but also from guidance issued in the healthcare community. To that extent, Montgomery has opined that ‘the traditional paradigm that sees the health professions and the institution of the NHS as the principal problem, forces to be constrained, needs to be replaced by a broader paradigm that sees them as part of the solution.’⁷⁵⁶

In addition to his writing on shaping the subject, Montgomery, like other pioneers, plays an important public role in reviewing and implementing law and policy in various aspects of the healthcare system. For example, in 2012, he became ‘the Chair of the Nuffield Council on Bioethics, an independent body that examines and reports on ethical issues in biology and medicine’.⁷⁵⁷ In that same year, he also became the Chair of the Health Research Authority, established to protect and promote the interests of patients and the public in health research.⁷⁵⁸ Prior to 2012, he performed several other public service roles in relation to HCL. These include ‘Chair of the Human Genetics Commission, which advised the UK Governments on ethical and legal issues relating to that field; Chair of the Steering Committee for the UK Brain Banks Network, having chaired the Strategy Committee, which recommended to the UK Clinical Research Collaboration that it should be established’, and a

⁷⁵⁵ Montgomery, ‘Time for a paradigm shift? Medical law in transition’ (2000) 53 *Current Legal Problems*, 363, 364.

⁷⁵⁶ *Ibid* 407.

⁷⁵⁷ Staff Profile, <http://www.southampton.ac.uk/law/about/staff/jrm.page#publications> (accessed: 11/9/2013).

⁷⁵⁸ *Ibid*.

member of the Organ Donation Taskforce, 'which considered the case for introducing an opt-out system for donation in 2008'.⁷⁵⁹

H. KEN MASON, ALEXANDER MCCALL SMITH AND GRAEME LAURIE

For the sake of better appreciation of the role of Mason, McCall Smith and Laurie in the development of the field of HCL, I deem it appropriate to discuss them together. The justification for grouping them together lies in their leading textbook, which epitomises a huge component of their influence on the development of the subject. Mason and McCall-Smith collaborated together in authoring major monographs and textbooks in the field. When McCall Smith retired from active research in HCL, Laurie replaced him in the academic collaborative venture with Mason.⁷⁶⁰

Mason is arguably the first medical doctor and lawyer to have started working in this field during its nascent stages in the early 1980s. As Smith stated in a Foreword to a collection celebrating the contribution of Mason to HCL:

Ken Mason is one of those rare scholars who have mastered a number of quite different disciplines – in his case, medicine, law and bioethics.⁷⁶¹

Mason has authored several monographs, articles⁷⁶² and a textbook in this field and it was thus no surprise that his achievements in HCL were celebrated, as noted earlier. The philosophical underpinning of Mason's scholarship was relatively different from other pioneer scholars. Laurie noted that Mason's scholarship in HCL did not 'doggedly adhere to

⁷⁵⁹ Ibid.

⁷⁶⁰ Information based upon a 'Personal Interview with Professors Ken Mason and Graeme Laurie' in October, 2013. Extract of Transcript of Interview in Appendix 4.

⁷⁶¹ Sandy McCall Smith, 'Ken Mason - An Appreciation' in S McLean (ed), *First Do No Harm - Law, Ethics and Healthcare* (Aldershot: Ashgate 2006) xv.

⁷⁶² Professor Ken Mason, <http://www.law.ed.ac.uk/people/jkenyonmason> (accessed: 16/1/2014).

the mantra of ‘patient autonomy’ but advocated a balance between private interest and community interests.’⁷⁶³

Sandy McCall Smith, on the other hand, was a criminal lawyer who developed an interest in HCL and co-authored the first six editions of *Law and Medical Ethics* with Ken Mason.⁷⁶⁴ The latter was former ‘Chairman of the British Medical Journal Ethics Committee until 2002, the former Vice-Chairman of the Human Genetics Commission of the United Kingdom, and a former member of the UNESCO International Bioethics Committee’.⁷⁶⁵ Lastly, Graeme Laurie⁷⁶⁶ serves as a ‘member of the BMA Ethics Committee’ and most recently, as a ‘member of the Royal Society Working Group on Science as an Open Enterprise’.⁷⁶⁷ He is a ‘member of the editorial teams of the *European Journal of Health Law*, and *Medical Law International*’.⁷⁶⁸ Laurie was ‘the Chair of the permanent UK Biobank Ethics and Governance Council from 2006-2010’.⁷⁶⁹

The foregoing brief profiles of the pioneering scholars in the development of HCL in England and Wales sets a context that will contribute towards our comprehension of their thoughts on the developmental trajectory of the subject, as gathered through an empirical survey, which I now turn to.

5.1.6. FINDINGS FROM AN EMPIRICAL SURVEY OF THE VIEWS OF PIONEERING HEALTHCARE LAW SCHOLARS ON THE HISTORICAL DEVELOPMENT OF THE FIELD

⁷⁶³ 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* (Aldershot: Ashgate 2006) ch 9, 132.

⁷⁶⁴ Alexander McCall-Smith, <http://www.alexandermccallsmith.co.uk/about-the-author/full-bibliography/> (accessed: 16/1/2014).

⁷⁶⁵ Ibid.

⁷⁶⁶ Professor Graeme Laurie, <http://www.law.ed.ac.uk/people/graemelaurie> (accessed: 16/1/2014).

⁷⁶⁷ Ibid.

⁷⁶⁸ Ibid.

⁷⁶⁹ Ibid.

As discussed in Chapter Two, I interviewed seven pioneering HCL scholars as part of the empirical legal research aspects of the thesis. The findings⁷⁷⁰ that I present for analysis and discussion here were derived from responses to questions from four thematic areas, namely:

- the relationship between law and medicine before 1980;
- the surge in academic interest in law and medical ethics post-1980;
- the role of the courts and the legal profession in the emergence of a distinct body of healthcare law;
- potential attractiveness of healthcare law in England and Wales as a potential export to other jurisdictions.

Within the context of these broad themes, other sub-themes also emerged during the interviews, including the question of the discrete status of HCL in the light of its substantial borrowings from other branches of the law and also the nature of the relationship between HCL and ethics/bioethics. Many revealing findings emerged which I proceed to present and analyse. For each sub theme I present the relevant responses of respondents and their analyses before concluding on that particular sub-theme.

5.1.6. . VIEWS ON THE RELATIONSHIP BETWEEN LAW AND MEDICINE BEFORE 1980

Proceeding on the basis of the assumption made in this thesis and justified earlier (in Section 1.5.2) that it was not until after 1980 that a distinct body of HCL gradually became visible, I sought to ascertain what the respondents⁷⁷¹ considered to have been the relationship between law and healthcare or medicine long before 1980. To begin with, all

⁷⁷⁰ See: Section 2.2.3.1. of Chapter Two (above) for how I processed and analysed the data to arrive at these findings.

⁷⁷¹ I succeeded in getting opportunity to interview seven (7) out of the nine Pioneer Scholars that constitute my sample. The other two were not available.

the seven respondents were unanimous about the fact that there has always been some form of engagement between law and medicine. Noteworthy here is that the respondents had different opinions concerning the specific focus of law in its interaction with medicine or health care in that long period before 1980. It is apposite at this juncture to quote each of them before any further analysis is done.

Skegg:

The law has related to issues arising in health care for centuries, e.g. the licensing of various professionals, the law relating to asylums and lunatics, abortion, negligence/manslaughter. There have long been books about the law for medical practitioners, in addition to those on 'medical jurisprudence' (which might now be described as forensic medicine). A search of the index volumes to Holdsworth's multi-volume *History of English Law* would lead you to the statutory regulations relating to the UK medical professions, etc.⁷⁷²

McLean:

Most of the cases that arose before 1980 were more about criminal issues; for example about abortion and that sort of thing. Very few issues that we now regard as mainstream medical law - for example cases on negligence - arose, so there wasn't a national jurisprudence as such except for a very limited body of law. Arguably the majority of activity before 1980 was at the international level, so there were a number of international declarations about using human beings in research and so on, particularly following the Nuremberg Trials; and some of the medical professional associations had a fair amount to say but basically what existed in the way of case law was relatively scarce.⁷⁷³

Grubb:

Before the 1980s, it won't be easy to describe a development of law that systematically dealt with the relationship between doctors and patients or healthcare generally. The law came out of criminal law and it was analysed like that... Actually, what is interesting is primarily, criminal law was how the academic analysed [it], as far as there was any medical law [Sic, if I may say]. In fact, criminal law was rarely used to prosecute anybody in a medical case. There are some famous prosecutions of doctors for unlawful abortion (the *Bourne* case), and the famous case of the paediatrician in 1981 (*R v Arthur*) and also the only thing you heard about them was the trial, because very often, the criminal trial of a doctor ended up in a verdict of acquittal and the summing up by the judge but never got to the appellate court. By contrast, there were medical negligence cases; there were not many though, that went to the court regularly before the 1980s and even

⁷⁷² Extract from 'Transcript of Interview with Professor Peter Skegg, See Appendix 4

⁷⁷³ Extract form ' Transcript of Interview with Professor Sheila McLean, See Appendix 4

before the 1970s, it was just a handful of cases. There was in fact no medical law going on in the court apart from the odd prosecution and a smattering of medical negligence cases; it was completely undeveloped in the courts.

Brazier:

I think that we have neglected the fact that there is a long history of the law's involvement in medicine, if you look back in 16 and 17th centuries, a number of cases went to court between patients and physicians and surgeons; there were also cases where college of surgeons fighting college of physicians. There was quite a lot of discussion in the media about what we call medical law, quite critical of quacks. Once the different medical professions came together in 1858 with Medical Act 1858. And even more as the state took over funding of medicine; there came period when litigation more or less disappeared and there was a period of extreme deference to medics. Although there were cases towards 1950s and beyond; it was the medical gentlemen who must be right. In England lots of people were hesitant to challenge medics with the inception of NHS: most people were so grateful to be able to get medical care free; go to the doctor for free. That gratitude inhibited criticism for a very long time. It seems about 30 years or so; it took a generation to grow up who took NHS for granted. I think medical law went into abeyance for about 100 years and then began to rise in early 1980s...

Mason:

There has always been medical law in so far medicine has always been subject to the law. ..It should be negligence .If people asked you what you mean about medical law, the answer would be the law of medical negligence. The way that medical law was being taught in the universities was by Department of forensic medicine. Forensic medicine was a matter of pathology; I chose to follow it as medical practice. We call medical law here by the title, medical jurisprudence. I started teaching it around 1980s. I taught it with Alexander McCall Smith. Before 1980, you expected your doctor to behave in correct proper way and the effect of Kennedy was to question our original belief in doctors.

Montgomery:

I think the main thing is that the early writing covered quite a lot of things around. The early writing covered lot of things around clinical negligence. On my shelf I do have a 19th century book given by my father years ago. I will start with *Nathan on Medical Negligence* in 1957. I have works from 1970s by Skegg and Kennedy. The works in the 1970s picked issues mainly around the interface between criminal law and medicine. I am not sure if before 1980, it really felt like anything like law relating to medicine. What Nathan's book was about (taking negligence and applying it in a particular context) was not seen as being enormously different; so if

you look at it, it does not cite or discuss the *Bolam* case although it had been decided, so it does not look at an application of tort law in an area.⁷⁷⁴

Laurie:

There are two books which Sheila McLean edited in the 1970s- *Legal Issues in Medicine* and *Medicine, Morals and the Law*. *Legal Issues in Medicine* is interesting book because it is a collection of essays: a lot of them talked about criminal law issues. Before 1980s the law engaged with doctors either in criminal context or negligence law. Indeed, McCall Smith came into medical law as a criminal lawyer and not tort of law. What we have seen is that in the post 1980s we have had less of criminal law as other areas of the law have grown up in broadening their perspectives on the law and medicine relationship. Britain and other European countries were taking a lot of lead from America so lot of it was around litigation but because UK was no very litigious we didn't have a body of law as such.it was something on the radar in UK until Kennedy and Mclean began to question authority of medical profession. I could not have had interested in medical law before 1980s as I was a child. I studied medical law from 1987 to 89. It was immediately after the Sidaway case; same time as the Gillick case; so I think it was very good time to study medical law because they landmark decision was laid down at the time I was interested in the subject; so lots of discussion we had in class was about deference of the court to the medical profession. My degree was in forensic medicine.

- **ANALYSIS AND DISCUSSION:**

The responses of the respondents bring to fore important perspectives that illuminate our appreciation of the situation that was extant before emergence of a discrete body of HCL in the post-1980. In the first place, the relationship between law and medicine was arguably two way traffic so speak. Medical doctors needed to have their profession safeguarded against quackery; thus law aided medicine by introducing a licensing regime.⁷⁷⁵ Similarly, forensic medicine was also needed in adjudication of complicated cases in which the facts contained significant dose of medical issues. Thus, any scholarly reflection on any aspect of

⁷⁷⁴ Extract from 'Transcript of Interview with Professor Jonathan Montgomery, 22/10/2013'.

⁷⁷⁵ See Views of Skegg and Brazier , above.

law and medicine relationship during the early period did not really critique medicine on basis of external standards of acceptable or proper practice as a future discrete body of HCL might seek to do.

Indeed, Skegg, who started writing on topics concerning law and medicine in the early 1970s, was quite emphatic that the existing works at the time did not reflect his vision of what HCL (although he prefers the term 'medical law') was supposed to be addressing. Indeed, he clearly sounded frustrated with the situation in those days since the works at the time, including those of 'medical jurisprudence', only sought to facilitate an understanding of how medicine could benefit legal knowledge and its application rather than how law could be utilised as a vehicle to direct medicine to serve our needs. Skegg's assessment of type of scholarship dealing with law and medicine in the pre-1980 finds corroboration in Brazier's view that the courts as well as authors at the time deferred to 'the medical gentleman'.⁷⁷⁶The views of Skegg and Brazier can be taken to represent the picture of the era of excessive deference in HCL.

Moreover, legal academic exploration of issues pertaining to law and medicine during the period under consideration was done predominantly as part of criminal law scholarship. This finding is evident from views of McLean, Grubb, Montgomery, Laurie and inferentially from views of Skegg and Brazier. Obviously lacking in such an academic approach to law and medicine in the pre-1980 is scrutiny of medical power vis-a-vis patient empowerment. Thus, it is reasonably plausible that courts, lawyers and even academics writing in the area engaged with healthcare issues without necessarily appreciating that the matters at stake deserved to be approached differently from other problems dealt with by the law. As Foster and Miola note 'medical law is complex...since it should reflect the complexity of its

⁷⁷⁶ See Views of Brazier quoted above

astonishing subjects, human beings.⁷⁷⁷ It is not only criminal law that was employed in the law and medicine relationship during the period. As Montgomery, Brazier and Grubb pointed out there were also some civil cases but were dealt with by courts and academic commentators through routine analytical framework of traditional law particularly tort. The treatment of civil cases in the context of healthcare like any other civil matter demonstrated that the law was insensitive to peculiar challenges in this area such as the disequilibrium of power in the doctor-patient relationship, excessive medicalisation of otherwise non-technical medical matters.

For example, *Bolam* was decided in 1957 and established an important principle which remained in abeyance until 1980 when the House of Lords gave imprimatur to it in *Whitehouse v Jordan*.⁷⁷⁸ It is instructive to note that once HCL became visible as a discrete body of law, *Bolam* became a touchstone for any discourse on the doctor-patient relationship and many other areas of the field. Indeed, many areas of HCL are said to have been victims of 'Bolamisation' or 'Overt Bolamisation'.⁷⁷⁹ Thus, as Montgomery has noted above, for a dedicated book on medical negligence to have been published in 1957 without any discussion of a principle within a case that would later principle pervasive principle in HCL discourse, reinforces the observation that the law and any scholarship around prior to 1980 confined issues from the interface between law and medicine to the doctrinal frameworks of the traditional areas of the law.

The nature of the law and medicine relationship prior to 1980 warrants some explanation as to why the situation was the way it was. When respondents were invited to

⁷⁷⁷ Foster, Miola, n 723 above, 517.

⁷⁷⁸ [1981] 1 WLR 246 at 258, as per Lord Edmund-Davies.

⁷⁷⁹ See M. Brazier and J. Miola, 'Bye-Bye Bolam: A Medical Litigation Revolution?' (2000) 8(1) *Medical Law Review* 85.

attempt to provide justification for the state of the law-medicine relationship one of them (Skegg) decline and rather stated that such a question necessitates a 'whole PhD thesis'.⁷⁸⁰ Several rationales were given by the other respondents who addressed this aspect of the interview. Brazier argued that :

... People were much less likely to litigate generally; so we moved gradually towards much more litigious society. Social attitudes began to change; between 1950s in England, vast majority of people had very conservative values; vast majority attended some sort of church so views on things like sexual conduct; family life were very much uniform and the other factor was gradually development of medicine created all sorts of new dilemmas which did not exist before.⁷⁸¹

It is worth pointing out that Brazier remarked that beyond 1950 social attitude began to change. Brazier's rationalisation of the nature of the law-medicine relationship during the period finds support in an account given by McLean that:

Patients in those days were much less likely to challenge clinical decisions and the culture of medical paternalism was still very powerful in those days; so patients, I think, in a sense colluded with that and simply didn't challenge when things went wrong; there wasn't a culture of openness among healthcare professionals. And so there was no obvious reason for the law to become engaged because there wasn't a big volume of people actually registering complaints about the way that they have been treated in the healthcare system.⁷⁸²

The conservative social attitude that made people unlikely to often challenge wrong treatment in their clinical experience as Brazier and McLean cited was further reinforced in Grubb's account when he stated that:

There was much less interest by the general public in how doctors behaved. Doctors were seen as central figuring in medicine with patients; much less public interest in questioning what they did; doctors were the kings of their castle; masters of their real; kings of the realm, therefore the courts and lawyers through litigation rarely became involved. If something went wrong it was rarely challenged in the legal way.⁷⁸³

Thus, while three respondents were generally in agreement that conservative social attitude of not challenging noble profession of medicine accounted for the state of law and medicine

⁷⁸⁰ See Skegg's Interview responses in Appendix 4

⁷⁸¹ Extract from 'Transcript of Interview with Professor Margot Brazier, See Appendix 4

⁷⁸² Extract from Transcript of Interview with Professor Sheila McLean, See Appendix 4

⁷⁸³ Extract from Transcript of Interview with Professor Andrew Grubb, See Appendix 4.

relationship pre-1980, Skegg found it impossible to provide reasons without a major research but the remaining three respondents (Montgomery, Mason and Laurie) postulated that there had not been any critical societal awakening concerning a demand for accountability over medicine until Kennedy's BBC Reith Lectures, 'The Unmasking of Medicine'.⁷⁸⁴ Grubb had similar conviction when he remarked that 'Kennedy's *The Unmasking of the Medicine* started to cause society to think about doctors and whether their decisions should be challenged and if so how should it be questioned.'⁷⁸⁵ This consensus reinforces my earlier argument in Chapter 1 that the publication of 'The Unmasking Medicine' was crucially catalytic in stimulating scholarly reflections on themes that eventually crystallised to become subject matter of the discipline of HCL.

It has been demonstrated from the views of the seven respondents that there were some interactions between law and medicine. Cases presented from medical practice to law were not differentiated in any significant way from how the law dealt with all other cases. Academic reflections on law and medicine prior to 1980 were not concerned about proper boundaries of medical power and issues of patient empowerment. Indeed, writing in the area of law and medicine relationship was often done by members of the medical profession so much so that works by non-medical scholars were the exception rather than the norm. There is a consensus among pioneering HCL Scholars that the posture of law as well as scholarship regarding law and medicine relationship were very deferential towards medicine. A very important inference worth drawing from the views of the respondents, especially Brazier, McLean and Grubb suggest that social change is relevant for law to be in proper disposition to hold medicine to greater accountability which advances patient empowerment against excessive medical paternalism. Having clarified the situation during

⁷⁸⁴ See Transcript of Interview, Appendix 4.

⁷⁸⁵ Extract from 'Transcript of Interview with Professor Andrew Grubb, Appendix 4.

the long period pre-1980, it has set the scene for us to appreciate the thoughts of the pioneering scholars regarding the law-medicine relationship post 1980.

5.1.6. B. VIEWS ON THE SURGE IN ACADEMIC INTEREST IN LAW AND MEDICAL ETHICS POST-1980

A number of strands are embedded in this broad theme pertaining to surge in academic interest in the field post 1980. First, the pioneering HCL expressed their views on whether there had really been an appreciable increase in academic interest in HCL and medical ethics post 1980 Skegg, who presented written responses via email, stated:

The interest was developing in the 1970s: e.g. Ian Kennedy's BBC radio programmes and his being invited, though a mere Lecturer at that stage, to deliver the Reith Lectures. The invitation, and the lectures themselves, can be seen both as a symptom and as a cause. Ian's Reith Lectures were very significant in the UK, but I suspect less so in the USA, where Bioethics was born in the 1970s (if I understand it aright).

There are many reasons for the surge, but in terms of the law they include the growth of UK law schools and in numbers of academic lawyers and graduate study; the fashion for taking on subjects that were not already dominated by major academics; and the much greater recourse to the courts to deal with medico-ethical dilemmas, which was linked to the increased willingness of the courts to deal with matters prospectively. (The introduction of RAE/REF may also have added to the incentive to move into new fields.) Incidentally, one way of measuring the increased academic interest in medical / health care law would be to look at the "Special Interests" listed by UK members of the SPTL/SOLS in the Annual Directory at (say) 5 year intervals.⁷⁸⁶

McLean also agreed that the post 1980 period really marked a surge in academic interest and explained that:

It is difficult to work out why. I think in part it was probably because other academics knew it was happening, a couple of courses were running and students interest was enormous with over subscription by students, and there was increased coverage of medico-legal issues on the television and the news. I think there was perhaps also a bit of student pressure; once people were aware that the subject was being taught; it persuaded other academics that the subject was worth pursuing. I did not have problem in trying to get publishers but I had problem trying

⁷⁸⁶ Extract from 'Transcript of Interview with Professor Skegg, See Appendix 4

to convince colleague to embrace the discipline. It was not accepted very comfortably by lots of academics in the early days.⁷⁸⁷

Like Skegg, Mason remarked that:

There has always been medical law in so far as medicine has always been subject to the law. What you are referring to here is medical law as an organized discipline or subject on its own. If you're talking about medical law as a discipline then I have no doubt that it was the series of lectures given by Ian Kennedy which aroused peoples' minds and marked the start of the subject. The lectures aroused peoples' minds as to different views of medical law rather than just as a matter of medical negligence... If you like, the lectures made people see medical law not just as negligence but rather a matter of medical ethics. At the same time and quite fortuitously, the subject was being developed in Scotland by Sheila McLean in Glasgow. She had also started writing on medical law in the early 1980s. Nonetheless if you look back those writings were important. *Kennedy published the Unmasking of Medicine in 1981. Kennedy is still the one who started the discipline of medical law.*⁷⁸⁸ ...the effect of Kennedy was to question our original belief in doctors.⁷⁸⁹

For Brazier the new field was bound to excite academic interest because:

There is so much to do. All things you have talked about before changes. Changes in medicine, technology and society. So it needs lots of people to address all those questions. More and more academic lawyers and professional practitioners became much more socially aware, much more interested in the kind of law not much more akin to property law, contract etc. The influx of women into academia made quite a lot of difference. Of the younger generation of medical lawyers I will say two thirds are women and I think they are the very successful ones. For what I am going to say I have to be cautious because of my feminist colleagues but I think just as in medicine you see women becoming pediatricians so in medical law lots of women came in; although there are women who are wonderful commercial lawyers and similarly male colleagues who are wonderful medical lawyers. The subject matter attracted women. One of the things medical law does for academics in a way not all other areas of law does; it offers opportunity for you to do things outside the university system. You get opportunity with Department of Health, medical profession, Ministry of Justice.

Grubb in his response stated that:

There was demystifying of the role of professionals in society and so challenging professional judgment was suddenly not a taboo; doctor and nurses making profound decisions, which have profound effect on people. I think it was par to the

⁷⁸⁷ Extract from 'Transcript of Interview with Professor Sheila McLean, Appendix 4

⁷⁸⁸ Emphasis added.

⁷⁸⁹ Extract from 'Transcript of Interview with Professor Ken Mason and Graeme Laurie, Appendix 4

demystifying professional in general. Academic interest in medical law grew slightly ahead of people litigating over it. It was just lawyers here. There was stream of academic interest by others medical ethics, philosophy. A very distinguished moral philosopher Jonathan Glover was interested long before that. His book *Causing Life And Death* is a classic. It was equivalent of Skegg's book on Law and Medicine. Peter Skegg was a very distinguished academic and his work was both authoritative and settled. He contributed enormously to development of medical law in the common law world. He taught in UK at Oxford substantial part of his career.

My concern was simply that Skegg was fundamentally a criminal lawyer and viewed at medical law from criminal law perspective and there was nothing wrong with that; but when I was starting I was trying to do that through the eyes of other areas in medical law. So Skegg's book is absolutely definitive on criminal law perspective. But I am interested in broadening our understanding of medical law from A to Z whereas Skegg's work comes with much nuanced authoritative analysis from point of view of criminal law.

Similarly, Montgomery says:

I think what changed in the 1980s is because of Ian Kennedy's Reith lectures. He argued that there was a common theme. I will say the *Unmasking of Medicine* is the starting point. *The Unmasking of Medicine* is interesting because it was not particularly well received by doctors or medical sociologists who didn't think it would be helpful or it was something new, but it had massive impact on legal scholarship so it suddenly became a subject in its own right on that basis. Kennedy's book is really important because it opened up the subject to lawyers. When I reviewed Kennedy and Grubb *Text and Materials*, I did say that it did not really live up to the promise of *The Unmasking of Medicine* as it did not address public health issues which were largely scratched over. I was strongly influenced by *The Unmasking of Medicine* and what I did was a reaction to what I didn't like about it so I will put that down as the lynch point. *The Unmasking* made it clear that the subject was neither for lawyers alone nor doctors alone. The lectures were a public forum. I think a second publication which is crucial is Mason and McCall Smith, 1980/81 because what did was to make it possible to teach medical students because you had a textbook. I was not doing that because I only came in the mid-1980s and teaching. But I think you see an interest in medical schools in trying to work out how to respond to medical teaching so there was Pond Report towards the end of 1980s which consider what syllabus might be in teaching medical law in the medical schools. I think one of the key people was a priest from Edinburgh. So I think on the legal side Ian was actually crucial because he gave an identity. I think Mason and McCall Smith developed something which medical schools to develop a syllabus and so it will be wrong to say that the medical people did not respond; I also think the BMA was really important so they had their hand book which began to grow in to something which would help people work out what to do. So at that stage you had the GNC which had its blue book which told you what will get you into trouble. These were all handy in the 1980s so people began to have interest and so they became literature in the 1980 in way that wasn't previously. If you look

at the journals you had medicine, science and the law-- a lot of it was about medical aspect of criminal law cases but it was not about legal aspect of medical practice and in the 1980s what you get is the legal aspect of medical practice and training. so I will tract it through the hand book of medical ethics and you will see how that expands and later on in the 1990s what the GMC did - emergence of good medical practice was quite significant. But I think in the 1980s it was led from the BMA and I think they had a key role to play in their medical ethics department did that.⁷⁹⁰

Laurie, who is relatively new compared to the other six Pioneering Scholars observed that:

In the 1980s there were not that many medical lawyers that you know about - Kennedy, Brazier, Grubb, McCall, Mason, Sheila. The real explosion was in the 1990s and after 2000. I think the passing of the HRA 1998 is an important date because that was the year in which HL decided the Bolitho case- the first time that court began to say we need to control standard of care for medical profession.

Historically, medical law has been a marginal aspect of family law; human rights etc. There are still few chambers that specialize in medical law but that is changing. If you look at the court particularly the HC in E & W; over the last 50 years they have taken interest I particularly in certain core concepts but I am not sure that in itself is a good thing; I think the courts are becoming more paternalistic particularly if you look at the Judge Munby, now Lord President; He has a particular view of medical law which has been influential in shaping medical law in England and Wales. His contribution is open to critique; I think he has a very particular view on dignity, autonomy. I f you expose those views to other disciplinary perspectives especially bioethicists and philosophers' they will have very much to say. I think he has very much driven the court's intervention in medical law. Media has been actively reporting on medical law; there has been number of parliamentary intervention. So the profile of medical law has been raised for bad reasons: so that medical law has to come in a very reactive way. There are also number of scandals - organs; tissues etc. In a positive sense I think law schools have come to realise that actually human health is such a fundamental part of the human condition that we have got to engage with the role of law in protecting and promoting human health and wellbeing; and actually medical has been seen as a very marginal area but if you look at the discipline you have to involve almost all areas of the law- private law; judicial review; public law; international law- thus medical law is incredibly rich and multi-dimensional.so medical law has progressed from being marginal area at the edges to the centre of law's role in society and teaching.⁷⁹¹

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⁷⁹⁰ Extract from 'Transcript of Interview with Professor Jonathan Montgomery' 25/10/2013.

⁷⁹¹ Extract from 'Transcript of Interview with Professor Laurie' 15/10/2015.

Mason's remarks are quite significant in seeking to situate the beginning of the discipline in time and space. This is particularly true since Mason and McCall Smith had published the first edition of their book in 1983. Furthermore, it is evident from the above quotation that in terms of the scope of HCL in the period before 1980 it was no more than medical negligence and some criminal law implications of certain aspects of medical practice. Another significant finding is that, according to the pioneering scholars in the field, the development of HCL as a discrete body of law can be traced to just after 1980 when Kennedy gave his 1980 BBC Reith lectures, which, as already noted, were subsequently published as *The Unmasking of Medicine* in 1981. Although the respondents were unanimous that HCL as a legal field developed post 1980, it needs to be emphasised that none of them can be taken to have meant that HCL as at 1980 or even a year or two later had attained all the defining characteristics as considered earlier in Chapter 3. On the contrary, a proper interpretation of their responses regarding the commencement date of a distinct body of HCL is a period necessarily beyond 1980. Apart from McLean and Brazier,⁷⁹² all the other five respondents mentioned that the Reith lectures and ensuing publication constitute a watershed in the emergence of what some prefer to call 'modern medical law.'

From Montgomery's response, two pertinent inferences may be drawn. One is that he considered Kennedy's *The Unmasking of Medicine* as not only opening up the field of HCL to lawyers but also serving as a blueprint (or 'manifesto') of what academics and legal policymakers ought to be reflecting in their works in the field. The other inference is Montgomery's disappointment at what might appear to be Kennedy's lack of commitment

⁷⁹² It does not necessarily mean that these other two object to suggestions made by the five since there was no direct question on that.

in not sticking to the ideals of the *Unmasking of Medicine* in his later major work with Grubb, *Medical Law: Text and Materials*.⁷⁹³

Since it was accepted by all the respondents that the discipline became sufficiently visible after the 1980s, I was curious to comprehend a possible explanation for the apparent lack of challenge to medical dominance and its allied paternalism, which had prevailed during the long period prior to 1980. This line of inquiry generated interesting responses, mainly from McLean, Grubb and Brazier, as the rest did not address this aspect of the question directly.

Brazier responded elaborately that:

As the state took over the funding of medicine, there came a period when litigation more or less disappeared and there was a period of extreme deference to medics. Although there were cases towards the 1950s and beyond, it was the medical gentlemen who 'must be right'. In England lots of people were hesitant to challenge medics with the inception of NHS: most people were so grateful to be able to get medical care free; to go to the doctor for free. That gratitude inhibited criticism for a very long time. It seems it took about 30 years or so before a generation grew up who took the NHS for granted. I think medical law went into abeyance for about 100 years and then began to rise in the early 1980s. There are several different reasons. People were much less likely to litigate generally, so we moved gradually towards a much more litigious society. Social attitudes began to change; between the 1950s in England, the vast majority of people had very conservative values. The vast majority attended some sort of church so views on things like sexual conduct and family life were very much uniform and the other factor was that gradually the development of medicine created all sorts of new dilemmas which did not exist before... As social cohesion lessened, people began to possess different views on morals. Thus you begin to get case like *Gillick* - challenging contraceptives to an unmarried young daughter- If the case had been heard in 1950s, it would have been laughed at; the idea that an unmarried 16 year old can get access to contraceptives in 1951 would have been just too awful to go into the newspapers. And the development of different forms of medical technologies and procedures likes transplantation. It is not one thing but different things happening almost at the same time - changes in social attitudes and changes in medicine.⁷⁹⁴

⁷⁹³ (London: Butterworths 1989).

⁷⁹⁴ Extract from 'Transcript of Interview with Professor Margot Brazier, 22/10/2013'.

Pulling all these responses together, one key finding that can be established is the perception amongst pioneering scholars that the reluctance or failure of patients to challenge their dissatisfaction with healthcare in the period 1948 – 80 could be attributed to their gratitude for free healthcare via the NHS, creating a culture of solidarity as well as a more conservative social attitude during the period.

Additionally, the survey also revealed a variety of reasons to explain why the pioneering scholars developed an interest in this field. The majority of those interviewed attribute it partly to accident and others due to their passion for human life, which is the site of interaction between law and medicine in this subject. This finding is buttressed by their diverse responses. First, Skegg states that:

I first started researching in this area in 1966, as a law student in New Zealand. In 1969 I published an article arguing for what came to be called *Gillick* competence... I commenced doctoral research in this field at Oxford in October 1969, and continued with this full-time until I became a Fellow of New College Oxford in October 1971. English health care law (though we didn't use that term then) remained my main research and publishing activity until 1984 when I returned to New Zealand to become a Professor of Law at the University of Otago... My interest in the subject dates from 1966... 1966 was the year when my teenage girlfriend (since late in 1963, and now wife for most of the 50 years following) started her nursing training. So one element... was hearing about the issues she was faced with on the ward and seeking, as a law student, to work out their legal ramifications. But there was more to it than that. I was puzzled by the attitude to abortion in the circles in which I moved, so [I] made use of the opportunity, to write a research paper on that topic. This contributed to my interest in this area of the law. My interest was also fostered by reading... Glanville Williams' *Sanctity of Life and the Criminal Law*... Had I agreed with all of it, and an article on consent issues published the previous year in *Med Sci Law*, I doubt if I would have been stimulated to continue in the field. I soon found other fascinating publications, most importantly the proceedings of a CIBA Foundation seminar edited by GEW Wolstenholme and M O'Connor *Ethics in Medical Progress* (1966)...⁷⁹⁵

According to McLean:

It was some sort of accident. I was working at the time in the Forensic Medicine Department and for my then professor, the department always did a little bit of

⁷⁹⁵ Extract from 'Transcript of Interview with Professor Peter Skegg, 29/10/2013'.

teaching to law students and he suggested that we should expand the amount of teaching that we did and basically told me to go and venture a course and so it was very much an accident that brought me into it. I suppose that I have always see medical law as a kind of human rights issues and so I think I wanted to explore from the kind of angle that I was particularly interested in.⁷⁹⁶

Grubb recounted his entry into the field as:

When I first started teaching in the Cambridge in the early 1980s in the law school; there had been long time an elective course for medical students started by Glanville Williams' it was popular for medical students. Because it I had been started by Glanville; it was run by the law faculty so when I got there I was asked to take it on by running. Because I was teaching criminal law. I was criminal lawyer and a tort lawyer; administrative law lawyer because we have the NHS by the government. So I had three main interests that might have worked. There was no medical lawyer so I took it on. Gradually I got interested in it. The courses consisted of few lectures from me and guest lecturers by people from medical background and lawyers including Ian Kennedy. On evening in a bar I said to him I was trying to write a book on medical law and he accepted that we should write to ether and first edition came out in 1989. The reality it the more I got into it the more I became a medical lawyer. Within 6 years I really got into it and did lots because the materials were accumulating so there were lots to grapple with. After 5 or 6 years I called myself medical lawyer because I wanted to do. I started a course with colleague in Family; which was becoming popular children's interest etc. We started an elective in 3rd year for law students in Cambridge in 1986 or 7 thereabout.⁷⁹⁷

Brazier explained how she ended eventually in this field:

I got interested in late 1970s; my work was in professional negligence generally. So I wrote a paper on solicitors and surveyors; I got to doctors and I found that it is so much more interesting and I started to read Canadian cases on informed consent and that gradually urged me into medical law. I think I wrote my first article on "Informed Consent to Medical Care" I wrote it during my maternity leave in 1979 (but it might have been published in 1980). It was based largely in Canadian cases because there was very little English law so gradually I became interested in it. One thing about medical law is I met and worked with people who are not lawyers. So I met John Harris, Tony Dyson, and Dr Mary Lobjoit who was fantastic pioneer insisting that we should teach medical ethics to medical students. So combination of these things got me interested in medical law.⁷⁹⁸

Montgomery also explained that:

A lot of my career has been about being at the right place at the right time. And the reasons why I am interested in it were a mixture. One was that by then my

⁷⁹⁶ Extract from 'Transcript of Interview with Professor Sheila McLean, 16/10/2013'.

⁷⁹⁷ Extract from 'Transcript of Interview with Professor Andrew Grubb, Appendix 1

⁷⁹⁸ Extract from ' Transcript of Interview with Professor Margot Brazier, Appendix 1

girlfriend (now my wife) was training as a nurse while I was a student so I did my undergraduate course in 1980-83. I did a one year LLM... that was about the time that the *Unmasking of Medicine* was coming out as a book. I was also interested in the issues around ethics because at that stage I was expecting not to stay in legal academia for very long, I had a place in theological college to study theology in order to be ordained in the Church of England. So I had an interest in life and death issues and these sorts of big ethical questions about how we value life. So I started being interested in a combination of the teaching needs and a little bit of personal need. My academic research interests at that stage were around children rights so another aspect of accident was that at the time the *Gillick* litigation was going through, I was mainly teaching family law with an interest in children's rights. So I started working on *Gillick* from the point of view of there is a case about children's rights and I realised that raised issues about children rights and parental rights and how they merge together. And of course I started teaching what was then a medical law and ethics course. I used that as a sort of case study so it became a medical law case.⁷⁹⁹

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It stands out clearly from Montgomery's response that he came into this field of law for two main reasons. One was his remote interest fuelled gradually by HCL-related questions that he had to answer from his partner who was training as a nurse at the time. The other major reason was his dissatisfaction with how the leading light on the academic status of HCL, Ian Kennedy, had presented the subject to the public and legal academy in the 1980s. This particular motivation has been consistently evident in the way Montgomery has developed his vision for the field of HCL through his scholarship and public service roles. For example, he has on various occasions and in different contexts criticised Kennedy's type of HCL, which proceeds from a prior postulation about the doctor-patient relationship and rather contends that the proper emphasis of the subject ought to be on ascertaining and shaping the actual norms of the healthcare system that dictate the realities of HCL.⁸⁰⁰

⁷⁹⁹ Extract from 'Transcript of Interview with Professor Jonathan Montgomery, Appendix 4.

⁸⁰⁰ For example, see: J Montgomery, 'The Legitimacy of Medical Law' in S McLean (ed), *First Do No Harm: Law, Ethics and Healthcare* (Aldershot: Ashgate Publishing 2006) 4; J Montgomery, J Montgomery, J Montgomery, 'Time for a paradigm shift? Medical law in transition' (2000) 53 *Current Legal Problems*, 363; J Montgomery,

Grubb, on the other hand, has pursued an academic career in HCL largely as a result of his fascination with the interface between law and science (in particular medicine). He states that:

I happened to come into [medical law] because of the course I was asked to run so I got a kind of eclectic interest in law. I have never been interested in just tort, criminal law, etc. I like to mix and match if I can. So, medical law was relatively untouched in terms of systematic analysis and I had to borrow from different areas of the law; this suited my academic personality. I read science in secondary school. *I was generally interested in the scientific area. So I became quite interested to the extent that I could do it to master what was going in the medical field as well especially reproduction genetics which was quite technical; so I liked the background factual areas which were coming up rather than being interested in bridge building or planning. [I was] not really interested in that.*⁸⁰¹

5.1.6. C. VIEWS ON THE RELATIONSHIP BETWEEN HCL AND MEDICAL ETHICS

Additionally, empirical research has explored the views of pioneering scholars on the perceived relationship between HCL and medical ethics in England and Wales. Apart from Skegg all the respondents had something to say that was relevant to this issue. Respondents that I encountered face to face were able to provide relatively detail responses due to interactive conversation. For instance, Grubb points out that:

One area that judges have been dutiful in is in the area of moral issues, which is conventionally for moral philosophers and this is purely coincidental. Lawyers don't have any expertise in moral philosophy; some do but it is not because they are lawyers, but because they were interested in it. That is equally true for judges and so when issues are debated in the two professional realms - law and philosophy, the interaction between them is quite difficult for judges and you can see that in cases like the persistent vegetative case of Tony Bland or the conjoined twins case. When they are presented with pure argument based upon philosophy it is difficult for the judges to adjudicate because that is not what they do or where they came from; and perhaps it is not what the court is about but it is almost impossible to think about the problem of what you do in the conjoined twin case (one will die or one will survive in the operation) or the withdrawal of artificial hydration and nutrition from a PVS patient. It is difficult to see without looking at both sides, so

Health Care Law (Oxford: Oxford University Press 1997); J Montgomery, 'The Compleat Lawyer - Medical Law as Practical Reasoning: Doctrine, Empiricism, and Engagement' (2012) 20 *Medical Law Review*, 8.

⁸⁰¹ Extract from 'Transcript of Interview with Professor Andrew Grubb, 22/10/2013' (emphasis added).

you get some judges looking across from both disciplines to help them with their legal arguments.

Montgomery remarks that:

I think one question we have not adequately answered yet which HCL is now increasingly vexed by is the law and moral problem. When I wrote a piece entitled 'The Legitimacy of Medical Law' in 2006, I began to realise that the whole enterprise revolved around Ian Kennedy... The impression was that we must first guess what should happen in healthcare and then use the law to ensure that the doctors did that. So there was a debate about whether the question of what is the right thing to do was separate from the question of what doctors should do; and further, whether there was no such link between the two. I described that as some kind of hierarchy, the applied philosophy deals purely with what is the right thing to do and law is a tool you used to make sure that practice operates like that. And if you think a bit like that then the law and moral problem - when can we enforce morality? - should be answered because we don't generally believe that you can move straight from taking a moral view to imposing this on people who think differently. So that is how I began to think: that if that is how I understand Ian Kennedy's version of the subject, to make it work I need to solve this... *So when you look at how the law really operates it doesn't simply translate our views on the right thing to do, and it isn't to make doctors do it.* And one of the reasons it does not do that is it assumes that doctors are already engaged in that enterprise of trying to do the right thing. One of the problems that needs to be solved is when can we justify using the coercive power of law in areas that in a plural society we don't agree on. I don't really have an answer to that yet... *What I have found myself doing is actually being involved in public engagement. In... 'Law and Demoralisation of medicine,' I noted that people like Ian Kennedy, Margot Brazier, and Sheila McLean had all done similar things. McLean had been involved in the post Diane Blood debate, Margot has been involved in the Retained Organ commission after the Alder Hey Scandal; Ian had done Bioethics on Xenotransplantation.* So I thought this is something academic lawyers have been doing and it is not the same as working out in abstract what the law should be. It is not quite the same as telling doctors what to do; it is about engaging in a deliberative process to try and work as a society in improving our understanding of things so that it connects law and ethics in a different way.⁸⁰²

According to Brazier:

There could be tension at the moment within judicial system... on the issue where medical law interact with social values or morals again there is tension; between very conservative judgement and hands off judgement like Mr Justice Munby on the morning after pill saying that the law has no business here. The increasing difficulty in bringing claims; abolition of legal aid so ordinary medical negligence case is going to become very difficult. Government wants to make it much more difficult to bring claim to judicial review so cases in which people challenge allocation for health care resources are going to be much more difficult... And there

⁸⁰² Extract from 'Transcript of Interview with Professor Jonathan Montgomery, 25/10/2013' (emphasis added).

is a tension in relationship between religion and medical law; that seems to me a fact that states have to account of religion⁸⁰³

Mason briefly stated that:

I think medical law is interesting because it makes us [sic: ask] deep questions about how much law can be an effective social tool... There may be some assistance from legal analysis ...to the health professionals [sic: when they have to] take very difficult decisions. That might be good area but I resist in being too dogmatic about the role of law in the development of medical jurisprudence.⁸⁰⁴

McLean also endorsed involvement of the law court in matters relating to medical ethical disputes when she stated:

The engagement of law in this area is extremely important and I cannot think of another forum when you can obtain disinterested decisions I think the role of lawyers is important in this area; it is not always interested in the way I would like but at least it provides an independence forum for addressing these questions so I am in favor of the law continuing to be involved in resolving these disputes.⁸⁰⁵

Laurie remarked that:

If you want to develop deep medical jurisprudence you need different discipline to work together; you need to ask when law should intervene in medicine and when is it appropriate to leave matters to medical discretion. So what I have been interested in is that question of limits of law in medicine.⁸⁰⁶

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Significantly, there was unanimity among the respondents that HCL is inextricably linked with bioethics/medical ethics, despite the truism that the courts are not experts in dealing with moral issues. Thus, Grubb reinforces the inevitable intercourse between HCL and medical ethics in grappling with cases that straddle law and morality. Even where judges clearly point out that it is law that they have to apply in such controversial cases, it is still possible to see moral deliberations lurking in the backdrop of their reasoning.⁸⁰⁷

⁸⁰³ Extract from 'Transcript of Interview with Professor Margot Brazier

⁸⁰⁴ Extract from 'Transcript of interview with Professor Ken Mason.

⁸⁰⁵ Extract from Transcript of interview with Professor Sheila McLean.

⁸⁰⁶ Extract from Transcript of Interview with Professor Graeme Laurie.

⁸⁰⁷ *Re A (children) (conjoined twins: surgical separation)* [2000] 4 All ER 961 is a prime example of this.

This interconnected legal and moral thesis in HCL was further acknowledged by Montgomery, but in the form of thinking from lawyers and medical professionals, as well as the wider society through the combined realities of medical practice and medical advances, in order to yield regulatory policy outcomes that mediate any contested ethical positions on a matter. Thus, Montgomery rationalises the link between HCL and ethics in a unique way. He concedes that HCL cannot avoid the issue of medical ethics or contested moral positions in healthcare. Neither should these conundrums be avoided until they rear their heads in litigation, nor should it be left to HCL scholars and bioethicists to merely speculate and find some sort of a priori panacea which may not necessarily coincide with the realities of medicine. A preferable approach, according to Montgomery, is a pragmatic one which involves all stakeholders reflecting on the actual experiences of medical practice vis-à-vis medical advances through the prism of various moral positions in a morally pluralistic society.

It appears from the various responses that there are two schools of thought regarding what the relationship between HCL and medical ethics (and perhaps morality generally as Respondents use the two words without precise definition) ought to be. Montgomery, Laurie and Mason appear to suggest that medical ethics ought to be dealt with largely out of direct involvement by the law. In other words, these three Pioneering scholars seem to prefer minimalist approach for law as far as ethical issues in healthcare are concerned. Such an approach tend to assume that the law and for that matter law courts are not better than health care professionals in resolving ethical dilemmas in medical practice and medical advances. However, these Respondents did not draw clear boundaries between three HCL '(medical law), medical ethics and medical morality' as Foster and Miola

have helpful done in their recent profound analytical article.⁸⁰⁸ On the other hand, McLean, Grubb and Brazier belong to school thought which holds that law (and for that matter the law courts) are better suited to be final say in cases or situations of medical ethics contestation. Their preference for leadership role of the law in medical ethics controversy seem to be premised upon their recognition that the law court can be a more neutral ‘umpire’. This approach coincides happily with the strong case made by Foster and Miola in their article aforementioned. Nevertheless, McLean, Brazier and Grubb have also not clarify the senses in which they use the concepts- ‘medical ethics’ and ‘morality’- as Foster and Miola have done in their article.

5.1.6. D. VIEWS ON THE STATUS OF HCL AS A DISCRETE FIELD OF LAW

As a follow-up to the issue of the connection between HCL and medical ethics, I asked the respondents whether HCL can actually be considered as a discrete field of law at all since it borrows almost all its rules from other branches of law. This yielded interesting responses from respondents. According to Brazier:

Medical law cannot claim strictly any particular principles of law as exclusively its own but we have got the foundational laws which create the building blocks of the legal system; tort, contract, equity, land law. *Then we have got next part of lawyers training which is to apply the law to a crucial area of human life which may be family law, medical law, and employment law. So we have got a kind of the founding blocks and law and so medical law is law.*⁸⁰⁹

A similar response was given by Grubb. As far as he is concerned:

Like many subjects, Property law [for example], is probably not breakable down to its own constituents. It is a bit like fundamental Particles in Physics: most particles are made up of the particles yet they look different. Proton neutrons are made up of quarts. Likewise there are quarts in law; and most law is either of neutron or proton particle size, so to speak. Medical Law is really a blend of other things but it

⁸⁰⁸ C. Foster, J. Miola, ‘Who’s in Charge? The Relationship Between Medical Law, Medical Ethics and Medical Morality?’ (2015) 23 *Medical Law Review* 505, 529.

⁸⁰⁹ Extract from ‘Transcript of Interview with Professor Margot Brazier, 18/10/2013’ (emphasis added).

is its own unique blend of other things and that is why it is medical law. You have to know more about other things before you can know medical law.⁸¹⁰

Laurie on the other hand opines that:

In a positive sense I think law schools have come to realise that actually human health is such a fundamental part of the human condition that we have got to engage with the role of law in protecting and promoting human health and wellbeing; and actually medical law has been seen as a very marginal area but if you look at the discipline you have to involve almost all areas of the law- private law; judicial review; public law; international law. Thus medical law is incredibly rich and multi-dimensional. So medical law has progressed from being a marginal area at the edges to the centre of law's role in society and teaching.⁸¹¹

Mason also responded in similar terms:

Although we have always had criminal law but civil law engagement of medicine has increased during the last 30 years. There are core concepts and values that hold the different aspects of medical law together: the notion of autonomy; human health' dignity ' wellbeing; best interest; caring. These all require particular consideration of how law actual operates to protect human being and their health. We have dev rich conceptualisation of dignity and autonomy; necessarily to lawyers and the courts but through the multi-disciplinary working we have come to appreciate far better what these concepts mean for human flourishing so I think these concepts sew medical law together rather than saying it is just aspect of contract; tort or any other areas of the law.

According to McLean:

... Medical law has now developed a lot of jurisprudence that makes it able to claim to exist as a discipline. In the early stages, there was much more overlap with other areas of law, such as family law. When I started it was difficult to decide on what topics to include, because it was not being taught in the UK. So it was difficult to decide on topics to include. But with advances in medicine like human reproduction, end of life care and genetics, I think there is a distinct jurisprudence which non-medical lawyers will not necessarily be familiar with, so it is a subject that can claim its own jurisprudence.

A close reading of these five responses reveals a common thread running through them. All three respondents share the conviction that the central subject matter of HCL - human life - is too serious a matter for it not to be given special attention by law. Moreover, it is evident that although a broad appreciation of many branches of the law is a prerequisite for comprehending or performing analysis in HCL, there is a need for rules and doctrines from

⁸¹⁰ Extract from 'Transcript of Interview with Professor Andrew Grubb, 22/10/2013.'

⁸¹¹ Extract from 'Transcript of Interview with Professor Graeme Laurie, 15/10/2013'.

these other fields of law to be tweaked or bent, as it were, to serve the purposes of HCL as was canvassed in Section 1.7 of Chapter One. Also, it needs to be pointed out that Skegg and Montgomery did not speak directly to this issue but it can be inferred from their various responses that they are convinced that HCL is a distinct discipline.

5.1.6. E. VIEWS ON THE ATTRACTIVENESS OF ENGLISH AND WELSH HCL TO OTHER JURISDICTIONS

Last but not the least, the empirical research has revealed a varied subjective appreciation by the pioneer scholars of what aspects of HCL in England and Wales can be considered attractive for emulation by other jurisdictions, beginning with Montgomery, who stresses the need for any jurisdiction seeking to borrow aspects of English and Welsh HCL to ascertain whether its healthcare system is similar to the one in the country seeking to borrow such elements. Once that condition has been met, he suggests that:

The statutory code which has a degree of internal coherence and great clarity can be taken over into other jurisdictions. You can take the Mental Capacity Act, the Human Tissue Act and translate. Whether they will be the ones to use, I think that is different. I think the common law tradition, if my argument over the years has been right, then whether it will make sense to take things like informed consent and our version of standard of care will depend upon how much confidence you have in the medical profession and its organization in the country you are talking about.⁸¹²

On the other hand McLean opines that:

...the relative easy access to court is something that could be learnt by other jurisdictions who are struggling with these kind of issues. I think there are a number of mistakes perhaps that have been made in the past that English law is now trying to rectify in terms of the emphasis on patients' rights as opposed to the emphasis on doctor's duties and if people can learn from that, not having to go through the process of making the mistake in the first place, I think that would be enormously helpful... I think one of the most important things from the patient's point of view is the extent to which the courts have been willing to protect the notion of confidentiality and privacy; it is extremely important in the age of genetics... UK courts have been very cautious in allowing public arguments to overtake the

⁸¹² Extract from 'Transcript of Interview with Professor Jonathan Montgomery, 25/10/2013'. A copy is available on file.

legitimate interests or rights of the individual, for example, in authorizing disclosure of otherwise private genetic information.⁸¹³

Grubb is also of the view that the regulation of assisted reproduction in England and Wales has worked very well in practice. He does not so much mean the precise wording, but the structure of decision-making, licensing and regulation through the Human Fertilisation and Embryology Authority, so other countries exploring how to regulate this aspect of medical practice can emulate this example.⁸¹⁴ Brazier expresses a similar opinion:

Things like laws on transplants can be adapted to suit your local circumstances. The Human Fertilisation and Embryology Authority is attractive, as many people from abroad look at it as an example. If a jurisdiction outside sees a problem it is useful to look critically at England and find out how good was it or bad was it and say we are going to take the good bit. [Questions such as] how they apply to my country resources and religion are all important factors.⁸¹⁵

5.2. CONCLUSION

The exploration undertaken here has made it clear that although the claim in England and Wales that HCL having the status of a distinct body can, at first blush, be ascertained by ticking boxes against the indicia or defining characteristics of a field of law, an identification of the historical factors which have necessitated the attainment of these characteristics could be highly contentious since such factors are located in the realm of subjectivity. Nevertheless, it has been demonstrated in this chapter that it is rather a combination of factors which have operated in diverse ways to accelerate the emergence of a distinct body of HCL *as a potential framework to facilitate patient empowerment* and the external scrutiny of ethical dilemmas associated with medical advances. First, a renewed interest in liberalism which later found concrete expression in the *European Convention on Human Rights*, placed into domestic law in the UK via the *Human Rights Act, 1998*, has also made a huge impact on

⁸¹³ Extract from 'Transcript of Interview with Professor Sheila McLean, 22/10/2013'.

⁸¹⁴ Extract from 'Transcript of Interview with Professor Andrew Grubb, 22/10/2013'.

⁸¹⁵ Extract from 'Transcript of Interview with Professor Margot Brazier, 18/10/2013'.

⁸¹⁵ Ibid.

the maturation of a field of HCL. Secondly, the increasing intervention of non-medical professionals in deliberations on moral aspects of medical practice have wrestled medical ethics from the monopoly of the medical profession, culminating in a new field of inquiry: bioethics, which have influenced legal thinking about healthcare and advances in medical technology. Thirdly, the increasing vigilance of the British media over positive developments in medicine, as well as the scandals and malpractice in healthcare, have created public awareness and sustained the public's interest in bioethical discourse. Finally, my empirical research has revealed how pioneering scholars recall the historical development of the field and has shown that the interest of academic lawyers in exploring issues relating to healthcare, bioethics and human rights has significantly accelerated the visibility of the field in legal and medical practice, as well as university curricula.

CHAPTER SIX

IS THERE A NEED FOR THE DEVELOPMENT OF A DISTINCT BODY OF HEALTH CARE LAW IN GHANA?

6.0. INTRODUCTION

This chapter draws upon the diagnostic exploration undertaken in Chapter Four regarding the relative absence of a field of HCL in Ghana. I present three key arguments in this chapter. First, I contend that the phenomenon of patient vulnerability recognised in the English and Welsh jurisdiction, which has a fully developed body of HCL, are abundantly

present in Ghana, in comparatively serious forms. The myriad of problems confronting healthcare in Ghana renders patients more vulnerable to the extent that they are largely disempowered in the healthcare enterprise. Second, I argue that the absence of regulatory framework for the advances in medicine, which have contributed towards the emergence of a discrete body of HCL in England and Wales, and are gradually entering medical practice or healthcare in Ghana, can provide many issues for potential HCL scholars and policy makers to speculate about. Finally, I explore lessons that Ghana can draw from English and Welsh experience. This lesson drawing also includes consideration of recommendations for Ghana elicited directly from Pioneering HCL Scholars in this jurisdiction.

6.1. THE REALITY AND RAMIFICATIONS OF PATIENT VULNERABILITY IN GHANA

A field of law does not emerge in a vacuum; it is usually driven by significant needs. Consequently, whether or not it is necessary to have a discrete body of HCL in Ghana is largely contingent upon the existence of a practical need which warrants such a field of law. I argue in this section that the incidence of exploitation of patient vulnerability and the regulatory vacuum in relation to medical advances being imported into Ghana suggest strongly that there is a need for a discrete body of HCL. The thesis hastens to clarify here that a mere development of a distinct subject of HCL per se will not necessarily provide an instant solution to the conundrum of patient disempowerment but could assist in creating awareness about the issue among the public and policy makers.

In order to explore indicators of patient vulnerability in Ghana, it is apposite to offer a working understanding of the phrase 'patient vulnerability' in this thesis

Patient vulnerability has been explained as ‘an inability of patients to retain control of their life situation or to protect themselves against risks/threats to their integrity.’⁸¹⁶ Kennedy aptly explains patient vulnerability, noting:

As between the doctor and the patient, there is an inevitable imbalance or disequilibrium of power. The doctor has information and skill which the patient, who lacks these, wishes to employ for his benefit. When it is remembered that among the powers possessed by the doctor is the privilege to touch and even invade the body of another and as a consequence exercise control to a greater or lesser extent over that person, it will be clear that with the best will in the world, and conceding the good faith of the doctors, such powers must be subject to control and scrutiny, from an abundance of caution.⁸¹⁷

Of course, every patient would like his or her doctor not only to be competent but more importantly, to put the patient’s interest over and above that of the doctor’s. The importance of this desire amongst patients cannot be overemphasised. As Mehlman helpfully notes, it is important to the patient for three good reasons:

First, you have far less power than the doctor ... if you are sick you will need care urgently, you are not in a good position to insist upon seeing the most highly qualified and trustworthy physician. Second, the doctor often has to do things that you cannot monitor because you are untutored or oblivious. Third, your health and well-being are in peril, and most likely you are worried and afraid. Some experts say you can be so intensely affected by your circumstances that you are no longer the same person.⁸¹⁸

It is imperative to note that patient vulnerability is not an abstract construct or mere rhetoric in relation to the healthcare experiences of patients; it manifests itself in medical malpractice and gross violations of patients’ rights. I thus proceed to survey some of the reported incidence of medical malpractice and violation of patients’ rights that manifest

⁸¹⁶ VF Irurita, ‘The problem of patient vulnerability’ (1999) 6 *Collegian*, 10, 11.

⁸¹⁷ I Kennedy, *Treat Me Right - Essays in Medical Law and Ethics* (Oxford: Oxford University Press, 1988) ch 16, 387.

⁸¹⁸ MJ Mehlman, ‘Dishonest Medical Mistakes’ (2006) 59 *Vanderbilt Law Review*, 1137, 1139 (references omitted).

explicit or tacit exploitation of patient vulnerability. The illustrations are largely drawn from judicial decisions, media archives and academic literature.

First, there are few judicial decisions that are relevant to the issue of the exploitation of patient vulnerability. Some of these decisions have already been discussed in Chapter Four. Thus, the purpose of citing some of these decisions here again is not necessarily to explain what was decided in those cases, or to suggest that the existence of just a few judicial decisions indicates that the exploitation of patient vulnerability only occurs infrequently, but to offer real case examples which graphically illuminate patient vulnerability. To begin with, in the afore-discussed *Darko v Korle-bu Teaching Hospital*,⁸¹⁹ instead of the right knee being operated on, the team of surgeons in the leading teaching hospital in Ghana operated on the left knee of a patient. The hospital refused to further attend the patient as a protest over a medical negligence suit the patient had initiated against them. Clearly, the decision of the hospital to refuse further treatment when the patient sued them can reasonably be attributed to the obvious imbalance of power in the doctor-patient relationship. Indeed, the posture of the hospital seems to suggest that, in so far as a patient had consented to the doctors treating him, he did not have any right whatsoever to challenge an act or omission by them, let alone drag them to court for redress.

Moreover, in the previously discussed case of *Elizabeth Vaah v Lister Hospital and Fertility Centre*,⁸²⁰ it took court action before medical records were released. For our present purposes, it is evident from *Vaah* that a patient is helplessly vulnerable in their clinical experience unless the law intervenes to guarantee certain safeguards. A reasonable

⁸¹⁹ *Frank Darko (Minor) (Suing Per Next Friend Gladys Darko, Mother)*, Suit No. AHR 44/06, Judgment by Accra Fast Track High Court dated 24/06/2008. Unreported (copy available in my folder).

⁸²⁰ Unreported but the suit number is HRCM 69/10 Fast Track Court, High Street, Accra, Ghana (copy available in my folder).

inference from the decision of the hospital not to disclose medical records to an aggrieved patient is ostensibly to conceal alleged malpractices perpetrated against the patient.

Another illustration of the exploitation of patient vulnerability may be found in *Somi v Tema General Hospital*, where a 36-year pregnant woman was rushed to hospital with an ante partum haemorrhage. The doctor on night duty had finished earlier than expected at 4.00 a.m. instead of 8.00 a.m. and the morning doctor on day duty did not report until 10.00 a.m. The nurses tried to keep the patient alive but they could not hear the heartbeat of the unborn child. The patient was finally taken to the theatre after an inordinate delay. Neither the mother nor the baby survived the operation.⁸²¹ Significantly, this case reveals a glaring lack of respect for a patient's right to receive reasonably prompt care at a health institution in an emergency case. Indeed, if there was a vibrant culture of consciousness of patient rights among healthcare professionals, it would be more likely that the necessary accountability mechanism would have been put in place in the defendant hospital to check the lateness of the doctors, in order to avert a recurrence of this incident.

Furthermore, in *The State v Kweku Nkyi*,⁸²² a student nurse at the Kumasi Central Hospital was asked to treat a sick child. He injected the sick child twice with what he believed was mepacrine. The child's condition immediately deteriorated and he died within a few hours. A post-mortem examination revealed that the death of the sick child was caused by arsenic poisoning.⁸²² It is reasonable to infer here that the case of allowing a student nurse to treat a child without supervision by a properly qualified healthcare professional is symptomatic of the vulnerability of patients in Ghana.

As noted above, the paucity of judicial decisions does not necessarily imply that medical malpractice and scandals relating to patient vulnerability do not occur in the

⁸²¹ *Somi v Tema General Hospital* (1994-2000) CHRAJ 196

⁸²² [1962] 1 G.L.R. 179-199

Ghanaian healthcare system in appreciable proportions. On the contrary, the reality is that only a few aggrieved patients are able to pursue redress in court, or even in a supposedly less cumbersome quasi-judicial forum like the CHRAJ. Abject poverty, coupled with ignorance and illiteracy confronting many patients in Ghana is another layer of complexity regarding patient vulnerability. In order to construct a fuller picture of the stark reality of patient vulnerability in Ghana, it is appropriate to survey some of the many stories in the media concerning medical malpractice and scandals.

The media in Ghana is replete with numerous stories of medical malpractice which ultimately result from either deliberate or unintended exploitation of patients' vulnerability in the country. Notable examples will be cited here to buttress the claim made earlier that Ghana's healthcare is bedevilled with numerous incidences of medical malpractice which do not find their way into courts or other quasi-judicial fora (such as CHRAJ).

Recently, *The Insight*, a Ghanaian newspaper, reported that a patient had died from complications arising from gauze which a doctor had negligently left in the belly of the patient after surgery.⁸²³ This was revealed by another doctor who desperately tried to save the life of the patient, but pleaded anonymity. The paper, which reported that it had compiled tens of such cases across the country to be published in the near future, revealed that 'some members of the Ghana Medical Association (GMA) who spoke to "The Insight" on the case of medical negligence want action to stop the malpractices.'⁸²⁴

⁸²³ Insight Reporter, 'Killed by a Doctor' (*The Insight*, 2014) <http://www.ghanamma.com/killed-by-a-doctor/> (accessed: 12/3/2014).

⁸²⁴ Insight Reporter, 'Killed by a Doctor' (*The Insight*, 2014 edn) <http://www.ghanamma.com/killed-by-a-doctor/> (accessed: 12/3/2014).

Another shocking example is a report featured in *The Mirror* under the heading 'Doctors render woman barren ...after leaving towel in her abdomen.'⁸²⁵ The report runs as follows:

A 26-year-old woman who went for a caesarean section at the Brong Ahafo regional hospital in Sunyani is furious at the medical team that took the operation for a tactless act that nearly cost her her life and has left her barren because the team left an operation towel in her abdomen. Ms. Ernestina Adade Konadu went through the ordeal two years ago when she went to the hospital to deliver. Consequently, the woman, whose first attempt at having a baby resulted in this disastrous manner, is demanding GHC150,000 as compensation from the hospital. The botched caesarean section, in the process of which Ms. Konadu lost her baby, after which she went home with another complication, took place on October 7, 2010. Ms. Konadu endured severe abdominal pains for over a year before diagnosis at a different health facility, revealed that the pains she had been experiencing were the result of an object lodged in her abdomen. A subsequent operation to remove the object revealed an operation towel which had been left in her abdomen after the caesarean section a year earlier. According to her medical report, the operation to remove the towel rendered the victim barren, meaning that she could no longer conceive and bear children. Moreover, her medical condition has so deteriorated that she can no longer engage in any hard work. *After investigations into the matter, the authorities of the Brong Ahafo Regional Hospital confirmed and recognised the incidence of negligence on the part of the medical team but said the hospital was not in a position to pay compensation to Ms. Konadu.* Ms. Konadu has, therefore, appealed to the Minister of Health, all relevant statutory bodies and the coalition of non-governmental organisations on human rights issues to step in to ensure that the right thing is done to save other patients from suffering similar fate. *According to her, the Brong Ahafo Regional Chief State Attorney, Madam Afia Serwaa, who is also counsel for the Brong Ahafo Regional Hospital, had warned her to back down on her demand or she (Madam Serwaa) would go public with Ms. Konadu's medical condition.*⁸²⁶

The above media report raises pertinent issues that represent some of the layers of complexity concerning patient vulnerability in Ghana. First of all, the narrative suggests that the hospital medical team, who were guilty of serious medical negligence, had exploited the vulnerability of the patient. Another plausible inference is that either proper records of the surgical procedure were not completed, or the doctors failed to carry out a proper post-

⁸²⁵ The Mirror Reporter, 'Doctors render woman barren ...after leaving towel in her abdomen' (*GhanaWeb*) <http://mobile.ghanaweb.com/wap/article.php?ID=251108> (accessed: 1/9/2014).

⁸²⁶ Emphasis added.

surgery review of the patient. As Edwin has aptly noted, 'by not disclosing a medical error, the doctor conspicuously places his own interests above that of the patient to the detriment of the patient, thereby violating a patient-centred ethic.'⁸²⁷ Beyond the gross abuse of the rights of the patient by the doctors, the official government lawyer responsible for advising the hospital exacerbated the already pathetic situation of the vulnerable patient by threatening that if she did not abandon her grievance she would risk having her medical condition made public. It is submitted that regardless of the nature or degree of sensitivity of her medical condition, if the allegation by the patient is true, then it is telling evidence of patient abuse and the exploitation of her vulnerability in Ghana.

Another example of the numerous media reports of medical malpractice in Ghana is a story broadcast on a radio station concerning the death of twin babies during delivery.⁸²⁸ Earlier scans taken during the patient's antenatal days had indicated she needed a caesarean section delivery, but nurses at the hospital on that day forced her to deliver the normal way.⁸²⁹ Realising she could not stand the pain, she began crying, upon which a doctor advised she should have the caesarean section.⁸³⁰ However, there was no anaesthetist available during the surgery. The patient alleged that the death of both twins was due to the absence of an anaesthetist while she was being prepared for the operation.⁸³¹

Related to the foregoing instances of malpractice is the manifestation of a culture where transparency is lacking in medical practice in Ghana, especially with respect to errors

⁸²⁷ AK Edwin, 'Non-Disclosure of Medical Errors: an Egregious Violation of Ethical Principles (2009) 43(1) *Ghana Medical Journal*, 34.

⁸²⁸ The Reporter, 'Tema General Hospital accused of 'killing' twin babies' (*Joy Online*, August 2010). <http://lifestyle.myjoyonline.com/pages/health/201011/55697.php> (accessed: 10/1/2014).

⁸²⁹ *Ibid.*

⁸³⁰ *Ibid.*

⁸³¹ The Reporter, 'Tema General Hospital accused of 'killing' twin babies' (*Joy Online*, August 2010). <http://lifestyle.myjoyonline.com/pages/health/201011/55697.php> (accessed: 10/1/2014).

and mishaps in medical operations. A significant example of this point is the reaction of the doctors at the Komfo Anokye Teaching Hospital (KATH), the second leading tertiary hospital in Ghana, towards allegations of a number of patient deaths due to the breakdown of life support machines in the hospital's Intensive Care Unit. Addressing a press conference in response to the death of six patients following the breakdown of the ventilators at KATH, Dr Awuah, the medical director stated:

It is medically unethical to reveal the number of patients who have died as a result of the broken down ventilators. With or without ventilators, patients die at the hospital.⁸³²

Two important points are worth noting from the foregoing quotation. In the first place, it is confirmation that some of the medical advances which prolong the lives of patients in some of Ghana's health facilities are being utilised. Secondly, it indicates that even for the limited number of life support machines available in Ghanaian hospitals, there appears to be a lack of an adequate accountability framework to safeguard patients. Notably, for the first time since its establishment in 2010, the media reported that:

Korle Bu Teaching Hospital (KBTH) has established information and complaints desks at the various out-patient departments (OPDs) to afford clients and patients the opportunity to seek redress for their grievances instead of going to the media. In addition, the hospital is to form a Clinical Ethics and Professional Committee to address the concerns and grievances of patients and clients. At a media briefing in Accra last Friday, the Chief Administrator of the hospital, Professor Nii Otu, said the committee would comprise experienced medical and para-medical professionals, religious leaders and individuals from other interest groups. He said such a committee would help the hospital to step up its drive to improve quality health care, adding that 'the core duty of the committee would be to address grievances of patients and clients bordering on our services.'⁸³³

⁸³² O Tawiah, 'Undercover Journalist 'Doctor' Probes Deaths At Ghana Hospital' <http://fairreporters.net/2012/03/12/under-cover-journalist-doctor-stops-avoidable-death-at-ghanas-second-largest-hospital/> (accessed: 16/1/2014).

⁸³³ LA Yeboah, 'Korle Bu going through face lift' <http://lucyadoma.blogspot.co.uk/search?updated-max=2011-01-06T02:45:00-08:00&max-results=7&start=35&by-date=false> (accessed: 22/01/2014).

The above press statement from KATH raises further concerns over the absence of a properly conceptualised legal framework to promote and protect patients' rights, while clearly clarifying the responsibilities of healthcare professionals. Indeed, the fact that it was only in 2010 that a major hospital like KATH initiated measures to address some of these concerns - at least according to the best available archival evidence - is quite suggestive of how bleak the situation is for the entire country, particularly with respect to non-tertiary health institutions there.

The phenomenon of the exploitation of patient vulnerability as revealed in the plethora of examples given above has far ranging ramifications that impinge on the quality of healthcare and the degree of patients' trust in the system. It is to these possible ramifications that I now turn. From the foregoing illustrations it can be discerned that healthcare providers tend to disregard request for information by patients or challenge from them. Such attitude of healthcare professionals could be symptomatic of a culture of excessive medical paternalism. As noted in Chapter Four and further reiterated in the present chapter, there are certain statutes and some case law which deal with issues arising in the doctor-patient relationship and in some other contexts of healthcare delivery in Ghana. Although some of the existing legislation address healthcare in perfunctory manner, it is true that other factors like cultural and social attitudes relating to healthcare professionals are partly responsible for disempowerment of patients in Ghana. It was against this backdrop that the Ghana Health Service adopted the Patient's Charter in 2002, a statement of patients' rights.⁸³⁴ The main aim was to 'promote an open and positive relationship between and amongst health workers and patients'.⁸³⁵ Despite the adoption of

⁸³⁴ Ghana Health Service, 'The Patients Charter'

<http://www.ghanahealthservice.org/aboutus.php?inf=Patients%20Charter> (accessed: 20/01/2014).

⁸³⁵ Ibid.

the Patient's Charter, the phenomenon of patient disempowerment persists in Ghana as was noted in Chapter Four.⁸³⁶ This reinforces the position taken earlier that creation of a body of HCL per se is not immediate solution to the conundrum of patient disempowerment.

The apparent lack of awareness of the Patient Charter and the fact that it appears to be disregarded by healthcare professionals is further amplified by a serious debate that took place in 2011 (i.e. almost a decade after the adoption of the Patient Charter) on a popular radio station, Joy FM, between two leading members of the medical profession in Ghana over whether or not there exists a mandatory duty for a doctor to explain the side effects of a prescribed drug.⁸³⁷ Arguing against the existence of a duty of risk disclosure, Dr Serebour, the Vice President of the Ghana Medical Association (GMA) at the time, insisted that there were no written laws or regulations binding doctors to explain the side effects of drugs they administered to their patients. On the contrary, Dr Jehu Appiah said that it was ethically mandatory for doctors to ensure that patients were made aware of the implications of the drugs administered to them before they were allowed to use them. This debate suggests that there is a certain culture or social attitude underlying how Ghanaian doctors view their duties in relationship to patients. Any progress towards patient empowerment would ultimately necessitates addressing these cultural or social factors.

It may be surmised that the doubtful legal status of the Patient Charter might partially account for the virtual lack of awareness and non-compliance with those rights and responsibilities. Although such an argument can only be pressed so far, it is notable that the situation may radically improve because, as noted in Chapter Four, the Charter has now

⁸³⁶ See: 4.1.3 of Chapter Four above.

⁸³⁷ http://ghanamedicalassociation.org/index.php?option=com_content&view=article&id=90&catid=49&Itemid=53 (accessed: 9/9/2013).

been invested with full statutory status due to the recent passing of the *Public Health Act, 2012 (Act 851)*. It remains to be seen whether merely formally legalising the Charter will enhance awareness and compliance and possibly generate more enforcement action in the form of litigation. However, it is important to point out that the content of the Charter is not sufficiently empowering from the patient's perspective, as the provisions are predominantly hortatory. This contrasts sharply with the framing of human rights and fundamental freedoms in the 1992 Constitution and other rights leading to enactments. Unlike the homiletic tenor of the Patient Charter, the usual legislative drafting tradition in Ghana regarding the enshrining of rights is to use an imperative modality of 'shall.'⁸³⁸ In that way, the obligation of the relevant duty bearer vis-à-vis the particular right is made more emphatic and capable of biting via judicial enforcement action. Moreover, the Charter does not provide any administrative body in the form of a Patients' Ombudsman or equivalent agency for the monitoring or secure compliance with the Charter, in addition to any court enforcement actions available to those who may opt for the arduous route of litigation.

Related to this lack of awareness of the Patient's Charter and other patients' rights statutes among healthcare professionals and the general public is the apparent indifference of Ghana's legal education towards HCL, as I noted earlier in Chapter Four. Such a gap in the training of future lawyers and judges could impact negatively on all the elaborate arrangements for securing patients' rights, as noted above in Section 4.1.4 of Chapter Four.

The academic appreciation of HCL by lawyers in Ghana is important not only for enhancing the protection and enforcement of patients' rights, but also in providing the requisite expertise at the disposal of policy and lawmakers as the need arises for a legislative

⁸³⁸ For the legal significance of 'shall', see the *Interpretation Act, 2009 (Act 792)* section 42: 'In an enactment the expression "may" shall be construed as permissive and empowering, and the expression "shall" as imperative and mandatory.'

panacea to be explored in response to the novel challenges posed by advances in medicine being replicated in Ghana. It is to the exploration of potential questions arising from these medical advances being utilised, or about to be utilised in Ghana that I now turn.

6.2. POTENTIAL LEGAL AND BIOETHICAL QUESTIONS RAISED BY MEDICAL ADVANCES IN GHANA

The nature of medical practice in Ghana has undergone significant transformation in many respects as a result of advances made in medicine as a healing art. Indeed, as Kennedy aptly notes in relation to England and Wales:

It is a trite observation that developments will always be taking place in medicine. In one sense there is nothing new in recent events, such as in vitro fertilization, the freezing of embryos, genetic engineering, or kidney transplantation and kidney dialysis. After all, there is a continuum of development and refinement of medical technology and medical skills, from the knife, the leech, and the potion, to surgery, antiseptics, and anaesthesia.⁸³⁹

This observation by Kennedy may be taken for granted when dealing with medical practice or healthcare delivery in a developed country like England and Wales. However, in Ghana, some of these developments in medical technology are gradually trickling into our healthcare system. Major medical advances which have challenged the boundaries of the law in developed countries like England and Wales and which are now being deployed in some of Ghana's health institutions include life support machines; in vitro fertilisation (IVF); heart surgery; organ transplantation, and the dialysis machine. At the moment there is no explicit regulatory framework that govern medical advances in Ghana.⁸⁴⁰ Evidence of the

⁸³⁹ I Kennedy, *Treat Me Right- Essays in Medical Law and Ethics* (Oxford: Clarendon Press 1988) 3.

⁸⁴⁰ Owusu-Dapaa, 'Ghana' in H Nys (ed), *International Encyclopaedia of Laws: Medical Law* (Alphen aan den Rijn, (NL: Kluwer Law International 2014) 131.

reception of these medical advances into healthcare in Ghana can be gleaned from media stories. In May 2012, it was reported that kidney transplants were going to be integrated into routine medical practice in Ghana's leading teaching hospital.⁸⁴¹ According to the media report:

Doctors at the Korle-Bu Teaching Hospital (KBTH) will begin undertaking kidney transplantation in the last quarter of this year. This will bring great relief to many kidney patients in the country who need a kidney transplant but cannot afford the high cost of travelling and transplantation abroad. Since 2008, the nation's premier hospital has undertaken 12 kidney transplants with the assistance of a team of transplant surgeons from Birmingham in the United Kingdom and the Transplant Links Community. Three of those transplants were performed in April this year.

In August 2012, a leading radio station carried a story that:

Thirty-five year old Mavis Owusu Asamoah of Kumasi has been diagnosed with End-Stage Renal Disease which requires a kidney transplant at the Korle-Bu Teaching Hospital to save her. A letter, signed by Dr Vincent Bioma, Nephrologist at the Korle-Bu Teaching Hospital puts the cost of treatment at fifty-five thousand Ghana cedis (Ghc55,000), about US\$29,000. The transplant surgery alone costs thirty-thousand Ghana cedis (Ghc30,000).⁸⁴²

Apart from such media reports, the academic literature can still be another source of information when seeking to gauge the extent of the use of medical advances and the potential challenges they may raise for law and bioethics in Ghana. In this regard, Agbernoku et al's empirical research is worth considering.⁸⁴³ The authors' empirical evidence from Kumasi suggests that although there is a low level of awareness of face and organ transplantation among the public, some patients remain open to the possibility of donating their organs, whether in Ghana or abroad.⁸⁴⁴ This finding can be a premise for a deduction that organ transplantation is gradually becoming part of medical practice in

⁸⁴¹ The Daily Graphic Reporter, 'Korle-Bu to Begin Kidney Transplant In Last Quarter' <http://www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=238839> (accessed: 17/1/2014).

⁸⁴² O. Tawiah, 'Multimedia Launches Appeal For Two Cancer and Kidney Failure Patients' <http://lifestyle.myjoyonline.com/pages/health/201208/93058.php> (accessed: 17/1/2014).

⁸⁴³ P Agbenorku, M Agbenorku and G Agamah, 'Awareness and Attitudes Towards Face and Organ Transplant in Kumasi, Ghana' 2013) 47(1) *Ghana Medical Journal*, 30–34.

⁸⁴⁴ Ibid.

Ghana. Furthermore, in 2008, Andrew Ready, a kidney transplant surgeon from UK undertook the first ever kidney transplant in Ghana. In a subsequent interview with the *British Medical Journal*, when asked about his proudest moment as a surgeon, Ready replied:

It was when I did the first ever organ transplantation in Ghana. When the kidney had been transplanted and re-perfused with the recipient's blood, urine started to pour from the ureter. The operating theatre was full of observers, and as I demonstrated the urine production they burst into applause and did so every time a spurt of urine emerged from the ureter. I think they saw this as symbolic of a step forward in the level of healthcare available, and I felt some of the excitement that the first transplant surgeons must have felt. That was three years ago, and the recipient of that transplant is back at college and enjoying life.⁸⁴⁵

Another medical advance which has been imported into Ghana is in vitro fertilisation (IVF). IVF was introduced into healthcare in Ghana by a Provita Specialist Hospital in 1995.⁸⁴⁶ The technology gradually spread to other health institutions in the country. Whilst news reports suggest that the general public is excited by the success of the few IVF centres in the country, there is no legal regulatory regime for the use of the technology.⁸⁴⁷ The increasing popularity of the various assisted reproductive technologies (ARTs) in Ghana, such as IVF, have recently received attention from the media. In particular, there was worry expressed by some religious leaders on the sale of sperm and other scandals in the use of ARTs. According to a media report published on 8th September, 2013:

The Catholic Bishops' Conference has condemned the sale of sperm in Ghana. This follows reports that fertility treatment is increasingly becoming popular in Ghana by the day. Health experts have raised alarm about the phenomenon. They are worried the increasing commercialization of sperm and egg donation might cause people to contract viruses such as HIV. For instance, a gynaecologist at the Komfo

⁸⁴⁵ S Carter, 'A kidney transplant surgeon' (*BMJ Careers*, 2011) <http://careers.bmj.com/careers/advice/view-article.html?id=20002163> (accessed: 17/1/2014).

⁸⁴⁶ BBC News Reporter, 'Ask our fertility specialist' <http://news.bbc.co.uk/1/hi/world/africa/3790803.stm> (accessed: 17/01/2014); Provita Specialist Hospital, <http://www.provitaspecialisthospital.com/?p=2&id=22> (accessed: 17/01/2014).

⁸⁴⁷ The Reporter, 'First Ever IVF Twins Delivered in Kumasi' <http://www.ghananewsagency.org/health/first-ever-ivf-twins-delivered-in-kumasi-62457> (accessed: 17/1/2014).

Anokye Hospital, Dr Ernest Kwarko, says the increasing commercialization of sperm and egg donation needs stringent measures to ensure recipients are not affected by the deadly virus. President of the Catholic Bishops Conference, Most Reverend Joseph Osei-Bonsu tells Joy News the sale of sperm is against God's principles. He explained that procreation is something that has to take place between a man and a woman; this, he said, means having children should take place in the context of marriage. 'And so if people are going to sell sperm then it takes it out of the area of marriage, that is why the Catholic Church is concerned, that is not right, it is wrong and so that shouldn't be done at all.' Most Reverend Joseph Osei-Bonsu rather advised childless couples to seek medical treatment. Meanwhile, the Ministry of Gender, Children and Social Protection says it has already begun consultations to begin a national dialogue on the phenomenon. Mercy Adjabeng, Public Relations Officer for the Ministry tells Joy News the dialogue will take place this year. 'Our strategy is to have national gender dialogue on emerging trends that are quite worrying. One is ... surrogacy – the situation where young girls are made to get pregnant for people - and then the sperm and egg donation.'⁸⁴⁸

A number of inferences can be drawn from the above media report concerning ARTs. In the first place, the report is indicative of the fact that ARTs have increasingly been integrated into healthcare delivery in Ghana, even if the service is dominated by private providers. Secondly, there are genuine concerns from one of the significant moral constituencies in Ghanaian society that unregulated ARTs will be a recipe for ethical dilemmas. Thirdly, it appears from the above quote that ARTs are being offered in some hospitals in Ghana but there is no dedicated regulatory regime on the subject. It has been demonstrated in this section that patients are disempowered against excessive medical paternalism. Also, the regulatory vacuum vis- a- vis medical advances in Ghana has been explored. These problems confront or have confronted England and Wales where a discrete body of HCL has evolved over the past three decades. The next segment explores lessons that Ghana may draw from English and Welsh experience.

6.3. EMPOWERING GHANAIAIAN PATIENTS THROUGH THE DEVELOPMENT OF A DISCRETE BODY OF HEALTH CARE LAW – LESSONS FROM THE ENGLISH AND WELSH EXPERIENCE AND RECOMMENDATIONS FOR GHANA

⁸⁴⁸ The Reporter, 'Catholic Bishops conference condemns sale of sperms in Ghana' (*Joy Online*) <http://edition.myjoyonline.com/pages/news/201309/112759.php> (accessed: 17/12/2014)

The present section develops the hypothesis that the development of HCL as a discrete body in any jurisdiction *per se is not an automatic solution* to the conundrum of patient disempowerment but it could rather *facilitate* the empowerment of patients. In this respect, I explore lessons that can be learnt from the development of HCL in England and Wales as a discrete body.

The legal transplantation of HCL from England and Wales is an inappropriate means of developing a discrete body of HCL in Ghana due to the obvious disparity in socio-economic realities and cultural values. This does not necessarily bar one from drawing useful lessons from the experience in this jurisdiction. Indeed, a critical study of the historical development of a discrete body of HCL in England and Wales will yield many important lessons. First, the study found that English and Welsh courts have been very cautious in pronouncing upon novel cases with significant ethical questions and have also used some of these opportunities to comment on aspects of medicine that need to be regulated by consensus mobilised by a legitimate democratic body like Parliament.⁸⁴⁹ Secondly, the adoption of any major statutory framework governing aspects of medical advances is usually preceded by broad public consultation, spearheaded by specially designated ad hoc commissions. Thirdly, the widespread integration of HCL into the curriculum of law schools has ensured that specialist competency can be developed or acquired in this relatively new, but important field of law. Fourthly, the interest of academic lawyers in researching and publishing extensively in HCL has ensured that a pool of requisite expertise has been created from which public policy dialogue can draw assistance. Also, the interaction of various factors in England and Wales as noted in Chapter has made autonomy emerged as an overarching

⁸⁴⁹ See generally: Chapters Three and Five.

principle or crucial norm that serve as a popular evaluative criterion in assessing judicial decisions and statutory intervention in the field.

In addition, soft law (other than formal delegated legislation) has become an important source of legal and bioethical norms of HCL. Moreover, the use of departmental and governmental public inquiries into healthcare delivery has brought errors made in medical practice into the glaring view of the public. Last but not the least, the sustained interest of the media in reporting on health and HCL on almost a daily basis ensures corresponding public awareness. In the light of all the foregoing lessons from the historical and empirical study of a discrete body of HCL in England and Wales, what concrete recommendations can be made for Ghana?

The evolving field of HCL in Ghana could benefit from the views of pioneer scholars who worked in this field of law during its maturation in England and Wales. I shall therefore consider some of the recommendations made by such scholars before I proceed to Chapter Seven and make my final recommendations on the way forward for empowering patients in Ghana through the development of HCL.

During an empirical survey targeted at pioneering HCL scholars in England and Wales, respondents were invited to share thoughts on the question, '[w]hat advice will you give to a developing country with a common law tradition like Ghana, which is seeking to draw lessons from the experience of England and Wales in this field of law?.' This generated diverse responses which I am now presenting for the purpose of considering what can be distilled from them as part of my recommendations for Ghana in Chapter Seven.

McLean, despite conceding that her lack of familiarity with the Ghanaian legal and healthcare systems rendered some generic views which she considered to be of potential

relevance to any jurisdiction seeking to develop its HCL. She expressed her thoughts as follows:

...when you are developing jurisprudence or a body of law it is important to accept that there may be a need to balance the interests of the individual and the interests of the community. For example it is in the interest of the community that they have healthcare professionals who are not afraid to carry out their profession and that they are given the right to exercise their own clinical expertise and discretion. However, this should not imply overriding the rights of individual patients. Indeed I expect that the quality of the co-operation between the patient and the profession will improve when both sets of interests and/or rights are mutually respected. Obviously the question of resources is also a very important one. . . However, it is also important to establish a system (reinforced by the law) which ensures not only that treatment is available but that patients are treated appropriately, both in personal and clinical terms. A satisfied patient is not always a patient who has been given everything which is or could be available; being respected in the healthcare enterprise can sometimes be sufficient for a 'good' medical experience.⁸⁵⁰

A critical issue discernible from McLean's suggestions is the need to strike a good balance between the delicate and competing interests of patients' rights on the one hand and the freedom of healthcare professionals to exercise their professional judgment in the delivery of healthcare, on the other, alongside the interests of the state. As McLean aptly points out, such a balance can only be achieved when there is a genuine recognition by the state as a regulator and the two other stakeholders (i.e. patients and healthcare professionals) that none of these seemingly contrasting interests in healthcare ought to be sacrificed at the expense of the others unless constricting one may inevitably enhance all.

Another major issue that emerges from McLean's view presented above is the need for a state to adequately channel resources into healthcare. Although resources are finite all over the world, it is indisputable that England and Wales has a far better resourced and superior healthcare system. Nevertheless, Ghana is bedevilled with gargantuan resource constraints, further worsened by the fact there is disproportionate resource allocation to

⁸⁵⁰ Extract from 'Transcript of Interview with Professor Sheila McLean, 16/10/2013'.

the detriment of healthcare. At this juncture, a quick glance at vital economic data on Ghana will illuminate the analysis of the issue of adequate resources embodied in McLean's suggestions. According to the World Bank, while Ghana's Gross Domestic Product (GDP) was worth US\$40.71 billion as at 2012, it has a population of 25.37 million.⁸⁵¹ Ghana's annual health expenditure per capita⁸⁵² projected for 2011-2013 by Bank is US\$79, representing just 4.8% its GDP. This also falls woefully below the global average per capita spending on health, US\$948.⁸⁵³ On the other hand, during the same period, the United Kingdom having a population of 63.23 million, had a GDP of US\$2.472 trillion and annual health expenditure per capita of US\$3,609. Clearly, these figures demonstrate that the resources invested in healthcare delivery in Ghana are woefully inadequate and this renders the question of whether patients are receiving all available care as rhetorical, rather than real in the context of Ghana. When McLean was asked whether she agreed with the proposition that HCL should not be developed in a country until its economy is adequately advanced, she was quite quick to debunk any such contention.⁸⁵⁴

Thus, it is imperative to realise that even in a country with an inadequately resourced healthcare system, like Ghana, the state must demonstrate good faith to deliver on its assumed international obligations 'to protect, promote and fulfil' the right to health and healthcare, as well as the bundle of all relevant healthcare rights.⁸⁵⁵ This clarion call to the courts (or other external accountability entities) for rigorous scrutiny to ensure that

⁸⁵¹ World Bank, <http://data.worldbank.org/country/Ghana> (accessed: 21/01/2014).

⁸⁵² 'Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.' World Health Organization National Health Account database (see: World Health Organisation, <http://www.who.int/health-accounts/en/> for the most recent updates) (accessed: 21/01/2014).

⁸⁵³ World Health Organisation, <http://www.who.int/health-accounts/en/> for the most recent updates).

⁸⁵⁴ Extract from 'Transcript of Interview with Professor Sheila McLean, 16/10/2013'.

⁸⁵⁵ International Commission of Jurists, 'The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights: A Compilation of Essential Documents' (International Commission of Jurists, Geneva 1997).

resources allocated to healthcare from a state's budget reasonably evince a clear intention of good faith on the part of the state to meet its obligations. Moreover, it is pertinent to underscore the fact that not all the things needed to improve the clinical experience of a patient are contingent upon the availability of adequate resources. Indeed, as McLean's⁸⁵⁶ earlier comment suggests, it is possible for healthcare professionals to adopt good attitudes towards patients without the need to deploy any significant resources and yet their approach can still impact positively on patients' clinical experience. For example, being polite to patients and patiently explaining their condition and the available therapeutic options to them do not require any huge financial outlay.

Mason and Montgomery underscored the necessity of not separating culture from HCL.⁸⁵⁷ According to Montgomery social structures and cultural circumstances of a country are important factors that need to be considered in any endeavour to stimulate development of HCL including the doctrine of informed consent.⁸⁵⁸ Montgomery's suggestion raises important issues concerning the relationship between the social structure in a jurisdiction and the formulation of a legal regime to govern its healthcare system. Drawing on the sociological origin of the doctrine of informed consent, for example, as narrated by Montgomery, the doctrine should not be transplanted hook, line, and sinker without the necessary modifications to suit the local exigencies of the borrowing jurisdiction. In this regard, the incorporation of the doctrine of informed consent in post-2011 statutes in Ghana concerning healthcare was arguably performed without much thought about Ghana's social and cultural context. At this juncture, in order to test the validity of Montgomery's emphasis on the sociological dimension of fashioning HCL rules

⁸⁵⁶ Extract from 'Transcript of Interview with Professor Sheila McLean, 16/10/2013'.

⁸⁵⁷ Extract from 'Transcript of Interview with Professor Ken Mason, 15/10/2013' and Extract from 'Transcript of Interview with Professor Jonathan Montgomery, 25/10/2013'.

⁸⁵⁸ Extract from 'Transcript of Interview with Professor Jonathan Montgomery, 25/10/2013'.

and norms, it is apposite to explore how this doctrine of informed consent has recently been incorporated into Ghanaian law.

The doctrine of informed consent has been incorporated into two new statutes. As earlier discussed in Chapter Four, the *Mental Health Act, 2012* (Act 846) makes reference to informed consent in various aspects of mental healthcare.⁸⁵⁹ According to section 61(3) of Act 846, 'a person with mental disorder shall not be used for teaching and research purposes without informed consent and where that person is incapable of giving *informed consent*, the consent shall be given by the personal representative of that person.' Secondly, the *Public Health Act, 2012* (Act 851) introduces the doctrine of informed consent into mainstream healthcare. The Sixth Schedule to Act 851 reproduces the GHS Patient's Charter. The relevant provisions mirroring the informed consent principle are as follows:

2. The patient is entitled to full information on the patient's condition and management and the possible risks involved except in emergency situations when the patient is unable to make a decision and the need for treatment is urgent.
3. The patient is entitled to know of the alternative treatments and other health care providers within the Service if these may contribute to improved outcomes.
4. The patient has the right to know the identity of the caregivers and any other persons who may handle the patient including students, trainees and ancillary workers.
5. The patient has the right to consent or decide to participate in a proposed research study involving the patient after a full explanation has been given; and the patient may withdraw at any stage of the research project.

It is worthy of note that the phrase 'informed consent' is not expressly used in the text of the Patient's Charter quoted above. Nevertheless, the stipulations regarding the rights of the patient largely coincide with the definition of informed consent given in section 91 of Act 846. Beyond actual clinical practice, Act 851 also extends informed consent to clinical

⁸⁵⁹ See: Section 4.1.2 of Chapter Four.

trials for new medical products and procedures and there it expressly uses the term 'informed consent'. Thus, Section 158 stipulates that:

[w]here the Authority grants authorisation for the conduct of a clinical trial of a drug, herbal medicinal product, cosmetic or medical device or procedure the trial shall not take place until

(a) in the case of the treatment of adult persons, the voluntary written informed consent of the person taking part in the clinical trial has been freely obtained by the person conducting the trial and for a person who cannot read and write in a language that the person understands;

(b) in the case of the treatment of a child or persons under legal disability, the voluntary written informed consent of their parents or legal guardians has been freely obtained by the person conducting the trial;...

Surprisingly, Act 851, which is one of the largest statutes to be enacted in Ghana in recent times, does not define what it means by informed consent in the provision quoted above or anywhere else. Nevertheless, the extent to which this informed consent principle embodied in the law reflects the true convictions and aspirations of Ghanaians is yet another matter for future empirical investigation.

In this connection, Grubb, in responding to the question regarding his advice on developing a discrete body of HCL, stressed the need to allow a large segment of HCL rules to be developed through the proper democratic consultation of stakeholders, rather than leaving almost everything to be worked out by the courts on ad hoc basis. He remarked that:

Developing [HCL] through the courts is a haphazard exercise because it depends upon the case coming up and judges' natural inclination is not to decide more than they need to decide so you may establish some principles and resolve a particular person's case but you don't get guidance as it may apply elsewhere because the judges are not interested in that... So developing through the courts can take a long time... public policy at a grand level can be done by legislature and consultation; [with] now what we call stakeholders; there is a huge number of those in any particular area of medical law in which it is important to know who the stakeholders are. So development through the courts is only a small part of the development of medical law. The majority of it and all regular aspects will need to be done through the democratic process of legislation including consultation. Those

can be very painstakingly slow and difficult to ever find a consensus on because there are so many different views on many controversial issues, it is difficult to formulate public policy in that way, but there is no any other way to do it.⁸⁶⁰

Against the backdrop of this quotation, aspects of new medical advances like IVF and organ transplantation may be considered examples of issues that may provoke different views due to cultural and religious diversity.

Brazier responded to the same question by considering by emphasizing the need for educating future doctors to appreciate the issues and values that HCL seek to advance:

...More generally the most important thing is to teach medical students properly. If we could produce in England and Ghana a generation of doctors who have good comprehension of the legal parameters in which they practice and train to reflect on the ethics of what they do, then there will be less need for medical lawyers.⁸⁶¹

The emphasis on teaching medical students, or future healthcare professionals, and the legal and bioethical norms that define the boundaries of proper medical practice are indeed laudable and crucially worthy of emulation in Ghana. To a large extent, if healthcare professionals do not assimilate good practices as embodied in the relevant laws during their medical education, then a fortiori they cannot be trusted to respect patients' rights in their professional practice. The merit in pursuing Brazier's suggestion is that it could help ensure that HCL in Ghana will not be perceived by healthcare professionals as confrontational, a perception that was regrettably held by some doctors in England and Wales.⁸⁶²

Last but not least, Laurie was concerned about placing too much emphasis on law in an attempt to safeguard patients' interests in healthcare in Ghana. He remarked:

... there is only so much that the law can do in developing a caring relationship. One piece of advice for Ghana is: don't ask too much of the law because the law is a crude tool to develop human relationships and core values. ..It is good to protect

⁸⁶⁰ Extract from 'Transcript of Interview with Professor Andrew Grubb, 22/10/2013'.

⁸⁶¹ Emphasis added. 'Extract from Transcript of Interview with Professor Margot Brazier 18/10/2013'. A copy is available on file.

⁸⁶² See: Chapter Three.

autonomy, dignity, but don't forget that at the end of the day, patients are in a vulnerable position and need to have a good relationship with their healthcare professional...the more we assert patients' rights it means more responsibilities for doctors and that makes doctors more oppositional and it thereby draws patients and doctors apart...⁸⁶³

It appears from Laurie's suggestion that there is a certain fear that using a rights-based approach to regulate the doctor-patient relationship may entail putting the two stakeholders on a collision course, which could aggravate the already vulnerable position of the patient. To my mind, when medical training is infused with heavy doses of HCL and bioethical education, healthcare professionals are more likely to appreciate the need for them to know, respect and uphold the rights of patients in their clinical interaction. It needs to be stressed however that being able to appreciate rights of patients per se is not a guarantee that one will uphold them. In the light of the foregoing, I shall now proceed to explore whether a case can be made for a rights-based approach to the development of HCL in Ghana.

6.4. CONCLUSION

It has been demonstrated in this chapter that there is a real need for patient empowerment in Ghana. This was established by interrogation of instances of exploitation of patient vulnerability drawn from available judicial and quasi-judicial decisions as well as a plethora of evidence from media reportage. Although, these sources could not provide exhaustive instances of patients abuse or disempowerment in Ghana, what these limited sources furnished give us reasonable insight into the predicament of disempowered patients against extremely powerful healthcare professionals that masquered under medical paternalism to either consciously or inadvertently to exploit patients.

⁸⁶³ Extract from 'Transcript of Interview with Professor Graeme Laurie, 15/10/2013'.

Moreover, it has also been contended here that these medical advances that generated bioethical dilemmas in England and Wales are being imported into Ghanaian medical practice. It has been established that there is legal regulatory vacuum regarding these medical advances- such as organ transplantation and IVF. Concerns have been expressed by some moral constituencies about these new developments and potential abuse and scandals that may accompany them. The Chapter has acknowledged that these challenges are not novel to Ghana as they have been experienced by other jurisdictions including England and Wales, albeit in a different context. While it was noted that the quest for patient empowerment and the concerns over medical advances stimulated emergence of a field of HCL, the Chapter expressed point that merely having a field of HCL will not be an immediate solution to the conundrum of patient disempowerment. On the contrary, it was acknowledged that such a distinct body of HCL could potentially facilitate empowerment of patients. In that respect the Chapter pointed out some of the lessons that Ghana could draw from English and Welsh experience in these matters. Particularly, views and recommendations of Pioneering HCL Scholars regarding what Ghana need to do to evolve a HCL regime that will safeguard patients' rights and give voice to them in healthcare matters. An important thread that run through these recommendations by the experts is that Ghana is a unique country by reason of its socio-cultural and economic circumstances therefore it needs to careful adapt doctrines and practices from other jurisdictions in a manner that will be suitable to her. Having the benefit of these guidance from experience of England and Wales I proceed to conclude the thesis and make recommendations on Ghana's forward march.

CHAPTER SEVEN

CONCLUSION AND THE WAY FORWARD FOR GHANA

7.1. SUMMARY OF ARGUMENTS AND RESPONSES TO THE RESEARCH QUESTION

It is now apposite to determine whether the objectives of the thesis with particular reference to the research question and its hypotheses have been attained. To reiterate, the research questions were as follows: How and why a discrete body of HCL emerged in

England and Wales and what lessons may be drawn from this for Ghana. The objectives of the thesis were: a) to clarify the status of healthcare law as a legal field and academic discipline in England and Wales; b) to explore the historical context of the development of HCL in England and Wales; c) to survey Ghanaian law for the existence or absence of a distinct body of HCL through the prism of English and Welsh HCL, and d) to explore potential lessons that can be drawn by Ghana from the English and Welsh experience. All these were ultimately intended to help in proving the hypotheses that: one, the quest for patient empowerment and the legal academic interest in medical advances have accelerated the emergence of HCL as a distinct body of law in England and Wales, and two, the need to protect patients' rights and enhance public awareness of the implications of medical advances should facilitate the development of a distinct body of HCL in Ghana. The justification for the choice of England and Wales as a comparator jurisdiction was elaborated upon in Chapter 1. Some preliminary matters, including my preference for the label HCL, were also clarified in the same chapter.

Methodological choices informing the research were explicated and justified in Chapter Two. Functional Comparative Methodology (FCM) was found to be appropriate for the general framework of the research, notwithstanding the fact that Ghana and England and Wales are at different levels of economic development. It was demonstrated in Chapters Five and Six that to some extent, both countries face similar challenges with healthcare, such as patient safety and rights. The FCM approach was supplemented by legal history and empirical legal studies in order to obtain verifiable evidence to buttress the central argument of the thesis, that the quest for patient empowerment and the growing interest of legal academics in medical advances in Ghana and the expected public awareness in that country are important motivations for the emergence of a discrete body of HCL.

In Chapter Three, a survey of the literature regarding the conceptualisation of a field of law (and for that matter a discrete body of law) revealed that there is no universal consensus on the definition of a legal field. However, the various positions articulated by diverse commentators can be reduced into four key indicators, namely: a legal field must have sufficient case law evidencing factual peculiarities which require specialised analysis; it must have significant interventionist or dedicated legislation to regulate specific relationships; it must have core principles which give it commonality and at the same time distinctiveness, and a field of law must be sustainable by securing a place in legal education and through the existence of scholarly works dedicated to the field. The Chapter demonstrated that not only has there been a significant quantitative increase in healthcare litigation in England and Wales since the 1980s, but more crucially, there are novel cases which present unprecedented legal and bioethical questions. The increasing resort to the courts for answers to some of this unfolding novelty in healthcare litigation is partly attributable to the empowerment of patients by way of according them a greater say in their clinical experience and the concomitant desire of healthcare providers to avoid blame or future liabilities by taking precautions. This includes seeking declarations on the legality of proposed sensitive medical procedures. It was also argued in this Chapter that the emergence of HCL has witnessed the adoption of many statutes and quasi-legislation, such as professional guidelines and directives that are not only novel but unique in terms of the subject matter they address. New technologies in medicine have brought up completely new questions that have stirred up tensions in the various moral constituencies of society and have necessitated the adoption of such dedicated statutes and quasi-laws.

In Chapter Four, I verified the absence of a discrete body of HCL in Ghana through the prism of the established characteristics of English and Welsh HCL. It was found that although

there has been some legislative intervention in macro-aspects of healthcare, many other indicia necessary for a discrete field of law to be constituted were lacking in Ghana. The drivers for the development of this field of law in England and Wales were explored in Chapter Five. It was found that a combination of factors operated in both independent and interconnected ways to facilitate the evolutionary trajectory of HCL. Thus, the general enthusiasm for the protection of human rights was anchored on individualism interrelated with the intervention of non-medical academics⁸⁶⁴ in their critiques on medical ethics. This was in the wake of biomedical scandals unearthed in the 1960s and 1970s, including the Nuremberg Trials and infamous questionable experiments on both sides of the Atlantic. Equally significant in the emergence of the discipline in England and Wales was specifically the vibrancy with which the media projected positive and negative happenings in medicine and healthcare into the spotlight. The prominence of healthcare issues during the period under consideration was noted in this Chapter to have whipped up public interest in debating some of the moral dilemmas generated by medical advances. Another notable contribution explored in Chapter Five was the role played by pioneering scholars in the field and their views concerning the development of the field. Particularly significant is the fact that their views reflected and validated my library-based explanation of the factors that led to the development of HCL.

Chapter Six engaged the major issue of the thesis, namely whether a case can be made for the development of a discrete body of HCL in Ghana. Proceeding from one of the working hypothesis that - *the need for protecting patients' rights and enhanced public awareness of implications of medical advances should facilitate the development of a distinct body of HCL in Ghana* - the Chapter first surveyed the manifestations and

⁸⁶⁴ J Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship* (Oxford, Hart Publishing 2007) 6.

exploitation of patient vulnerability in Ghana. This was done by examining the few cases presented to the courts and the stories reported in the Ghanaian media which have not yet necessarily been litigated. It was also found that there is a growing concern among the Ghanaian public concerning the spate of medical malpractice incidents and scandals in the country. Notably, it was pointed out that all the various forms of media, including the internet, are replete with discussions about the phenomena of medical errors, malpractice and scandals. It was also found that apart from the scandals, identifiable stakeholders, including the Ghana Catholic Bishop Conference,⁸⁶⁵ and the Association of Childless Couples of Ghana⁸⁶⁶ highlighted the regulatory vacuum that has been increasingly visible due to hitherto unknown medical advances, such as IVF, being imported into routine medical practice in the country.

Lastly, Chapter Six, having demonstrated that there is an unmet need in Ghanaian law as regards the failure to empower patients in healthcare, due to the absence of a discrete body of HCL, moved on to explore the viability of a human rights-based (HRB) approach for the development of HCL in Ghana. This HRB approach being advocated for Ghana in this thesis differs from the situation in England and Wales, where HCL reflects human rights but is not necessarily organised around human rights as I envisage them for Ghana. I have argued that there are already important conditions extant in Ghana which are suitable for a HRB paradigm for HCL in that jurisdiction. First, the stable constitutional democracy in Ghana over the last two decades has facilitated a culture of rights consciousness. Second, cheaper access to a quasi-judicial body for redressing human rights violations has addressed the lack of access to courts for the ventilation of grievances. Third, professional codes and

⁸⁶⁵ The Reporter, 'Catholic Bishops conference condemns sale of sperms in Ghana' (*Joy Online*) <http://edition.myjoyonline.com/pages/news/201309/112759.php> (accessed: 1/5/2014).

⁸⁶⁶ *Ibid.*

guidelines can be drawn up or revised to incorporate human rights-based language which healthcare professionals, as members of Ghanaian society, have become conversant with during the past two decades. Finally, factions of the vibrant community of civil society in Ghana, such as the Legal Resources Centre, and the Alliance for African Women Initiative can extend their advocacy role to include healthcare-related rights within their focus, in order to boost patient empowerment by raising awareness of patients' rights.

Without wishing to overstate the achievement of this thesis, a modest claim could be that it has succeeded in charting the historical trajectory along which a discrete body of HCL has developed in England and Wales. The rationales for the emergence of this field of law, which did not exist until the 1980s, have also been explored from different perspectives. Essentially, it was demonstrated that the development of this field of law in England and Wales was a product of the interaction of diverse factors. In relation to this outcome, the thesis also succeeded in empirically verifying the usually unexamined assumption in the literature that HCL has attained the status of a discrete field of law or discipline. The first hypothesis has been positively confirmed in Chapters Three and Five: that the critical motivation for the emergence of a discrete body of HCL in England and Wales during the period under consideration in this thesis was essentially the perceived need to increase patient empowerment, coupled with the interest of legal academics in exploring the interface between law and rapid medical advances.

Furthermore, this thesis has established that Ghana does not yet have a discrete body of HCL. The model of what constitutes a legal field or discrete body of law used to test the presence or absence of discrete HCL in England and Wales was utilised in the Ghanaian context. When the same criteria was applied to Ghana's legal terrain and how it interrelates with healthcare or medical practice, it was found that most of the indicia of a discrete body

of HCL were lacking in Ghana. Additionally, the thesis establishes that the conundrum of patient disempowerment emanating from excessive medical paternalism, coupled with the exploitation of patient vulnerability and the ethical concerns associated with medical advances, which have predominantly motivated the emergence of HCL in England and Wales, are also extant in Ghana. In this regard, some useful lessons can be drawn by Ghana with the necessary adaptation to suit its domestic circumstances, including its socio-cultural milieu and its level of economic development. The next section addresses the practical implementation of some of these lessons. Thus, the absence of HCL in Ghana, as revealed in Chapter Four, together with the glaring spectacle of unchecked exploitation of patient vulnerability explored in Chapter Six, significantly proves the second hypothesis of this thesis that 'the need for protecting patients' rights and enhanced public awareness of implications of medical advances should facilitate the development of a distinct body of HCL in Ghana.'

7.2 FINAL RECOMMENDATIONS FOR FACILITATING THE DEVELOPMENT OF HEALTHCARE LAW TO EMPOWER PATIENTS IN GHANA

Against the backdrop of the reality of patient vulnerability, coupled with the reception of some ethically sensitive medical advances into Ghanaian medical practice, and drawing upon an assessment of the views of pioneering HCL scholars and lessons from my observation of the historical development of a discrete body of HCL in England and Wales, I would propound the following specific recommendations for facilitating the development of HCL in Ghana as a way of empowering patients.

7.2.1. A PLEA FOR COMMISSIONING THE FIRST EVER PUBLIC INQUIRY INTO PATIENTS' EXPERIENCES AND THE ORGANISATION OF MAJOR HOSPITALS IN GHANA

The development of a discrete field of HCL that better safeguards patients' rights will be enhanced (and better rationalised) if an official account of the exploitation of patients' vulnerabilities is generated. This may be achieved with the setting up of a public inquiry to

undertake detailed investigations into patients' experiences and the operations of selected health institutions in Ghana. The findings and recommendations from such an inquiry could greatly assist in addressing fundamental issues affecting clinical safety and accountability, the professional culture in the healthcare system, and the rights of patients. This suggested initiative, if adopted in Ghana, would not be unprecedented. In England and Wales, for example, public inquiries⁸⁶⁷ into the healthcare system have played an influential role in setting aspects of the agenda for HCL and policy reforms.⁸⁶⁸ Having demonstrated the potential utility of a public inquiry to stimulate the development of HCL in Ghana, the next issue that must be considered is the practicality or viability of this proposal there.

The constitutional system in Ghana has already made provision for the use of public inquiries as a tool to probe matters of public interest. According to Article 278 of the 1992 Constitution of Ghana:

the President shall, by constitutional instrument, appoint a commission of inquiry into any matter of public interest where -

- (a) the President is satisfied that a commission of inquiry should be appointed; or
- (b) the Council of State advises that it is in the public interest to do so; or
- (c) Parliament, by a resolution requests that a commission of inquiry be appointed to inquire into any matter, specified in the resolution as being a matter of public importance.

Thus, there are three ways in which the power to set up a commission of inquiry may be deployed. The critical test for invocation of the power in all three circumstances is the need

⁸⁶⁷ I Kennedy, 'Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at Bristol Royal Infirmary 1984-1991' (Cm 5207, 2001).

⁸⁶⁸ For example, see: Department of Health, Great Britain, 'Learning from Bristol: the Department of Health's response to the report of the public inquiry in children's health surgery at the Bristol Royal Infirmary 1984-1995'

<http://beta.scie-socialcareonline.org.uk/learning-from-bristol-the-department-of-healths-response-to-the-report-of-the-public-inquiry-in-childrens-health-surgery-at-the-bristol-royal-infirmary-1984-1995/r/a11G00000017rtwlAA> (accessed: 17/03/2014); Secretary of State for Health, *Safeguarding Patients, the Government's response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries* (Cm 7015, London: the Stationery Office 2007)

to serve the public interest. The Constitution defines ‘public interest’ as including ‘any right or advantage which ensures or is intended to ensure to the benefit generally of the whole of the people of Ghana.’⁸⁶⁹ The broader definition of ‘public interest’ presents an enormous opportunity for formal investigation into any matter which affects the generality of the population. Undoubtedly, the issues of patient safety and patients’ rights can easily satisfy the test of public interest, since almost every person at one point in time may become a patient. It is therefore submitted that probing the operations of some of the selected healthcare institutions in Ghana and how they impact upon patients’ rights and safety are sufficient justification for the use of the constitutional power to set up a commission of inquiry. Notwithstanding the existence of this constitutional facility, no commission of inquiry has ever been established to investigate any matter relating to healthcare in Ghana. It is quite striking that since the commencement of the 1992 Constitution, at least ten commissions of inquiries have been set up to probe political matters.⁸⁷⁰ The issues investigated by these commissions of inquiry were often debated in the media in the same way that the many incidences of medical malpractices and scandals in healthcare are given media spotlight. The budgets of these commissions of inquiry are funded by the Government.⁸⁷¹ Since the nuances of clinical operations of healthcare institutions in Ghana in relation to patients’ experiences have never been subjected to an evidence-based public discourse, the setting up of a commission of inquiry into that subject may help to create a nationwide awareness of the subject and the building of a national consensus on how to

⁸⁶⁹ Article 295 of the 1992 Constitution.

⁸⁷⁰ For example, the Constitutional Review Commission set up by the *Constitution Review Commission of Inquiry Instrument* 2010 (C.1 64); the Ghana @ 50 Commission of Inquiry set up by the Commission of Inquiry (Ghana @ 50) Instrument 2009 (C.I. 61); the Judgment Debt Commission, etc.

⁸⁷¹ Article 295 of the 1992 Constitution.

address safety and patient rights in the country, within the constraints of available healthcare resources.

7.2.2. THE CREATION OF A PATIENT RIGHTS OMBUDSMAN

There is an urgent need for the creation of a functionary or institution along the lines of an ombudsman whose mandate would mainly focus on the healthcare system in Ghana in relation to the rights of patients. As noted in Chapter Six, there is a serious problem regarding a lack of awareness of patients' rights in Ghanaian society. The upshot of this ignorance is that there may be a tendency for patients to relate to healthcare institutions with the erroneous assumption that the care they are receiving is a privilege or favour that the healthcare institution and professionals are extending to them, so they should never have the audacity to question their clinical experience. The suggestion being made for the creation of the office of Patients' Rights Ombudsman (PRO) will assist in obviating or ameliorating the unchecked abuse of patients' rights and the compromising of patient safety.

The aims of a PRO scheme may vary depending on the priorities within a country. For example: it may be either general healthcare services or specifically health sector-oriented; individual patient or group-oriented; ethically or legally-oriented; oriented towards legal safeguards or quality improvement, and so forth.⁸⁷² Be that as it may, it is noteworthy that these aims are not necessarily mutually exclusive, so the PRO being recommended for Ghana in this thesis could be a blend of these varied aims. The most pertinent thing is that a unique model of PRO to be constructed for Ghana should ensure that awareness of patients' rights becomes profoundly embedded in the ethos and culture of healthcare delivery in

⁸⁷² E Segest, 'The Ombudsman's involvement in ensuring patient's rights' (1997) 16 *Medicine and Law*, 473-478; O Molven, 'Building a Patient Ombudsman Scheme: The Norwegian Experience' (2012) 31 *Medicine and Law*, 57-70.

Ghana. According to Fallberg and Mackenney, an ideal patient ombudsman scheme should include a certain minimum of features, namely: it should be regulated by law; it should have a common standardised system for handling requests; it should have full-time personnel who possess basic skills; it should report to the public, and it should have the power to access documents and be subject to regular evaluations.⁸⁷³ Thus, in order to design an effective PRO for Ghana, it would be helpful to reflect the above features.

The potential objection to this recommendation for PRO in Ghana is whether or not it is a duplication of a similar existing constitutional mechanism: the Commission on Human Rights and Administrative Justice (CHRAJ). Notwithstanding the fact that the Constitution of Ghana has created this permanent quasi-judicial body to be responsible for investigating human rights violations and administrative injustice, it is submitted that the call being made here for the establishment of a PRO is neither superfluous nor a recipe for undermining constitutional arrangements for the protection of fundamental human rights and freedoms. Patient rights are a reflection of general human rights and their implementation in specific situations related to healthcare, including submission to diagnosis and therapy.⁸⁷⁴ Thus, the suggestion for this new body to oversee patient rights should rather be seen as a call for the reinforcement of the constitutional goal of securing human rights for Ghanaians, particularly in relation to healthcare. As noted earlier in Chapter Four, CHRAJ was conducting annual surveys to gauge the extent of public awareness of the Patients Charter before it had been given a statutory footing. Nevertheless, the research undertaken in the CHRAJ archives confirms that no inspection has been carried out by CHRAJ on the actual functioning of health institutions in Ghana for the purpose of determining their compliance with human

⁸⁷³ L Fallberg and S McKenney, 'Conclusion' in L Fallberg and S Mackenney (eds), *Protecting Patients' Rights? A Comparative Study of the Ombudsman in health care* (Abingdon: Radcliffe Medical Press 2004) 80.

⁸⁷⁴ A Rabięga-Przylecka, 'Patient's rights in Poland against the background of new regulations' (2012) 31 *Medicine and Law*, 43, 44.

rights norms, particularly patients' rights. This deficit in the work of CHRAJ can be understood since CHRAJ has many responsibilities, but is beset with resource constraints. Thus, it is necessary for complete attention to be given to the inspection and investigation of health institutions. CHRAJ's present responsibility for handling corruption in public services, as well as fundamental freedoms and human rights in the entire country, strongly suggest that it cannot be expected to devote sufficient time and resources to the commitment which an effective PRO service requires. Indeed, whereas CHRAJ deals with human rights in general, a PRO would be required to focus exclusively on human rights in the healthcare context.

Moreover, the present recommendation is timely, since during the last general elections in 2012, one leading political party included a proposal for the creation of a health ombudsman in its manifesto. In an important campaign speech, the Candidate for the New Patriotic Party (NPP) stated:

In our efforts to enhance the quality of care, the NPP will create an ombudsman with the power to investigate and support complaints from patients in both public and private hospitals.⁸⁷⁵

This proposal has been criticised by Pratt, a media commentator, as being an unnecessary duplication, as supplanting the statutory duty of the existing Medical and Dental Council (MDC).⁸⁷⁶ It is submitted that Pratt's criticism is founded upon a misconception of the true legal mandate of the MDC. As has been argued elsewhere, the MDC is mainly responsible for ensuring that medical practice complies with regulatory standards set out under the MDC

⁸⁷⁵ Nana Addo Dankwa Akufo-Addo, 'Saving Our Health Service, Keeping Our People Healthy' (speech by Nana Addo Akufo-Addo, 2012 Presidential Candidate of the New Patriotic Party at the Sunyani Nurses Training College, Sunyani on 17 October 2012) <http://elections.peacefmonline.com/pages/politics/201210/140911.php> (accessed: 13/4/2014).

⁸⁷⁶ F Agyei-Twum, 'Pratt punches Akufo-Addo on Health Ombudsman proposal' (*Joy Online*, 19 October, 2012) <http://politics.myjoyonline.com/pages/news/201210/95779.php> (accessed: 13/4/2014).

Act.⁸⁷⁷ Thus, the role that my recommendation in this thesis is contemplating is far more extensive than the role of the MDC in relation to patients' rights. The PRO will not only receive and investigate complaints, it will also be proactive by undertaking a routine audit of the functioning of healthcare institutions in the country to ascertain the degree of compliance with their obligation to respect and uphold patients' rights.

Having demonstrated the mutual reinforcement between the existing constitutional arrangements and the new body being advocated, it is necessary to explore how the new body should be conceptualised and established. There are two possible routes that may be adopted for the realisation of this recommendation. One way is to create the PRO as a special unit or department within the existing structure of the CHRAJ. The likely negative consequence of this approach is that the effectiveness of the role envisaged for the PRO may be emasculated by the budget squeeze within the already overburdened CHRAJ. This may be ameliorated if the official to occupy the position of the PRO is given a rank as deputy commissioner of the CHRAJ. Such an exalted position of the PRO within the hierarchy of the CHRAJ could assist in positioning the PRO on a strong footing in the inevitable struggle for operational resources with other units or departments within the CHRAJ. The alternative route is to design and create a completely new entity outside the CHRAJ to play the role of the PRO. This option, which is my preference, will ensure that the PRO is truly independent and unfettered by any complex institutional bottleneck so that it can effectively deliver on its mandate.

7.2.3. INTRODUCING THE TEACHING OF HCL INTO THE CURRICULUM OF LAW, MEDICAL AND NURSING SCHOOLS⁸⁷⁸

⁸⁷⁷ E Owusu-Dapaa, 'Ghana' in Herman Nys (ed), *International Encyclopaedia of Laws: Medical Law* (Alphen aan den Rijn, NL: Kluwer Law International, 2014) para 70.

⁸⁷⁸ As recommended by Professor Margot Brazier. See: Chapter 6, Section 6.3, 'Transcript of Interview with Professor Margot Brazier'.

The utility of incorporating the teaching of HCL into the curriculum of educational institutions responsible for training future lawyers and healthcare professionals is self-evident and therefore does not warrant extensive elaboration. It is significant to note that as far back as 1988, the General Medical Council in the UK strongly recommended that medical ethics and law should constitute one of the core components of the medical curriculum.⁸⁷⁹ Making a similar recommendation for medical education in Ghana is therefore not out of place.

Consequently, the remit of this sub-section of the thesis will be to recommend what should go into the curriculum of HCL education in the various institutions in Ghana. Developing a curriculum for the teaching of HCL in various institutions will need to strike a fine balance between depth and coverage. In this regard, Gardener's advice becomes crucially relevant:

The greatest enemy of understanding is coverage... If you're determined to cover a lot of things, you are guaranteeing that most kids will not understand, because they haven't had time enough to go into things in depth, to figure out what the requisite understanding is, and to be able to perform that understanding in different situations.⁸⁸⁰

With the benefit of Gardener's admonition it is imperative to develop a different curriculum with a different emphasis for the three types of institutions which need to introduce the teaching of HCL. The curriculum for law schools will be relatively nuanced and deeper than the ones for medical and nursing schools, given the legal skills and knowledge that law students would already possess. Similarly, the curriculum for medical schools might emphasise aspects of the law that are relevant to the medical profession, whereas the HCL

⁸⁷⁹ General Medical Council, 'Teaching medical ethics and law within medical education: a model for the UK core curriculum' (1998) 24 *Journal of Medical Ethics*, 188-192.

⁸⁸⁰ HW Gardner, 'Educating for Understanding' (1993) 'The American School Board Journal', 24, cited in RN Nwabueze, 'Health care law curriculum and scholarship in Canada, USA and England: lessons for Nigeria', (2010) 44 *The Law Teacher*, 32-41.

curriculum for nursing schools would highlight the interface between law and the nursing profession. In the Table below, an attempt is made to suggest a HCL curriculum for the various educational institutions in Ghana that need to offer a course in this emerging area of the law.

TABLE 3: PROPOSED HEALTH CARE LAW CURRICULUM FOR HIGHER LEARNING INSTITUTIONS IN GHANA

LAW FACULTIES/ SCHOOLS	MEDICAL SCHOOLS	NURSING SCHOOLS/COLLEGES
1. The Role of Law and (Bio)ethics in the Regulation of Healthcare	1. General Introduction to Ghanaian Law and its Relevance to Medicine	1. General Introduction to Ghanaian Law and its Relevance to Nursing
2. The Doctor-Patient Relationship	2. The Relationship between Law, Medical Ethics and Bioethics	2. Nurses and Medical Liability
3. Autonomy, Informed Consent and Refusal of Treatment	3. The Rights of Patients and Duties of Doctors in the Doctor-Patient Relationship	3. Patients' Rights
4. Human Rights and Health Care	4. Medical Liability - Civil and Criminal	4. The Regulation of the Nursing Profession
5. Clinical Negligence and Medical Products Liability	5. The Regulation of the Medical and Dental Profession	5. Legal Issues in Medical Advances - IVF, Surrogacy, Abortion, Organ Transplantation
6. The Structure of Ghana's Healthcare System and Patient Access to Resources	6. Legal Issues in Medical Advances - IVF, Surrogacy, Abortion, Organ Transplantation	6. Public Health Law
7. Pharmaceuticals, Regulation and Research	7. Public Health law	7. Mental Health Law
8. Legal Issues at the End of	8. Mental Health Law	

Life: Dying, Death, Assisted Dying		
9. Abortion and Assisted Reproduction		
10. Organ Donation, Transplantation and Human Tissue		
11. Mental Health		
12. Public Health		

A close scrutiny of the above table reveals that many of the topics to be treated in the various institutions are similar. Nevertheless, it bears emphasising that the depth of coverage will be deeper for law students than their counterparts in the medical and nursing schools. This is justifiably so, as future lawyers need to have a deeper appreciation of both the substantive and procedural components of HCL in order to be in a better position to address disputes or contentions that may arise from medical practice or healthcare. Conversely, although medical and nursing students will not have the legal knowledge that law students possess, the way in which the curriculum in medical schools in the UK covers law could be looked at in order to ensure that this is taught at an appropriate level to facilitate understanding.

7.2.4 THE CREATION OF A SIMPLE CIVIL PROCEDURE FOR OBTAINING DECLARATORY JUDGMENTS FROM HEALTHCARE INSTITUTIONS

In order to overcome the situation whereby contentious and ethically sensitive procedures are undertaken in Ghana's hospitals, without clear certainty as to their lawfulness, it is recommended that a simple and straightforward procedure should be included in Ghanaian civil procedure for the sole purpose of enabling healthcare institutions

to seek declaratory judgments. Currently, declaratory judgments can be obtained just like any other remedy in civil suit. Thus, a healthcare institution which needs assurance of the lawfulness of a procedure, such as a surgical operation to separate conjoined twins which carries a high risk of one of the patients dying, would need to issue a writ of summons and go through the various stages of pleadings before the matter can be fixed for applications for directions (or pre-trial proceedings) so that the court can set the action down for trial on a definite date. All these processes can take more than two months before the matter comes up for a definite hearing.⁸⁸¹ It is trite to mention that in medicine or healthcare, time⁸⁸² is not merely a luxury, but is rather of the essence in many delicate procedures, since a few minutes' delay can result in an otherwise avoidable death.

A simplified procedure for obtaining declaratory judgments in relation to contentious medical procedures for adults who lack capacity may draw inspiration from the English and Welsh *Practice Direction (Practice Direction E – Applications Relating To Serious Medical Treatment)*,⁸⁸³ adopted in the wake of *Bland*-type cases.⁸⁸⁴ It is pertinent to note that the use of the term 'incapacitated patients' here does not refer to mental health patients, who are subject to the elaborate framework of the Ghanaian *Mental Health Act, 2012*. On the contrary, the term 'incapacitated patient' is used to refer to patients who are not ordinarily mental health patients, but due to a particular health condition or circumstance, lose the ability to exercise their right to self-determination with respect to proposed medical procedures. The procedure being contemplated under my present recommendation will also encompass children who lack the capacity to participate in decision-making concerning

⁸⁸¹ See generally: K Tetteh, *Civil Procedure* (Accra: Black Mask, 2011).

⁸⁸² J Harrington, 'Time as a dimension of medical law' (2012) 20 *Medical Law Review*, 491.

⁸⁸³ Courts and Tribunals Judiciary, 'Practice Direction – How To Start Proceedings'

<http://www.judiciary.gov.uk/wp-content/uploads/2014/05/9E-%E2%80%93-Applications-relating-to-serious-medical-treatment.pdf> (accessed: 2/7/2014).

⁸⁸⁴ *Airedale N.H.S. Trust v Bland* [2002] 1 All ER 794

crucial treatment or medical procedures. In this regard, it is pertinent to point out that the enforcement procedure under the Ghanaian *Children's Act, 1998 (Act 560)* is not appropriate for HCL cases involving children. The requirement for the establishing of a panel to sit as a Family Tribunal before a matter affecting a child can be investigated stands a high risk of delaying the disposition of time-sensitive HCL cases. The civil procedure rules should not only be simplified, but also expedited to deal with these special types of HCL cases.

It is submitted that the existing jurisdiction of the High Court regarding the enforcement of fundamental freedoms and human rights under Article 33 of the Constitution should be adapted to deal with applications for declaratory judgments in time-sensitive HCL cases. This procedure for human rights enforcement⁸⁸⁵ cannot achieve the urgency which the exigencies of contentious medical procedures usually call for. For example, the recent separation of conjoined twins which made headlines in Ghana required swift action in order to avoid further complications, since they were joined at the stomach and waist.⁸⁸⁶ Clearly, it was known to the doctors who undertook the operation that it was highly risky in terms of the survival of both twins involved, but they went ahead without seeking any declaration as to the lawfulness of a surgery which was known to be likely to result in fatality. This is in contrast to the approach taken by healthcare providers in the UK, who deemed it necessary to obtain a declaratory judgment before proceeding with a similar operation in *Re A (Conjoined Twins)*.⁸⁸⁷ A plausible rationalisation for choosing not to involve the courts in the decision to carry out the surgical separation of conjoined twins in circumstances known to be likely to be fatal in the Ghanaian case is that there is a lack of

⁸⁸⁵ The nuanced procedure for Article 33 of the Constitution is contained in the *High Court Civil Procedure Rules, 2004 (C.I. 47)*, Order 67.

⁸⁸⁶ The Reporter, 'Second separated Siamese twin also dies' <http://graphic.com.gh/archive/Health/second-separated-siamese-twin-also-dies.html> (accessed: 20/4/2014).

⁸⁸⁷ [2000] EWCA Civ 254.

enforcement of criminal law against healthcare professionals in Ghana. This is due to complex factors, including a lack of awareness on the part of the Ghana Police Service that healthcare professionals are still subject to the criminal law of the land when they make their best endeavours to save lives. That being said, Brazier and Ost have noted that even in a jurisdiction like England and Wales, where there is a fully matured field of HCL, the criminal prosecution of doctors is not popular compared to civil suits.⁸⁸⁸

7.2.5 THE ESTABLISHMENT OF A PERMANENT BIOETHICS COMMISSION

In order to avoid the ad hoc resolution of moral dilemmas generated by medical advances and even some routine medical practices in Ghana, it is recommended that a permanent body be set up by statute to continuously and systematically identify and promote policies and practices that ensure that healthcare delivery and biomedical research are conducted in a socially and ethically responsible manner. This is imperative for a country like Ghana which has plural moral constituencies, due to the cultural diversity among the different ethnic groups in the country. Such a commission should be broad-based in its membership and independent in the discharge of its mandate. The reports it will produce may serve as a useful source of advice to lawmakers and professional bodies. In conceptualising the composition and mandate of the permanent commission recommended by this thesis, inspiration may be drawn from the Nuffield Council on Bioethics (NBC) in the

⁸⁸⁸ M Brazier and S Ost, *Bioethics, Medicine and the Criminal Law Volume III: Medicine and Bioethics in the Theatre of the Criminal Process* (Cambridge: Cambridge University Press 2013).

UK⁸⁸⁹ and the Presidential Commission for the Study of Bioethical Issues (PCB) in the USA.⁸⁹⁰

For example, the terms of reference of the NBC may be particularly instructive:

1. To identify and define ethical questions raised by recent advances in biological and medical research in order to respond to, and to anticipate, public concern;
2. To make arrangements for examining and reporting on such questions with a view to promoting public understanding and discussion; this may lead, where needed, to the formulation of new guidelines by the appropriate regulatory or other body;
3. In the light of the outcome of its work, to publish reports; and to make representations, as the Council may judge appropriate.⁸⁹¹

The composition of the recommended permanent ethics commission will partly determine its credibility and independence. In this regard, it will be necessary to allow a representative to be selected from major stakeholders in matters pertaining to morality, traditional culture, major religions and active researchers in medical sociology, theology, healthcare law, and health-related human rights. On the basis of these thematic stakeholders, representatives may be drawn from the Christian Council of Ghana, the National Catholic Secretariat, the Ghana Islamic Federation, and the National House of Chiefs.

Admittedly, some aspects of the mandate envisaged for the recommended permanent bioethics commission are being taken by the Clinical Trials Technical Advisory Committee (CTTAC) of the Food and Drugs Authority (FDA), recently created by the *Public Health Act, 2012*.⁸⁹² Nevertheless, it is submitted that the CTTAC in its present design under the law cannot be considered adequate for the purposes of addressing the tensions between morality, law and medicine, particularly in relation to new technologies and procedures in

⁸⁸⁹ Nuffield Council on Bioethics, 'Exploring Ethical Issues in Biology and Medicine' <http://www.nuffieldbioethics.org/about> (accessed: 17/4/2014).

⁸⁹⁰ <http://bioethics.gov/about> (accessed: 17/4/2014).

⁸⁹¹ Nuffield Council on Bioethics, n. 888 above.

⁸⁹² See: Public Health Act 2012 (Act 851), s. 150.

medicine. The object of the CTTAC is to provide the FDA 'with on-going and timely medical and scientific advice on current and emerging issues related to clinical trials.'⁸⁹³

Clearly, it is evident from the stated purpose of the CTTAC that it is not mainly concerned with the moral or ethical dilemmas associated with healthcare and medical advances; rather, it seeks to provide technical scientific data to be used as a basis for cross-checking the scientific and medical claims of applicants for approval or licence from the FDA. Undoubtedly, furnishing the FDA with independent technical scientific data is important as it will ensure patient/consumer safety. Nevertheless, it is not every drug or medical device which ensures patient safety that may be accepted as appropriate by society. This is particularly so where there are contested moral ramifications regarding a drug or medical technology. Consequently, the obvious option apparently needed to address this gap is that CTTAC should either be allowed to continue intact as established by Act 851, or should be substantially reformed in terms of its mandate, composition and relationship with the FDA in order to ensure its independence and credibility. Even if the latter does occur, there are still ethically contentious areas in healthcare which do not necessarily relate to drugs, for example, the refusal of life-sustaining medical treatment. To that extent, the recommendation for a new commission being made here is still relevant.

7.2.6 CONTINUING PROFESSIONAL EDUCATION IN HCL FOR JUDGES, LAWYERS AND HEALTHCARE PRACTITIONERS

As demonstrated in Chapter Four, the legal aspects of healthcare have not been incorporated into the curriculum of universities offering law programmes in Ghana. In fact, the Chapter confirms that medical ethics and law have never been part of medical education in Ghana. The combined effect of these deficits in legal and medical education, at least from

⁸⁹³ Ibid 151.

the perspective of patient empowerment and safety, was equally explored in Chapter Six. Although a specific recommendation has been made above for the introduction of HCL and its variant modules in Ghanaian law faculties and medical schools, it is important to address the knowledge or awareness gap among the large number of already qualified lawyers (including judges) and doctors who have completed their formal education and are now practicing their vocations. To obviate this hurdle, it is recommended that a special short training course be designed around key themes in HCL, health and human rights for lawyers and medical practitioners. Since they are both well-organised professions, such a course could be included in the continuing professional educational programmes for the respective professions. This will encourage as many lawyers and doctors as possible to patronise such educational programmes, as they will be accumulating credit for the renewal of their licence.

7.5. THE LIMITATIONS OF THE RESEARCH AND ISSUES FOR FURTHER RESEARCH

Despite the significance of this study as noted earlier in Chapter One, there are limitations which need to be acknowledged and used as premises for delineating issues that require further research. First, due to the lack of systematic documentation of decisions of the Mental and Dental Council (MDC) of Ghana, access could not be obtained to the full gamut of disciplinary cases handled by the MDC since 1980. Thus, a statistical pattern could not be generated from decisions of the MDC concerning the violation of patient rights. In this regard, it would be useful for research to be conducted into all the cases that have been decided by the MDC since 1980. This will give a profound insight into the nature of grievances that patients bring against doctors and the attitude of the MDC towards such

cases. Such a work may benefit from similar research carried out by Smith in relation to the UK's General Medical Council.⁸⁹⁴ Secondly, the views of healthcare professionals, especially doctors, could shed more light on the necessity to incorporate HCL and ethics-related modules in medical school curricula. The views of medical officers in charge of hospitals that have been involved in scandals reported in the media could also have been elicited through interviews, but the difficulty of access and resource constraints prevented me from including these aspects in my research. Thus, it may be necessary for further empirical research to be pursued in this area. Thirdly, the lawyers who have handled the few available decided cases on medical malpractice could have also been approached for views on matters being investigated in this thesis, but logistical constraints have impeded their inclusion in my study. This also provides another issue for further empirical legal research in the future.

Finally, as noted in Chapter Six (Section 6.3), post-2012 statutes enacted in Ghana embody the informed consent doctrine. However, there is no evidence of public consultation preceding the passing of these statutes, so it is uncertain whether this foreign doctrine has been adapted to reflect the cultural ethos and true aspirations of Ghanaian patients. Consequently, an empirical investigation to ascertain the views of the public on their understanding and expectations regarding the incorporation of the informed consent doctrine in Ghanaian law will be quite a useful enterprise. Finally, the fact that the comparison in this thesis was made only between two jurisdictions is a limitation in itself since other approaches to dealing with the same problems studied in relation to England and Wales and Ghana were not explored.

⁸⁹⁴ RG Smith, 'The Professional Conduct Jurisdiction of the General Medical Council, 1858-1990' (Oxford Socio-Legal Studies, Oxford: Clarendon Press 1994).

7.6. FURTHER EVALUATION OF STRENGTH AND WEAKNESSES OF METHODOLOGICAL APPROACH OF THE THESIS

In Chapter Two it was indicated that the nature of the research problem the thesis is dealing with did not lend itself to one methodology. It was contended that adopting a single methodology run a high risk of not being able to achieve the set goals of the research. In the light of that precaution the thesis adopted a blend of three legal research approaches namely- Functional comparative law approach, non-doctrinal legal history and empirical legal studies. Having gone through the research and reached conclusion of the thesis it is apposite that a critical reflection is done the strength and weaknesses of this methodological approach.

The earlier discussion in Chapter in critiquing each of the three disparate methodologies was largely theoretical as most of what was known about them was predominantly from the literature. Nevertheless, at this stage these approaches have been tested by the entire circumstances of the research experience so an informed critique can be done here. There are advantages of deploying the three research approaches together. To begin with, the thesis sought to understand how a distinct body of HCL emerged in England and Wales and in relation to that explore lessons for Ghana. The broader objective of such question was to establish whether the problem of patient disempowerment and bioethical dilemmas of medical advances had any significant relationship with a distinct discipline of HCL.

The functional comparative approach assisted the research to compare and contrast what exist in the two jurisdiction studied without strictly superimposing what is in one over the other. This was made possible by supplementing the comparative aspect of the methodology with 'lesson drawing.' The lesson drawing disposition of my approach to the research meant that the great disparity between England and Wales, and Ghana did not invalidate the comparison as would have been the case with legal transplantation. Furthermore, the empirical legal studies enabled the thesis to satisfy some of aspects of originality. Indeed, the data collection through email survey and the semi structured interview of the Pioneering HCL Scholars generated data previously unable in the literature.

The blending of three legal research approaches was fraught with its own problems and limitations and some of them were encountered in the course of the research. One, there was the danger of overlapping in terms of theoretical underpinnings and practical deployment of some of the approaches. For example, non-doctrinal legal history and functional comparative law both do not limit themselves to strict legal doctrine- in terms of case law, statutes and academic analysis of those laws- but also go further to engage sources and materials that are will be rejected by a typical black letter law researcher.

APPENDIX 1

[ETHICS CLEARANCE FROM LANCASTER UNIVERSITY]

Stage 1 self-assessment approval

Ethics (RSO) Enquiries

Sent: Wednesday, September 04, 2013 10:00 AM

To: OwusuDapaa,

Ernest

Cc: Ost, Suzanne; Skogly, Sigrun

Dear Ernest,

Thank you for submitting your completed stage 1 self-assessment form for *An inquiry into the emergence of health care law in England and Wales as a distinct body of law-what lessons can be drawn from this in relation to Ghana?* **I can confirm that approval has been granted for this project.**

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress) to the Research Ethics Officer;
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval. Please contact the Research Ethics Officer, Debbie Knight (ethics@lancaster.ac.uk 01542 592605) if you have any queries or require further information.

Kind regards,

Debbie

Debbie Knight

Research Ethics Officer

Research Support Office

B58, B Floor,

Bowland Main

Lancaster University

Lancaster, LA1 4YT

Email: ethics@lancaster.ac.uk

Tel 01524 592605

Web: Ethical Research at Lancaster:

<http://www.lancs.ac.uk/depts/research/lancaster/ethics.html>

Looking for funding opportunities specific to your research?

Go to the [RSO website](#) to search the *Research Professional* funding database.

This email

APPENDIX 2

Dear Sir/Madam,

I am a PhD student at Lancaster University School of Law. I am exploring the historical development of medical law/health care law as a distinct body of law in England and Wales. As part of my PhD, I am seeking to determine the extent to which medical law/health care law has been incorporated into the curriculum of law schools in England and Wales. To this end I am writing to enquire:

(1) whether you offer an undergraduate module in medical law/health care law

(2) if so, what year did the module commence?

If you do offer such a module, I would be most grateful if I could have a copy of the module outline, syllabus, or handbook. I will only use this information for my PhD research as outlined above. If you have the time to respond to my request by 10th September, 2012, this would be very much appreciated.

Thank you for your help and please do not hesitate to contact me if you have any queries.

Ernest Owusu-Dapaa, PhD student

Law School
Bowland North
Lancaster University
Lancaster
LA1 4YN

APPENDIX 3

Semi-structured interview guide:

1. **Law and Medicine's relationship before the 1980s**

- a. How did the law relate to issues arising in healthcare during the long period before the 1980s?
- b. Why did the law relate to medicine in the way it did?
- c. As an academic, did you have a research interest in matters relating to law and healthcare before the 1980s?

2. **The surge in academic interest in law and medical ethics post-1980:**

- a. How did you develop an interest in law and medical ethics?
- b. Did you encounter any challenges as you embarked upon the publication of your research into this new area of the law?
- c. Can you explain if there was a particular objective(s) which you wanted to pursue by focusing your academic interest on this area of the law?
- d. Do you consider that there was a surge in academic interest in law and medical ethics post-1980? If so, please can you explain why you think this happened?

3. **The courts, legal professions and the emergence of a distinct body of healthcare law:**

- a. How would you describe the general stance of the courts and legal professions in relation to this field of law?
- b. Do you think that the courts and the legal professions could have contributed differently to the development of this area of the law? Please explain your answer.

4. **The potential of English and Welsh healthcare law to be exported;**

- a. Are there aspects of the body of healthcare law in this England and Wales which you think could and should be emulated by other jurisdictions?
- b. Which direction do you think English and Welsh healthcare law is currently facing - towards the patient, or towards the medical profession? Or towards something or someone else?
- c. What advice would you give to a developing country with a common law tradition like Ghana, which is seeking to draw lessons from the experience of England and Wales in this field of law?

APPENDIX 4

TRANSCRIPT OF INTERVIEW

Student: Ernest Owusu-Dapaa

Supervisors: Professor Suzanne Ost and Professor Sigrun Skogly

Working Title:

An Inquiry into the Emergence of Health Care Law in England and Wales as a Distinct Body of Law - What Lessons Can be Drawn From This in Relation to Ghana?

Hypotheses:

1. The quest for patient empowerment and the legal academic interest in medical advances accelerated the emergence of health care law as a distinct body of law in England and Wales.
 2. The need for protecting patients' rights and enhanced public awareness of implications of medical advances should make health care law more visible in Ghana.
-

Semi-structured interview

1. Name of Interviewee: PETER SKEGG KENNEDY

Mode: Written Responses via Email

1. Law and Medicine's relationship before 1980s–

a. How did the law relate to issues arising in health care during the long period before 1980s?

The law has related to issues arising in health care for centuries e.g. the licensing of various professionals, the law relating to asylums and lunatics, abortion, negligence/manslaughter. There have long been books about the law for medical practitioners, in addition to those on “medical jurisprudence” (which might now describe as forensic medicine). A search of the index volumes to Holdsworth’s multi-volume *History of English Law* would lead you to the statutory regulations relating to the UK medical professions etc.

Your question “how did the law relate to . . .” does not admit of a simple answer, at least from me.

b. Why did the law relate to medicine in the way it did.

Given my inability to answer your initial question (which would require several PhD theses to answer at all adequately); I am sorry to report that I can’t answer this one either.

c. As an academic did you have research interest in matters relating to law and health care before the 1980s

Yes. I first started researching in this area in 1966, as a law student in New Zealand. In 1969 I published an article arguing for what came to be called *Gillick* competence (although by the time of the *Gillick* decisions what we now call *Gillick* competence was accepted in most Torts and Family Law textbooks, usually – if I remember correctly – which a reference to my Anglicised (Mod L Rev) version of my 1969 NZ article.

I commenced doctoral research in this field at Oxford in October 1969, and continued with this full-time until I became a Fellow of New College Oxford in October 1971. English health care law (though we didn’t use that term then) remained my main research and publishing activity until 1984 when I returned to New Zealand to become a Professor of Law at the University of Otago (the post I still hold, almost 30 years later).

In the 1970s Ian Kennedy and I were the two English academic lawyers whose main focus was on “the law and health care” (to use your expression). There were, however, other academic lawyers who wrote in that field in the later 1970s and the early 1980s: from memory, Glanville Williams, John Finnis, Graham Zelicke, Joseph Jacob, John Finch, Gerald Robertson, and before long John Keown.

I self-identified above as being an “English” academic lawyer, not so much because England is the land on my birth (although not upbringing) but because throughout the 1970s I was working on English *medical law* and from 1971 I was employed at an English University,

Having now used the term “medical law”, perhaps I should explain that I did not use that term in the 1960s or very early 1970s, as at that stage I thought in terms of the traditional categories of tort law, criminal law, contract law, etc. . . . And I avoided using the term “medical jurisprudence”, as the textbooks on that subject seemed much more concerned

with medicine relating to law rather than with law relating to medicine. Their accounts of the law were usually brief and unimpressive.

I first used the term “medical law” in my entry in the 1973 edition of the Directory of Members of the Society of Public Teachers of Law (now renamed the Society of Legal Scholars). I thought at the time, and for a great many years later, that I was coining the term, which I used in an article the following year and in the subtitle of a book a decade later. (I am not aware of any use of the term in the UK in a pre-1973 directory, a pre-1974 article, or a pre-1984 full title of a book: please let me know if you find one.) Ian Kennedy did not use the term in his entry in the 1974 SPTL directory, but adopted it in his 1975 entry.

Glanville Williams was the major English (strictly speaking, Welsh) academic who preceded Ian and my entry into the medical law field. I do not think Glanville ever used the term medical law, but was he still writing he would be viewed as a medical lawyer (although very far from being exclusively one). For the ways in which Glanville’s, Ian’s and my contribution to the development of the subject have been viewed, see the oft-quoted assessment by the then editor of the *Medical Law Review* at [1998] *Med L Rev* 136 and the first paragraph of the third chapter in John Keown’s *Law & Ethics of Medicine* (OUP, 2013)

My reason for first using the term “medical law” was twofold. One was that I came across a US book entitled *Legal Medicine*, and realized that my area of interest was the precise opposite: *Medical Law*. The other was that I was asked to lecture on Public Order as part of the Constitutional Law at Oxford. Back to the time of Dicey this topic has included Public Order Offences, and this helped me realise that merely because something could be taught as part of a criminal law course did not mean that it could not find a place in a differently named subject. Nowadays courses and books on eg Sports Law and Entertainment law are so commonplace that I wonder why it took me (and others) in England so long to talk of Medical Law or (more recently) Health Care Law.

2. The Surge in academic interest in Law and Medical Ethics post 1980

a. How did you develop an interest in law and medical ethics?

My interest in the subject dates from 1966 (although I now realize that some of the groundwork had been laid by my criminal law teacher in 1964).

1966 was the year when my teenage girlfriend (since late in 1963, and now wife for most of the 50 years following) started her nursing training. Work on the wards came much earlier than it does nowadays. So one element (and the one that I usually provide when people ask how I became interested in the subject) was hearing about the issues she was faced with on the ward and seeking, as a law student, to work out their legal ramifications.

But there was more to it than that. I was puzzled by the attitude to abortion in the circles in which I moved, so made use of the opportunity, as part of the Auckland law course, to write a research paper on that topic. This contributed to my interest in this area of the law.

My interest was also fostered by reading (initially, for the research paper) Glanville Williams' *Sanctity of Life and the Criminal Law* (with, as I mentioned at the beginning of my contribution to the issue of the *Med L Rev* cited above, a mixture of fascination and frustration). Had I agreed with all of it, and an article on consent issues published the previous year in *Med Sci Law*, I doubt if I would have been stimulated to continue in the field. I soon found other fascinating publications, most importantly the proceedings of a CIBA Foundation seminar edited by GEW Wolstenholme and M O'Connor *Ethics in Medical Progress* (1966), which I acquired and read closely.

b. Did you encounter any challenges as you embarked upon publication of your research in this new area of the law?

None whatever.

As I mentioned above, I became a Fellow of New College in October 1971. Within the next four or five years – before finishing my DPhil – I published articles in a fair range of journals, including all three of what I then regarded (before the days of the OJLS) as being without doubt the three leading UK law reviews: the LQR, CLJ, and MLR.

Only once was an article turned down by the editor to whom I had first submitted it, and I was aiming high as it was a second submission to the LQR in a very short time. (It has been cited more than any other article I wrote in my 15 years at Oxford!)

In the late 1980s the law editor for OUP canvassed members of the Oxford Law Faculty about possible monographs and then reported back to me that of all the possibilities discussed mine was the one that he was keenest to bring to fruition. (My one compromise, given that “Medical Law” was then a rarely heard term, was to use that expression in the subtitle rather than the main title.)

So I see the 1970s and 1980s as a marvellous time to publish on English medical law.

c. Can you explain if there was particular objective (s) which you wanted to pursue by focusing your academic interest towards this area of the law?

No, I chose to work in this area for my DPhil at Oxford because there were some issues/misunderstandings that were “bugging” me and I wanted to sort them out and then

return to NZ to focus on what I thought would be my main long-term interest: NZ constitutional history. But the subject then “took off” and I have been running to keep up with it ever since.

d. Do you consider that there was surge in academic interest in law and medical ethics post 1980? If you consider there was a surge, please can you explain why you think this happened?

The interest was developing in the 1970s: eg Ian Kennedy’s BBC radio programmes and his being invited, though a mere Lecturer at that stage, to deliver the Reith Lectures. The invitation, and the lectures themselves, can be seen both as a symptom and as a cause. Ian’s Reith Lectures were very significant in the UK, but I suspect less so in the USA, where Bioethics was born in the 1970s (if I understand it aright).

There are many reasons for the surge, but in terms of the law they include the growth of UK law schools and in numbers of academic lawyers and graduate study; the fashion for taking on subjects that were not already dominated by major academics; and the much greater recourse to the courts to deal with medico-ethical dilemmas, which was linked to the increased willingness of the courts to deal with matters prospectively. (The introduction of RAE/REF may also have added to the incentive to move into new fields.)

Incidentally, one way of measuring the increased academic interest in medical / health care law would be to look at the “Special Interests” listed by UK members of the SPTL/SOLS in the Annual Directory at (say) 5 year intervals.

3. The courts, legal profession and the emergence of a distinct body of health care law.

a. How would you describe the posture of the courts and legal profession generally toward this field of law?

Clearly it has become of much greater interest to them. Here too an examinations of lawyers’ directories etc might well reveal that in the 1970s there were relatively few eg barristers advertising (though we mustn’t call it that) their interest and expertise in the area, whereas by the 1990s there were more and nowadays many.

The area is such a wide-ranging one that I am suspicious of generalisations. However, I think the courts are less inclined to leave difficult ethical issues to the medical profession to the extent they once did. (Whether this is beneficial, except to the lawyers’ bank accounts and academics’ publication records, is of course a different matter.)

The academic study of the law sometimes focuses unduly on case law, especially that of appellate courts. Statute law, and tribunal decisions, do not always received appropriate attention.

b. Do you think that the courts and the legal profession could have contributed towards the development of this area of the law differently? Please explain.

Yes. For example, they could have left more of these matters to be decided by doctors.

Are there better ways of resolving these issues, when the affected parties have not been able to reach agreement?

Tomorrow I hope to be able to email a list of my 1970s publications. I will also try to copy and attach the relevant part of the 1976 survey, which indicates that UK law schools did not offer courses in the subject at that stage.

From: Peter Skegg [peter.skegg@otago.ac.nz]
Sent: Tuesday, October 29, 2013 4:06 AM
To: Owusu-Dapaa, Ernest
Subject: Additional information (and a correction)
Dear Ernest,

Having now printed out the answers that I sent you, I have seen that there were quite a number of grammatical errors and omitted words.

The one significant mistake was about the time when I received encouragement from the OUP law editor: I meant to write "late 1970s" rather than "late 1980s".

My list of academics who showed an interest in medical law in the 1970s should have included Prof Gerald Dworkin, then of Southampton. By the early 80s Andrew Grubb, then of Cambridge, was a major player.

I will attach a pdf of Graham Zellick's survey. (He went on to become VC of the University of London.)

A list of my first decade of medical law publications is set out below.

Kind regards,

Peter

1969 'Capacity of Minors to Consent to Medical Procedures on Themselves' 4 *Recent Law* 295-30.

1973 'Consent to Medical Procedures on Minors' 36 *Modern Law Review* 370-381

1974 'Liability for the Unauthorized Removal of Cadaveric Transplant Material' 14 *Medicine, Science and the Law* 53-57.

1974 'Irreversibly Comatose Individuals: "Alive" or "Dead"?' 33 *Cambridge Law Journal* 130-144.

1974 'A Justification for Medical Procedures Performed Without Consent' 90 *Law Quarterly Review* 512-530.

1974 'Medical Procedures and the Crime of Battery' [1974] *Criminal Law Review* 693-700.

1975 'Informed Consent' to Medical Procedures' 15 *Medicine, Science and the Law* 124-132.

1975 'Human Corpses, Medical Specimens and the Law of Property' 4 *Anglo-American Law Review* 412-425.

1976 'The Interpretation of the Human Tissue Act 1961' 16 *Medicine, Science and the Law* 193-199.

1976 'Medical Procedures and Two Offences Against the Person' 16 *Medicine, Science and the Law* 264-265.

1976 'The Case for a Statutory "Definition of Death" ' 2 *Journal of Medical Ethics* 190-192.

1977 'Liability for the Unauthorized Removal of Cadaveric Transplant Material: Some Further Comments' 17 *Medicine, Science and the Law* 123-126.

1977 'English Law relating to Experimentation on Children' [1977] 1 *Lancet* 754-755.

1978 'Authorization of the Removal of Cadaveric Transplant Material at Common Law' 18 *Medicine, Science and the Law* 90-92.

1978 'The Termination of Life-Support Measures and the Law of Murder' 41 *Modern Law Review* 423-436.

2. NAME OF INTERVIEWEE: SHEILA McLean [hereafter 'SM']

DATE: 16/10/2013 TIME: 19:00

MODE: TELEPHONE CONFERENCE VIA SKYPE RECORDING

Semi-structured interview Guide

1. Law and Medicine's relationship before 1980s

a. How did the law relate to issues arising in health care during the long period before 1980s?

SM: Probably in a very limited way. Most of the cases that arose before 1980 were more about criminal issues; for example about abortion and that sort of thing. Very few issues that we now regard as mainstream medical law - for example cases on negligence arose - so there wasn't a national jurisprudence as such except for a very limited body of law. Arguably the majority of activity before 1980 was at the international level, so there were a number of international declarations about using human beings in research and so on, particularly following the Nuremberg Trials; and some of the medical professional associations had a fair amount to say but basically what existed in the way of case law was relatively scarce.

b. Why did the law relate to medicine in the way it did.

SM: I think in part; patient in those days were much less likely to challenge clinical decisions and the culture of medical paternalism was still very powerful in those days; so patients, I think, in a sense colluded with that and simply didn't challenge when things went wrong; there wasn't a culture of openness among healthcare professionals. And so there was no obvious reason for the law to become engaged because there wasn't a big volume of people actually registering complaints about the way that they have been treated in the healthcare system.

c. As an academic did you have research interest in matters relating to law and health care before the 1980s

Yes I had interest before 1980. I set up the first honors Programme in medical law in the UK in 1976; so I was working in that area pretty much before anybody else was. In E & W, it started after 1980. Ian Kennedy was doing some teaching at Kings College London around the same time, but as a discipline it really took off nationally quite a long time after I had been teaching it. I believe the 2nd full honors programme in medical law was actually in University Edinburgh and that started in 1980.

2. The Surge in academic interest in Law and Medical Ethics post 1980

a. How did you develop an interest in law and medical ethics?

SM: It was some sort of accident. I was working at the time in the Forensic Medicine Department and my then professor, the department always did lit bit of teaching to law students, suggested that we should expand the amount of teaching that we did and basically told me to invent a course and so it was very much an accident that brought me into it.

b. Did you encounter any challenges as you embarked upon publication of your research in this new area of the law?

SM: The first book that I edited was actually 1981- Legal Issues in Medicine. I didn't encounter any such challenges; I found publishers who were very keen to publish in that kind of area so it wasn't problematic at all at that stage.

c. Can you explain if there was particular objective (s) which you wanted to pursue by focusing your academic interest towards this area of the law?

SM: I suppose that I have always seen medical law as focusing on human rights issues and so I think I wanted to explore from that kind of angle.

I think medical law has now developed a lot of jurisprudence that makes it able to claim to exist as a discipline. In the early stages, there was much more overlap with other areas of law, such as family law. When I started it was difficult to decide on what topics to include, because it was not being taught in the UK. So it was difficult to decide on topics to include. But with advances in medicine like human reproduction, end of life care and genetics, I think there is a distinct jurisprudence which non-medical lawyers will not necessarily be familiar with, so it is a subject that can claim its own jurisprudence.

d. Do you consider that there was surge in academic interest in law and medical ethics post 1980? If you consider there was a surge, please can you explain why you think this happened?

Yes, there was. It is difficult to work out why. I think in part it was probably because other academics knew it was happening, a couple of courses were running and students interest was enormous with over subscription by students, and there was increased coverage of medico-legal issues on the television and the news. I think there was perhaps also a bit of student pressure; once people were aware that the subject was being taught; it persuaded other academics that the subject was worth pursuing. I did not have problem m trying to get publishers but I had problem trying to convince colleague to embrace the discipline. It was not accepted very comfortably by lots of academics in the early days.

3. The courts, legal profession and the emergence of a distinct body of health care law.

a. How would you describe the posture of the courts and legal profession generally toward this field of law?

SM: I suspect it wasn't regarded as being a special area of law initially so I think the courts were simply taking traditional principles and applying them to some somewhat unusual cases. Initially, in the English courts, there was a deferential approach to the medical profession I think what you had was a kind of assumption that we shouldn't be challenging doctors and it was actually quite difficult for patients to succeed in litigation. Arguably, this

deferential attitude inhibited the development of the discipline to an extent, although this approach has now changed

b. Do you think that the courts and the legal profession could have contributed towards the development of this area of the law differently? Please explain.

SM: they could first of all by recognizing the human rights issues that were at stake; it was assumed that people were just had a grievance and wanted to talk about it, but not necessarily that there was a human rights element to the claims that they were trying to pursue and I don't think the courts took that as seriously as they might have in the early stages. The legal profession also didn't really take medical law terribly seriously in the early stages, so there was no incentive coming from the legal profession itself to move in the direction of looking more closely at the discipline; that probably changed in part because of the increase in the number of people who were actually complaining or had grievances about healthcare and it then became an area in which lawyers could reasonably think about specializing and still earn a salary ; so when my first groups of students graduated they would have been no jobs in medical law; they would have gone off into another areas of the law because there was no niche for medical law but there is no longer the case.

4. The potential of English and Welsh health care law to be exported

a. Are there aspects of the body of health care law in this country which you think could and should be emulated by other jurisdictions?

SM: The relatively easy access to court is very important because then obviously rights are addressed. I think it is something that could be learned by other jurisdictions who are struggling with these kind of issues; I think there are a number of mistakes perhaps that have been made in the past that English law is now trying to rectify in terms of the emphasis on patients' rights as opposed to the emphasis on doctor's duties ; and if people can learn from that not have to go through the process of making the mistake in the first place , I think that would be enormously helpful. People can learn from mistakes that I think have been made as well from the good parts of the law.

I think one of the most important things from the patient's point of view is the extent to which the courts have been willing to protect the notion of confidentiality and privacy; this is extremely important, particularly in the age of genetics. The idea that there are situations in which the individual sometimes is as important as the community is significant. UK courts have been very cautious in allowing public arguments to overtake the legitimate interests or rights of the individual, for example, in authorizing disclosure of otherwise private genetic information.

b. Which direction do you think English and Welsh health care law is currently facing - towards the patient or medical profession? Or something or someone else?

SM: Probably, none of these things. the problem of law is that it has to establish tests to which judges adhere. In the past the test that was used was very doctor friendly; I think increasingly we are seeing some movement in cases such as *Chester v Afshar* in which there is no doubt the court did something radical, and arguably bent some of the traditional legal rules. But I think the difficulty is that the law almost cannot do one thing or the other because what it has to do is to stick to the test that has been developed. So while there is a certain movement towards recognizing that patients have very real interests in participating directly in the decisions about their own healthcare, and I think there is a clear recognition that there are right issues involved in this, I think the law will always end up being cautious. This is an inevitable consequence of being a rule based system.

In the case of consent to treatment, some have argued that we have, in fact, gone too far in providing information and that this is equivalent to abandoning patients. However, I think this misses the point because it is not that patients are swamped with information which is unintelligible to them rather that when a treatment is recommended a clear explanation of that recommendations should be given to the patient; there is nothing paternalistic or 'abandoning' about advising a patient about what is the sensible or appropriate medical option, and nothing in the law of consent that prohibits or discourages such advice. However after that it is the patient's decision to make I think that this is not patient abandonment but rather treating the patient as an adult who has an interest in the treatment process.

The engagement of law in this area is extremely important and I cannot think of another forum when you can obtain disinterested decisions I think the role of lawyers is important in this area; it is not always interested in the way I would like but at least it provides an independence forum for addressing these questions so I am in favor of the law continuing to be involved in resolving these disputes.

c. What advice will you give to a developing country with a common law tradition like Ghana, which is seeking to draw lessons from the experience of England and Wales in this field of law?

SM: I am not entirely sure that I could that given I am not familiar with the Ghanaian legal system, but one thing I keep coming back to is that when you are developing jurisprudence or a body of law it is important to accept that there may be a need to balance the interests of the individual and the interests of the community. For e.g. it is in the interest of the community that they have health care professionals who are not afraid to carry out their profession and that they are given the right to exercise their own clinical expertise and discretion. However, this should not imply overriding the rights of individual patients. Indeed I expect that the quality of the co-operation between the patient and the profession will improve when both sets of interests and/or rights are mutually respected.

Obviously the question of resources is also a very important one. States must try to ensure that any healthcare system is adequately and appropriately resourced, which requires financial investment as well as investment in training staff. However, it is also important to establish a system (reinforced by the law) which ensures not only that treatment is available but that patients are treated appropriately, both in personal and clinical terms. A satisfied patient is not always a patient who has been given everything which is or could be available; being respected in the healthcare enterprise can sometimes be sufficient for a 'good' medical experience..

So you don't agree HCL should not be developed in a country until its economy is developed/?

SM : I think if we took that position then we will be authorizing states to fail to meet their international obligations because most states have actually signed up to all the initial declarations that talk about right to health or health care ; it is too easy a route to say yes we don't have the resources to do that and used that as an explanation for not living up to international obligations that they have; I think government should think about where they are outing resources if it is becoming an issue.

3. NAME OF INTERVIEWEE: JONATHAN MONTGOMERY (JM)

DATE: 22/10/2013 TIME: 16:00

MODE: FACE TO FACE

Semi-structured interview Guide

Law and Medicine's relationship before 1980s

1. How did the law relate to issues arising in health care during the long period before 1980s?

JM: I didn't start as academic in 1984 so I am looking back at when I first started. I think the main thing is that the early writing covered quite a lot of things around. The early writing covered lot of things around clinical negligence. On my shelf I do have a 19th century book given by my father years ago. I will start with Nathan on Negligence in 1950s. I have work from 1970s by Skegg and Kennedy. The work in 1970s picked issues mainly around interface of criminal law and medicine. It is quite interesting that end of life and sanctity of life, consent were the only matters. There was also a bit of material in the 1970s around novel procedures like transplantation, such as whether transplantation will be legal by Gerald Dworkin in Southampton who discussed whether transplant of organ is lawful. Kennedy also point to Glanville William's Sanctity of Life; so sanctity of life issues, bit about consent, clinical negligence. There was very little around public health and modern healthcare. When I began to research, there was a bit of work done on liability of hospital in the 1980. I did discover that there was work in 1950s and even before the NHS was created.

2. Why did the law relate to medicine in the way it did.

JM: I am not sure before 1980; it really felt like anything law relating to medicine. What Nathan's book was about taking negligence and applying it in a particular context not seen as being enormously different; so if you look at it does not cite or discuss the Bolam case although it had been decided so it does not look at application of tort law in an area. When I look at Skegg and Kennedy works it doesn't look a subject as it was a piecemeal lecture. I think what changed is in the 1980 because of Ian Kennedy's Reith lectures. He argued that there was a common theme. I will say the Unmasking of medicine is the starting point. Around same time Mason and McCall Smith wrote their first edition (1981). Sheila became International Bar Association Professor of Medical law in 1983. The unmasking of medicine is interesting because it was not particularly well received by doctors or medical sociologists who didn't think it will be helpful or it was something new, but had massive impact on legal scholarship so it suddenly became subject on its own right on that basis.

3. As an academic did you have research interest in matters relating to law and health care before the 1980s.

JM: I worked closely with Joe Jacobs on Encyclopedia of Health Services and Medical law; when I reviewed his work in the Modern Law Review, medical law in the shadow of Hippocrates. Joe too was very critical of Kennedy's lectures and he said he did not have anything new to say but my understanding is that they were rivals. Kennedy's book is really important because it opened up the subject to lawyers. When I reviewed Kennedy and Grubb text and Materials, I did say that it did not really live up to the promise in the Unmasking of Medicine as it did not address public health issues which were largely scratched over. I was strongly influenced by the unmasking of medicine and what I did was a reaction to what I didn't like about it so I will put that down as the lynch point. The Unmasking made it clear that the subject was neither for lawyers alone nor doctors alone. The lectures were public forum. When I wrote Law and Accountability and Professionalism was reflecting what I read from sociologist. It made me read around Illich and sociology and professionalism and I found slightly different from Kennedy had picked up so I found myself position myself not to what I thought was orthodoxy that Ian was developing.

The Surge in academic interest in Law and Medical Ethics post 1980

4. How did you develop an interest in law and medical ethics?

JM: The accident bit was that I was teaching Southampton and Gerald Dworkin whom I mentioned earlier who had done work on transplantation got a job in London and he had been running a half option in the undergraduate curriculum on law and medicine and ethics. And it was a lot of students demand for it and I said I could do that because I am quite interested in it so I go into actually teaching it as accident. A lot of my career has been in at right place at right time. And the reasons why I am interested in it were a mixture. One was that by then my girlfriend now my wife was training as a nurse and while I was a student so I did my undergraduate course in 1980-83 I did one year LLM and I read some of the stuff they were given on law and ethics and I thought it was not very good so I got interested in we could do much better than that and that was about the time that the Unmasking of medicine was coming out as a book. So the Reith lectures I don't remember but I remember the book. then I also interested in the issues around ethics because at that stage I was expecting not to stay in legal academia for very long, I had a place in theological college to study theology in order to be ordained in the Church of England. so I had interest in life and death issue and these sort of big ethical questions about how we value life. So I started being interested in combination of the teaching needs and a little bit of personal need. My academic research interest at that stage were around children rights so other aspect of accident was the time of the Gillick litigation was going through and I was mainly teaching family law with interest in children's right so I started working on Gillick from the point of view of there is a case about children's rights and I realised that got issues about children rights and parental rights and how they merge together. And of course I started teaching what was then medical law and ethics course I used that as sort of case study so it became a medical law case for med it started as family law case and it became a medical law case and how we regulate doctors.

[JM: I think my views on that .my reasons for thinking that have changed a bit over the last couple of decade. When I started on it I was particularly responding to first of all my frustration with the fact that the Unmasking of the medicine had carved the more territory than medical law cases and materials book that Ian and Grubb produced then. The text and materials book (by Kennedy and Grubb) were pulled out of master course they did at Kent. But they felt to me much narrower than the scope issues that the Unmasking of Medicine had risen; so I was searching for something that explained how you could get some sense of limits of the subject but not are restricted to what doctors did in their clinics. I think the second dimension why I chose HCL was that because I was married to a nurse, I had a strong sense from her that what went on in the hospital certainly wasn't best understood as being about what doctors did; and you need to understand other professionals as well; that got me interested into professional rivalries and I tried to get perspective of what was going; which was automatically medically dominated. Doctor's Handmaiden's contribution- that

was very much prompted by that sort of perception but there is also a bit of that in the 1989 Journal of Law and Society piece which was originally a paper on the Hart workshop at the Institute of Legal Studies; there is a bit in that about the fact that the narrow conception of medical professionalism didn't enable us to ask some questions about teams and how teams operated. I had already identified then when nurses and other professionals fitted in little bit of nurse bit of pharmacist and also a bit on liability of hospital wards needed to be taken into account more fully than in Kennedy and Grubb's work was doing; so I then looked to how could you define a scope and that took me to the European social charter and also to a little bit about the WHO; so what I found was that a set of definition while looking at the internal law of human rights in the context of right to health and health care and that is where I sort decided that HEALTH CARE LAW was the label to use but you will see it is a bit loose because there is a whole chapter on public health law in my book; so it could have been health and health care law and as the current debate going on about whether actually we should call it healthcare law or whether it is better to call it health law . and if you are interested in exploring that then I think there is full explanation of that is in Jim and Tommy Hervey's book on European health and there is also a version of it in Legal Studies, where they sort of do version there first chapter which discusses those definitional problems so that was how I got into as I was trying to shape the textbook that I write. NOW, I think the picture is slightly different and now I think we need to stress on slightly differently some of those things and I still prefer to call it HEALTHCARE LAW but I particularly found out as I carried on working and the first point I really wrote this up was in in my Current Legal Problems Lecture in 2000 which is call Medical Law in Transition towards a new Paradigm' and I felt you could really scope what was going without saying sort of corporate activities that were happening so things like GMC Guide is not just for clinic, the things that NHS was doing about confidentiality and protecting confidentiality so that sort of strengthened my perception that we needed to talk about the institution that delivered health care so whereas when I started it , it was about saying medical law was too narrow ; what I found by the the time I got to that stage is I believe even in the narrow bits of medical law , you needed to understand better how the organisations and the institutions , the professional bodies operated to make sense of the territory. So it wasn't so much about the scope of it, it was also about the way in which you did it and the method to achieve it. I partly learn that when I was working on the Encyclopedia of Health Service and Medical law; because of the way the editorial process happened , it was not one of those accident ; I was reading every statute as soon as it came out to see what changes it made in the area and so I discussed that an awful lots of law was being created nothing of the statutes or the cases but subordinate legislation so I realised that to make sense of it all I needed to learn about lots of other things and the another accident I became involved in National Health Service Trust Board in the 1990 as a non-executive director and that meant I was able to see lots of health service circulars and I started realising that lot of the work around what the rules are was being disseminated through the health system in guidance from those kind of health circulars into the NHS. And so that became a new version of why it is health care law

because you had to have a whole set of materials that were only produced by the organization.

[Is that what you call the quasi law= JM: I call it quasi law initially mainly because I had a colleague in Southampton Professor David Kent who had done a little bit of work on quasi legislation which I had read. Now the language around European law is more about a discussion of soft law; so possibly soft law is a better way of describing it now. But it is something that has normative force but isn't necessary binding in the way that a statute or legal decision has precedent. Example of soft law will be Mental Health Act code of practice, Mental Capacity Code of practice. They are things that you are not obliged to follow to the letter because they are not legally binding but they have legal relevance. But once you agree that you also then begin to realise that it doesn't have to be something under the an auspice of Act of parliament to have some legal relevance; so for example when the Tony Bland case was decided they used the guidance from the British Medical Association and the royal college in order to understand how to look after people in PVS state; so that type of guidance became legally relevant even though it had no particular statutory authorisation and then you get things like the code of practice on confidentiality which NHS produced for its staff and that becomes legally relevant because NHS is under obligation obey lawful and reasonable instruction. In the doctor's handmaiden piece I explored that a little bit and part of that got into the textbook chapter on different types of law. So that led me to think we do need to talk about health care law even in the areas which are very narrowly medical law, you need a rich understanding of the sources of it that goes beyond strictly legal things and I think that is partly captured by health care law. I also more doubtful now about whether or not HCL is a label that could translate abroad because my reflections and this is quite recent; this is the last 5 or 6 years. My reflections recently has been that what I am rally describing that is a structure which is peculiar to socialised medicine system like the NHS where almost all the healthcare in the UK is delivered by people who work as employees in the NHS or foe the health service as GPs and so if you went to a system that did not have that central organisation then it might that the subject HCL would not quite work because you don't have the same common rules across the whole of the health delivery system. it is not true is all the way across the UK system but almost all the legal regulations we have are dominated by the fact that which work the same way as the professionals all work within the same structure. So I am wondering whether HCL is peculiarly English definition and then health law might be a better definition for the global discussion and the translations. it is not necessary that the way I have defined HCL could transplant because it could be peculiarly English or UK because of the socialised medicine system so that is what I am grappling with at the moment with definitional question.

[Public health law- JM; the types of activities that state do through their organized health services , responding to pandemic, a vaccination Programme; those are things that are done by professionals in an organised way ; more and more now through local government.it should not be excluded from healthcare law. But I also think there is whole lot of public

health around clean air, clean water etc. I felt the need to include this in my book but I define the scope to include rights.

Q Is mental health appropriate subject in Health Care Law

JM: I tried to cover it in my textbook when I started because it is such a big area in its own right. Since it is delivered by health professionals you cannot exclude it. I was involved in the Mental health Trust Board and I was seeing patient and tried to work out what question which come up ; I tried to work on question which came up in that context. I felt it was a very specialist area and I struggled with. I look at when we can compulsory treat or not.

I also struggled with Medicines and the law chapter. I largely defined what I put in the book by thinking on what I was asked to lecture about because I was often asked to talk to health professionals and how law related to their work. What went into the first edition of the book was very much shaped by that. Some of the topics were new with no cases so I had to reason from first principles. I was interested in addressing issues as health professionals would like to understand in relation to their work rather than for people in the court.

5. Did you encounter any challenges as you embarked upon publication of your research in this new area of the law?

JM: I think the quick answer is no. I did not feel like I did. I was lucky the first big article I worked on, it was in the are of children in modern law review and it was about the Gillick case; and I was analyzing different types of rights and there was actually quite lots of literature around that to work so coming from family law, I had family law colleagues who were there; it was very topical so there was lots of thing written in the papers; and so it wasn't that difficult to get into it. Because it was being driven out of teaching; I gradually built up some confidence in it by picking topics that were topical because it was only half option; I did not have the problem that I had with the book which was around definition; I just had to find 10 interesting topics to do a half option and it was a foundation subject we call it then so you did not have to cover everything. You could cover topics that were of interest; so I didn't find that difficult to place articles because I was working on in the phase between family law and healthcare law; there were family journals that you could put things then; and the other thing was that there was lot of edited collection beginning to emerge at that stage and so people would say we are working on this; are you interested in doing a paper and you say I am working on this at the moment and so that is quite interesting. For example, the doctors' handmaiden piece; there wasn't a big peer review hurdle at the time. I was interested in the relationship between the professions and health care law. There were lots of conferences which gave new scholars opportunity to try things out and publish. The whole Law and Bioethics by Freedman was good for new scholars as it made things easier

for them than mainstream journals. What I think was not necessarily such a good thing at that stage it becomes more difficult to know that people read your work. Because if it goes into the modern law review everyone sees it is there because not everybody buys the book of collection of essays. So I think there is strengths and weaknesses; but what I found was because the subject was not neatly defined by then; I was able to research things that I was interested in; I think what we have been doing now is different type of problem; is that such lots have been written about; it is a bit harder to find something new to say. I didn't find that as a problem partly because I wasn't so interested in things around death and dying that lots of people were writing about. Partly because I got interest in this sociological perspective on it and there even if I wrote about areas that people had written about; I wasn't duplicating what they were doing. I think that will be more difficult now because there is so much more literature it is harder to find a niche of your own. But that was not difficult at my stage.

6. Can you explain if there was particular objective (s) which you wanted to pursue by focusing your academic interest towards this area of the law?

JM: I am not sure how my objective was at the time. But I am very aware of it now. I found myself because I was asked to go and talk to health professionals and my wife is health profession working in clinic ; and because in the early 1990s I became heavily involved in the health service locally ; I felt myself asking questions about how the law could support improvements of health services so that brought together a bit of definitional question; is it health care or medical law because the area I was working were not necessarily medical but were about health professionals and more generally ; but a commitment to try and do things that would support other aspects of my public service career which were around improving patient safety to make things better for patients. Now with hindsight; I think that was quite different from the type of approach Ian Kennedy and his people; which got divorced from clinic and was more about public debate about what we expected in a more abstract terms of doctors and more in supporting an emerging interest from lawyers on how law might get involved ; and I wrote that up in the piece; Compleat Lawyer about Margot Brazier's Work last in 2011 in the Medical LAW Review and when I wrote that it made some sense to me at6 what some of things because I picked back from her work on how this work doctor in the clinic as opposed to how they work for lawyer in court. I don't think I was really aware of doing that at the time. Reflecting back I think that was implicit in the way in which I developed things. I think that took me away from being interested in the type of argument that will persuade a judge and got me more interested in how you could explain the law in

the way that health professionals would make sense of it and apply it and develop it on the assumption that mostly health professionals want to do the right thing and therefore they won't try to avoid the law; they will try and understand the law. So that got me interested in things like codes of practice and guidance; so my first bit of work on professional guidance was around research involving children in the 1992 with the British Pediatric Association and I worked on a working party on guidance on testing children for disorders in 1994 and we revisited in 2010 to see how well the principles and thinks to soft law/ quasi law thing. I got myself realising that if you wanted to influence practice actually not my many cases go courts but lots of people read textbooks and guidance and lots of people relied on the colleges or the British Medical Association; so like many other people, I spend time on the BMA Medical Ethics Committee trying to help them get a sound guidance so I guess that is all part of being motivated by trying to not see the law in opposition to healthcare but as a way of supporting healthcare. I did some work on rights which I wrote in early 1990s and I argue that rights were not necessarily in patients' interest because they encourage confrontational approach and I didn't think Ian used rights in a strong sense; I thought there were better ways of promoting patients interest so yes I think that to some extent I was influenced by working with J. Jacob and his book where he argued for the Hippocratic tradition being one which is value laden and not value free. Ian's work sort assumed that there was competing value set and that we shouldn't trust doctors. That has not been my experience. I am not sure Ian will say that; looking at what he learnt from the Bristol royal inquiry and his subsequent work, he has tried worked through the institutions much more. He also worked on guidelines inching xenotransplantation; he prompted the setting up of Nuffield Bioethics and went to chair subsequently so I don't want downplay his contributions at all because he has made a massive contribution. I perceive in the 1980s that he has set up a confrontation and that didn't attract me.

7. Do you consider that there was surge in academic interest in law and medical ethics post 1980? If you consider there was a surge, please can you explain why you think this happened?

JM: I think a second publication which is crucial is Mason and McCall Smith, 1980/81 because what did was to make it possible to teach medical students because you had a textbook. I was not doing that because I only came in the mid-1980s and teaching. But I think you see an interest in medical schools in trying to work out how to respond to medical teaching so there was Pond Report towards the end of 1980s which consider what syllabus might be in teaching medical law in the medical schools. I think one of the key people was a priest from Edinburgh. So I think on the legal side Ian was actually crucial because he gave an identity. I think Mason and McCall Smith developed something which medical schools to develop a syllabus and so it will be wrong to say that the medical people did not respond; I

also think the BMA was really important so they had their hand book which began to grow in to something which would help people work out what to do. So at that stage you had the GNC which had its blue book which told you what will get you into trouble .These were all handy in the 1980s so people began to have interest and so they became literature in the 1980 in way that wasn't previously. If you look at the journals you had medicine, science and the law-- a lot of it was about medical aspect of criminal law cases but it was not about legal aspect of medical practice and in the 1980s what you get is the legal aspect of medical practice and training. so I will tract it through the hand book of medical ethics and you will see how that expands and later on in the 1990s what the GMC did - emergence of good medical practice was quite significant. But I think in the 1980s it was led from the BMA and I think they had a key role to play in their medical ethics department did that.

[Q relationship between medical law and medical ethics?

JM : I think one question we have not adequately answered yet which is now increasingly vexed by is the law and moral problems - and I wrote a piece on Kens Mason's book- Legitimacy of Medical Law in 2006- I began to realise that the whole enterprise revolved around Ian Kennedy, he began from problem with sterilizing women who had consent . Someone had been to a seminary that he gave. The impression was we must first guess what should happen and then use the law to ensure that the doctors did that. So there was a debate about the right thing to do and separate from a debate about what doctors should do and no such links to the two. I described that as some kind of hierarchy , the applied philosophy is the right to pure bit as to the right thing to do and law is a tool is the tool you use to make sure that practice operate like that. And if you think a bit like that then the law and moral problem when can we enforce morality should be answered because we don't generally believe that you can straight move into taking a moral view and improve on people who think differently and so that is how I began to think if that is how I understand Ian's version of the subject , to make it work I need to solve this; so it was not quite the same as Demoralization of Medicine- which is mainly aimed to say actually law isn't really like that, so when you look at how the law really operates it doesn't simply translate our vie s on the right thing to do , isn't to make doctors do it. And one of the reasons it does not do that is it assumes that doctors are already engaged in that enterprise of trying to do the right thing. I also felt alongside that there was never less things when we try take a societal view on issues that were controversial and so some have said, I have given a conference presentation on this label, if you want to do re-moralization you will need to solve that problem. so one of the problems you need to solve is when can we justify using the coercive power of law in areas that in plural society that we don't agree on. I don't really have an answer to that yet, although my paper on legitimacy of medical law I just sketch some puzzle ones that didn't work very well. what I have found myself doing is actually engaging much more in governance approach so sitting on committee to produce guideline.; involve in

chairing the Human Genetics Commission now Nuffield Council Bioethics. Instead of doing it through legal regimes, I found myself doing it through involvement in some public engagement and at the very later on lecture on law and demoralisation of medicine, I noticed that people like Ian and Margot, Sheila had all done similar things. Sheila McLean had been involved in the post Diane Blood debate, Margot has been involved in Retained Organ Commission after Hayze Scandal Commission; Ian had done Bioethics on Xenotransplantation. So I thought this is something academic lawyers have been doing and it is not the same as work what the law should be. It is not quite the same as telling doctors what to do; it is how engaging in deliberative process to try and work as a society in improving our understanding of things so that it connects law and ethics in different way.

[Q. Is this unique to this area of the law because from jurisprudence, legal theory, there has been this unending question on the relation between law, legal positivism and natural law so isn't it the. JM: I know it is. I was trying to look out for you. I have the agenda of the first meeting of the society of public law teachers - law and medicine group- Ian and I were on the platform that, in my bit of that [I still have the notes once I find it] We started, I think, it was late 1980s. We started the medical law group of that society and it had its inaugural meeting as a sort of conference. I was asked to sit on platform with Ian talking about a sort of agenda for medical law and I discovered one of the things I said then was medical law was the place where we should be working through and contribute to the debate on law and moral problems and then I discovered in 2006 that. But I think you are absolutely right, it is a, long standing theme in jurisprudence and you will expect to see more of it in medical law than actually we have in its absence. Harris told me a few months ago that he regarded Life's Dominion of Dworkin as the best book on bioethics ever written. [Dworkin was Harris doctoral supervisor so he is biased]. If you read the main stream work on law and medical ethics, it is surprisingly weak on justifying the use of the law in issues of moral controversy in society. It sort of assume that you are having a debate on what the right ethical position is and it is ok just to use the law as a tool for helping people do it. But I think that is problematic. If you look at how I start my book, I start with the political process which produces law, the scope from international conventions, the type of law that they produce. What parliament does and I am very interested in (Hidden Law Making- a paper submitted to journal) - tries to look at how judges get involved in making law. It is again the role of judges in adjudication that Dworkin wrote about. I am looking at what has been exposed in the Nitson litigation around whether or not the court should get involve in creating a mercy killing defence to murder. The orthodox position as per Lord Brown Wilkinson in Bland's case, in this controversial areas judges should not do this it should be left to parliament and yet in lots of cases judges do it; so why is it sometimes they don't do it in others. So we argue that a proper account need to be given of this which I believe to be an account based on what John Austin called tacit legislation, with implicit parliamentary oversight, it can change what judges do it, or is based upon human rights argument that there are legitimate things that irrespective of what government or parliament think judges should protect because

they are issues of fundamental human rights. I think we have not asked enough question about the constitutional law structure of medical law; how it should be made and how it is legitimate to do so. And so over the last 5 years it has become more bothering to me and I think it is a big phase of what I expect to be doing next.

[Q How relevant is the issue of judicial activism / passivism] JM all that literature is relevant. to testing out those of sort of questions on the medical law context but I am surprised when I look at it. If you compare the piece that Penny Lewis wrote about Purdy case and Prey v DPP Guideline and the piece that I wrote about it. My piece was based upon a lecture I had given a year or so. Although the final version is able to reflect what Penny wrote, I crafted it before I knew it but when I looked that what I realised was that it rather reinforced the point that I was anxious about which is as well as asking what the law should be on the physician assisted decided prosecution, we also need to ask question about how it should be made. and I though it was outrageous how the law in Purdy case decided to force DPP to work out law on physician assisted suicide and the reason I though it was particularly outrageous, it was before parliament earlier. If it had not been before parliament there is a legitimate argument that if parliament won't act, the courts have to step in and try and refine the law. But you could not make that argument in the Purdy case so I thought the Purdy case was constitutionally illegitimate. Penny does not like the way in which the current law is restricted on assisted dying; so she knows the two dimension of the problem. This has led me in the last few years to realise there is a lot more to this than I though in 2011.

The courts, legal profession and the emergence of a distinct body of health care law.

8. How would you describe the posture of the courts and legal profession generally toward this field of law?

JM: I think there is a historical perspective here and I think if you look at the period until 2000, the best explanation of both what court and parliament have done was the explanation I argue in the 1989 in the Law and Medicine accountability which was shake by very friendly attitude towards doctors that believe in the fact that doctors were fundamentally trying to do the right thing .That is what I describe in the Law and Demoralisation as integration thesis'. And why I think lots of academic legal commentators and some of the legal practitioners were very anxious about that because they thought it didn't properly hold doctors to account., I think the law makers both in parliament and in the court held on to that till the late 1990s and then I think there begins to emerge an interest more in patient rights and I will point to two major features of that which is in my writings. One is the loss of confidence in medicine-m this is what Harry Wolf picked up in his lecture that was published in the medical law review-are the courts too deferential to medicine. I was already exploring that a lot bit when I did my Current Legal Problems

published in 2000 about in the wake of Bristol, Alderhays scandals, the idea that we could just trust doctors became more problematic. The other I will attribute to James Munby's emerging interest in using rights and I wrote on that on Law and Demoralisation under the heading 'the new model judge'. I think if you look at what is happening since about 2000 there is more and more judicial intervention and activism going on. If you go back that literature you alluded to that about passive and active judges think our judiciary is becoming more active. I don't think it more widespread now but I do think since 2000 it has been much more mixed and now that James Munby is such a senior Judge I will be interested to see whether it moves even further in that direction because I think that he is a very brilliant lawyer and I will put him the same category as Lord Denning and in the same way that I think he is brilliant lawyer and I am not sure I like the way he is taking things. I will take that as a historical shift. In the late 1970s through the 80s up to the late 1990s the attitude or posturing being about reinforcing medical practice and not holding it to account. Then I think it has been more ambivalent and gradually becoming more interventionist and activist. I am not sure that will necessary make better for patient but I think the law is becoming a more assertive.

[If you look at informed consent and the Bolam test, how the English courts] JM: if you trace that through I think. I wrote about Bolam in the late 1980s and thought that it dominated the whole area of HCL as opposed to what it was truly was. I then revisited it in 200 when I did CLP lecture asking whether Bolitho had changed Bolam and my conclusion was that it hadn't. I thought most of the activities there on improving the law around consent. So if you looked at the guidance which the colleges had produced and the GMC had produced, it had moved away from *Sidaway* position to much nearer to informed consent much nearer Lord Scarman judgment. It still took a long time to come through. The most important piece on Cambridge Law Journal, she tries to explore whether or not Bolitho has really changed things. I think she is persuasive now that it has changed thing. But the most interesting thing is *Chester v Ashfer*; I think as a matter of strict law it is inconsistent with *Sidaway* and it should have followed *Sidaway* because you are not allowed not follow earlier HL decision. It is pretty impossible to tell what *Chester v Ashfer* seek to test as doing. And yet there has been sea change in the assumption, if you read Department of Health Guidance on Consent, it doesn't cite *Sidaway* anymore. It just cites *Chester v Asher*. it is completely indefensible. I actually think that there has been driven by the courts; but I think that has been driven by the medical profession and the NHS; just deciding that *Sidaway* was not an acceptable position to take in the modern world. If you want see my take on *Chester v Ashfer*, check my article 'law and moralisation of medicine.'

9 Do you think that the courts and the legal profession could have contributed towards the development of this area of the law differently? Please explain...

JM: They could have become more interventionist earlier. I think there is a change in pattern now, they could have argued that standard of care was to be fixed by courts and not doctors. A lot of legal professionals have worked with doctors to improve their approach to ethics and the like.

The potential of English and Welsh health care law to be exported

10. Are there aspects of the body of health care law in this country which you think could and should be emulated by other jurisdictions?

JM: I think that is a question which is hard to ask in the abstract. You could study the law on transplant and see how it can be adapted to local systems. For example the Mental Health Act, you need adaptation but you can take the basic text not least because they were developed to respond to ECHR. There is a sense which is not on England specifically. You can take Mental Capacity Act, Human Tissue Act and translate. The statutory code which has a degree of internal coherence and great comprehension can be taken over into other jurisdictions. Whether they will be the ones to use, I think that is different. I think the common law tradition if my argument over the years has been right then whether it will make sense to take things like informed consent and our version standard care will depend upon how much confidence you had in the medical profession and its organization in the country you are talking about. If my argument in Law and Demoralization, described as the integrity thesis, our law is built on the assumption that you can rely in the profession having their own sense of values which we are only enforcing. If all depend upon how much confidence you have in Ghana in the professional regulation of doctors by themselves. If your assessment of the Ghanaian medical profession was that it developed its standards and policed them carefully; it will then make sense to use our type of approach to regulate; if on the other hand your impression of the Ghanaian medical profession was that actually it couldn't be trusted; I think we won't be the best model to use to translate. If my thesis is right is right around the need to look at soft law and institutional structure, does Ghana had a socialised medicine system that can create these values and help people live by them and give guidance on how to do it. If you did then that thesis will translate quite well but if you what you have is lots of individual practitioner who are very autonomous and the payment systems are fragmented and lots cannot afford anything; then I am not sure that the English system will work because it is too colored by the particular NHS context to easily transplant. So I will be nervous to transplant except places that had those sort of health system.

11. Which direction do you think English and Welsh health care law is currently facing - towards the patient or medical profession? Or something or someone else?

JM: Up until these latest things; might be facing different direction. On court basis. Most of the legislature structure, the working target of our law is to advise doctors on what is expected of them and shape what they are supposed to do so if you take the mental

capacity Act it could have said that if a patient doesn't have capacity you have to do XYZ but what actually does is to say that the doctor has a defence that he was without consent, if they reasonably believe that the patient doesn't pass this test. Abortion legislation doesn't say it is only lawful to carry pregnancy when there is risk of carrying is outweighed; it says if two doctors in good faith believe that; so all those things tell us in the way Sidaway demonstrate that what our law should ask itself how we should regulate professional practice and not what a patient entitled to. More recently what patient is entitled to be coming to the fore a little bit more so I think it is facing towards regulation of the profession. I don't necessarily mean that makes it worse for patient that is a separate debate about whether facing that way and reinforcing the value we in the end help the patients or not. Sometimes it does other times it doesn't. I will say facing the medical profession it does that because it is believed by the lawmakers, judges and parliament that are in the interest of patient so it is not choosing medicine instead of patient it is choosing medicine because of patient; it doesn't mean they are right to do that. The judges and legislature have thought health profession that it is good thing for them to be there as they do valuable things so legal regulation is to help them to do right things and then if you look at Shipman Inquiry and scandals in the NHS; that breaks down as a working assumption and therefore you will begin to think differently how you should regulate things.

12. What advice will you give to a developing country with a common law tradition like Ghana, which is seeking to draw lessons from the experience of England and Wales in this field of law?

JM: I wouldn't want to give advice because I will feel a bit colonialist! But if you want an opinion on recommendation about informed consent for Ghana, I think I will say you need to think hard about the culture and health system you are going into; so informed consent is I think essentially an American doctrine based upon the idea that people have lots of access to information; well educated; they live relatively independent lives of each other so you have this kind of atomistic idea that it is only about them and their decision. That already breaks down in our context where they see decisions as family decisions and we know that in areas like genetic medicine where the idea is that people think it is just about me as opposed to how I share it with my children or my partner that already is problematic and we see it when look at things like doctrine of undue influence who go and take advice from their faith leaders and their spouses we think that this might be undue pressure; that is where they get their advice from and that is what they think is the right thing to do. So I will encourage you what are the social structure and how do they operate; so if your culture is largely family based; your version of informed consent should not include say breach of confidentiality to tell family; it should when it is right or wrong to do that. in terms of access to information informed consent needs to reflect the type of educational level you are dealing with and if you have informed consent which stop people who are not literate being able to do informed consent because you have to sign consent form it doesn't give you what you are after; what you are after is about empowering people to having decision that they are comfortable with their own

bodies. Don't start with are the rule in UK; start with how do we improve the lots of patients in our system and then work out which legal systems have solved similar problems.

END. END. END. END

NAME OF INTERVIEWEE: ANDREW GRUBB

MODE: FACE TO FACE Meeting

DATE: 18/10/2013

Semi-structured interview Guide

1. Law and Medicine's relationship before 1980s

a. How did the law relate to issues arising in health care during the long period before 1980?

Before the 1980, it won't be easy to describe a development of law that systematically dealt with relationship between doctors and patients or healthcare generally. The law came out of criminal law and it was analysed like that. The initial scholars who dealt medical law were really criminal lawyers looking at issues like death and dying, transplantation. Probably the greatest legal academic of all times in England and Wales, Glanville Williams wrote about those kinds of issues; and he was actually criminal lawyer even though he was a legal polemic since he knew most of the law. He wrote on abortion, transplantation with focus for lawyers; there was nothing high level abstraction in medical negligence. There was smattering of cases like that. Actually, what is interesting is primarily, the criminal law was the how the academic analysed as far as there was any medical law. Practitioners in fact criminal law was rarely used to prosecute anybody in a medical case; there are some famous prosecutions of doctors for unlawful abortion (The Bourne Case); and the famous case of the pediatrician in 1981 (R v Arthur) and also the only thing you heard about them was the trial. Because very often the criminal trial of a doctor ended up in a verdict of acquittal and summing up of judge but never got to the appellate case. By contrast there were medical negligence cases, they were not many though, that went to the court regularly before the 1980 and even before the 1970s it was just a handful of cases.

There wasn't in fact no medical law going on in the court about the odd prosecution and a smattering of medical negligence cases; it was completely undeveloped in the courts. Kennedy once

said in an article he wrote about informed consent on Sidaway ; that at one time all you had to was few Victorian statutes and couple of criminal case ; there wasn't much and after that you had to just make it up. But it has changed now.

b. Why did the law relate to medicine in the way it did.

AG: There was much less interest by the general public in how doctors behaved. Doctors were seen as central figuring in medicine with patients; much less public interest in questioning what they did; doctors were the kings of their castle; masters of their real; kings of the realm, therefore the courts and lawyers through litigation rarely became involved. If something went wrong it was rarely challenged in the legal way. Academics were slightly ahead of that. This is because academic work out what should happen in the court rather than what has really happening most of the time. Glanville Williams, Peter Skegg and Kennedy were the grandfathers of medical law in the UK. They were slightly ahead of the game in questioning how the law dealt with relationship between doctor and patient; and of course Kennedy was the Unmasking of the Medicine started to cause society and chartering classes to think about doctors and whether their decisions should be challenged and if so how should it be questioned.

c. As an academic did you have research interest in matters relating to law and health care before the 1980s

AG: NO; because I was a student then. So I did not have any research interest since I was a student of law. Medical law was not something that I ever heard of as a student. I went to University of Cambridge and medical law was never a subject then; I had never heard of it. It was only when I started to teach that medical law came into my head as something to be looked at it. I was the first person to start a course in medical law for law students in Cambridge.

2. The Surge in academic interest in Law and Medical Ethics post 1980

a. How did you develop an interest in law and medical ethics?

AG: When I first started teaching in the Cambridge in the early 1980s in the law school; there had been long time an elective course for medical students started by Glanville Williams' it was popular for medical students. Because it I had been started by Glanville; it was run by the law faculty so when I got there I was asked to take it on by running. Because I was teaching criminal law. I was criminal lawyer and a tort lawyer; administrative law lawyer because we have the NHS by the government. So I had three main interests that might have

worked. There was no medical lawyer so I took it on. Gradually I got interested in it. The courses consisted of few lectures from me and guest lecturers by people from medical background and lawyers including Ian Kennedy. One evening in a bar I said to him I was trying to write a book on medical law and he accepted that we should write together and first edition came out in 1989. The reality is the more I got into it the more I became a medical lawyer. Within 6 years I really got into it and did lots because the materials were accumulating so there were lots to grapple with. After 5 or 6 years I called myself medical lawyer because I wanted to do. I started a course with colleague in Family; which was becoming popular children's interest etc. We started an elective in 3rd year for law students in Cambridge in 1986 or 7 thereabout.

b. Did you encounter any challenges as you embarked upon publication of your research in this new area of the law?

AG: I don't recall any difficulties for example in traditional law journal saying what is this all about. Most of the general journals would publish papers on medical law; MLR for e.g. LQR. CLJ being generalist journals; if you wrote a good enough paper it did not matter it was medical law. The subject grew such that the generalist journal could potentially become overwhelmed by the materials so I and Kennedy started the Medical Law Review in 1993 and subsequently Medical Law International also came up in Cardiff where I taught for a while. That was really the time that the generalist journals could not cope with increasing papers by many academics coming into the area. I didn't have any difficulties with publishers or other academics coming into it. If it was good enough it went and vice versa

c. **Can you explain if there was particular objective (s) which you wanted to pursue by focusing your academic interest towards this area of the law?**

AG: I found it fascinating. I suppose all others young academics the best advice that older academic gave younger academic in terms of research is find your own niche. Medical law which I happen to come into because of the course I was asked to run so I got a kind of eclectic interest in law. I have never been interested in just tort, criminal law etc. I like a mix match if I can. So medical law which was relatively untouched in terms of systematic analysis and I had to borrow from different areas of the law suited my academic personality. I read science in the secondary school. I was generally interested in scientific area. So I became quite interested to the extent that I could do it to master what was going in medical field as well especially reproduction genetics which was quite technical; so I like a kind of the

background factual areas which was coming up rather than being interested in bridge building or planning not really interested in that. I found doctoring interesting and developing the law from different areas just suited me at the time.

d. Do you consider that there was surge in academic interest in law and medical ethics post 1980? If you consider there was a surge, please can you explain why you think this happened?

AG: There was demystifying of the role of professionals in society and so challenging professional judgement was suddenly not a taboo; doctor and nurses making profound decisions which have profound effect on people. I think it was par to the demystifying professional in general. Academic interest in medial law grew slightly ahead of people litigating over it. It was just lawyers here. There was stream of academic interest by others medical ethics, philosophy. A very distinguished moral philosopher Jonathan Glover was interested ling before that. His book causing LIFE AND DEATH is a classic. It was equivalent of Skegg's book on Law and Medicine. Peter Skegg was a very distinguished academic and how work was both authoritative and settled. He contributed enormously to development of medical law in the common law world. He taught in in UK at Oxford substantial part of his career.

My concern was simply that Skegg was fundamentally a criminal lawyer and used at, medical law from criminal law perspective and there was nothing wrong with that; but when I was starting I was trying to do that through the eyes of other areas in medical law. So peter's book is absolutely definitive on criminal law perspective. But I am interested in broadening our understanding of medical law from A to Z whereas Skegg's work comes with much nuanced authoritative analysis from point of view of criminal law.

3. The courts, legal profession and the emergence of a distinct body of health care law.

a. **How would you describe the posture of the courts and legal profession generally toward this field of law?**

AG: It was very gradual' the emergence of medical law issue in the courts to a level now that we have even a medical law report to some extent. The courts were and are moving cautiously forward in medical law and a lot of the cases take more steps without taking grand forward leap like academic. There is now body of lawyers who will describe themselves as medical lawyers. I practiced in a chambers where there was substantial portion of the lawyers who did medical law; once upon a time you did only medical or

clinical negligence but it means so many other things now a days life and death decision; judicial review ; challenging funding decisions resources allocation; and entire panoply of functions carry out at public law level regularly subject to challenge in the court and there are lawyers to provide the service to allow the challenges to be taken forward; so legal profession has embraced medical law and the court has done that too. Though the development of it is being or as it is a correct approach for a judge one step at a time as is necessary; that is not what academic s to take all the steps to see where it line discussion ultimately goes and they are not representing a particular client but seeking to explore issues that arise in particular area and can go further than judges can. One area that judge has dutiful is area of moral issues for moral philosophers and this is purely coincidental; lawyers don't have any expertise in moral philosophy some do but it is not because they are lawyers because they were interested in it. That is equally if not more likely to be true , judges and so when issues are debated in the two professional; realm: law and philosophy ; the interaction between those is quite difficult for judges and you can see that in cases like PVS case Tony Bland or Conjoined twins case; when they are presented with pure argument based upon philosophy it is difficult for judges to adjudicated because that is not what they do or where they came from; and perhaps it is not what the court is about but it is almost impossible to think about the problem of what you do in the conjoined twin case; one will die or one will survive in operation or withdraw ANH from a PVS patient it is difficult to see without looking at both sides so you get some judges looking across from both disciplines to help them with their legal arguments.

b. Do you think that the courts and the legal profession could have contributed towards the development of this area of the law differently? Please explain.

AG: No I think that the courts and lawyers are concerned with things that people want to litigate over; unlike academics who can do whatever they consider interesting. It is possible in the medical law cases which Ian Kennedy called for; which are courts issuing declaratory judgments even though the point has not matured yet; for e.g. a criminal law point does the court need to wait to get prosecution address rather than asking civil court to resolve it. It is possible that in medical law context, Ian Kennedy called for it including the Gillick case and the case on Guide to Self-Deliverance, a hand book on means to commit suicide- whether it will be a crime. Judges don't like hypotheticals but they have tried their best to work with that.

4. The potential of English and Welsh health care law to be exported

a. Are there aspects of the body of health care law in this country which you think could and should be emulated by other jurisdictions?

AG: Our top judges in the Supreme Court and the Court of Appeal are very able and lots of our judgments are given by those judges. Consideration and though in any country which has similar issues arise just like the way our judges look at Australian and Canadian decisions; ; those judgments are reflection on other countries. I suppose one area we perhaps led, we weren't the first to do it , but our scheme has worked very well in practice is the area of fertility treatment; not the precise wording but the way the structure of decision making and licensing and the regulation through the Human Fertilisation and Embryology Fertility has worked in the UK (n I was a member of it for a period of years) is a reflection of it on countries of trying to regulate that aspect of medical practice because we seem to have done quite well.

b. Which direction do you think English and Welsh health care law is currently facing - towards the patient or medical profession? Or something or someone else?

AG: It is not easy to answer that. I don't think our law can be said to point to one clear direction only. We are living in a society which has come to embrace rights; patients have rights more often than we think of doctors as having rights. But usually we start our analysis with the right of the individual so that extent it is facing towards patients than any other way but that doesn't mean necessarily that [patient rights will necessary turn every case; that is just reflection of our society as a whole and not medical law as such; the emergence of rights based analysis as a result of incorporation of Human Rights Act permeate all areas.

c. What advice will you give to a developing country with a common law tradition like Ghana, which is seeking to draw lessons from the experience of England and Wales in this field of law?

Developing it through the courts is a haphazard exercise because it depends upon the case coming upon and judges naturally inclination is not decide more than they need to decide so you may establish some principles and resolve a particular person's case but you don't get guidance as it may apply elsewhere because the judges are not interested in that. Some judges' are more expansive than others. so developing through the courts can take long time. But some areas can be regulated through the courts because the courts =give right yes or no answer. And that is how it should be that is kind of public policy at grand level which can be done by legislature and consultation; which the courts don't before they give decision. What we now call stakeholders; there is huge number of the rose in any particular areas of medical law in which it is important to know stake. So development through the courts is only a small part of development medical law. The majority of it and all regular aspects will need to be done through the democratic purpose of legislation including consultation. those can be very painstaking slow and difficult to ever find consensus on; because there are as many as different views on many controversial issues so it is difficult to formulate public policy y in that way but here is no any other way to do it.

Q. when we say medical law, where is the medical law because often we draw upon areas of the law

AG: Like many subjects like Property law is probably not breakable down to an own constituents. It is a bit like fundamental Particles in Physics most particles are made up of the particles yet they look different. Proton ' neutrons are made up of quarks. Likewise there are quarks in law; and most law is neutron or protons bigger particle size. Medical Law is really a blend other things but it is own unique blend of other things and that is why it is medical law ; you have to know more about other things before you can know medical law.

You might give some thought to interactions between philosophers and lawyers; how does that affect medical law. That is possible influence if you look at influence which made the law what it is. Part of its unique blend of quarks; there is an element of moral philosophy that may shape the principles in a way that they are not shaped in other areas.

END. END. END. END. END.

NAME OF INTERVIEWEE: MARGOT BRAZIER

MODE: FACE TO FACE MEETING

1. Law and Medicine's relationship before 1980s

a. How did the law relate to issues arising in health care during the long period before 1980s?

MB: [As a general background I don't know if you have looked at the history of family law in this country since it also emerged in the post 1950s. It was only the later 1950s that family law emerged largely because first text book was published by Peter Bromley. There is interesting parallel between family law and medical law. If you can, do talk to Professor Cretney, who was a pioneer in family law. Many of the people in medical law came from family law, jurisprudence and tort backgrounds. Medical law draws together many strands of different legal disciplines. I tell students medical law is a good revision tool because to do well in medical law you have to be good with your tort, criminal law, human rights law, family law, property law. I challenge them that it is a rigorous discipline. It has so many strands that can take a while to bring them together. I think the true father of medical law in England and Wales is Skegg and he is the greatest influence on my career]

I think that we have neglected the fact that there is a long history of the law's involvement in medicine, if you look back in 16 and 17th centuries, a number of cases went to court between patients and physicians and surgeons; there were also cases where college of surgeons fighting college of physicians. There was quite a lot of discussion in the media about what we call medical law, quite critical of quacks. Once the different medical professions came together in 1858 with Medical Act 1858. And even more as the state took over funding of medicine; there came period when litigation more or less disappeared and there was a period of extreme deference to medics. Although there were cases towards 1950s and beyond; it was the medical gentlemen who must be right. In England lots of people were hesitant to challenge medics with the inception of NHS: most people were so grateful to be able to get medical care free; go to the doctor for free. That gratitude inhibited criticism for a very long time. It seems about 30 years so it took a generation to grow up who took NHS for granted. I think medical law went into abeyance for about 100 years and then began to rise in early 1980s. There is a physician called Thomas Percival but also wrote extensive tome on medical jurisprudence in the 1800'a; they have got it in John Ryland's library in Deansgate.

b. Why did the law relate to medicine in the way it did.

There are several different reasons. People were much less likely to litigate generally; so we moved gradually towards much more litigious society. Social attitudes began to change; between 1950s in England, vast majority of people had very conservative values; vast majority attended some sort of church so views on things like sexual conduct; family life were very much uniform and the other factor was gradually development of medicine created all sorts of new dilemmas which did not exist before; so that if in the 1950s a baby was born 32 - 33 weeks into gestation ; it was very unlikely to survive; few babies did but no decision had to be made but as neonatal care develop so that you could resuscitate babies at younger age and younger age; so problems arose as there would be disagreements between parents or between parents and doctors; as social cohesion became less and people got different views on morals . Thus you begin to get case like Gillick- challenging contraceptives to unmarried young daughter- if the case had been heard in 1950s, it would have been laughed at; the idea that unmarried 16 year old can get access to contraceptives in 1951 would have been just too awful to go into newspapers. And development of different forms likes transplantation. It is not one thing but different things happening almost at the same time- changes in social attitudes and changes in medicine.

c. As an academic did you have research interest in matters relating to law and health care before the 1980s

MB: I got interested in late 1970s; my work was in professional negligence generally. So I wrote a paper on solicitors and surveyors; I got to doctors and I found that it is so much more interesting and I started to read Canadian cases on informed consent and that gradually urged me into medical law. I think I wrote my first article on "Informed Consent to

Medical Care" I wrote it during my maternity leave in 1979 (but it might have been published in 1980). It was based largely in Canadian cases because there was very little English law so gradually I became interested in it. One thing about medical law is I met and worked with people who are not lawyers. So I met John Harris, Tony Dyson, and Dr Mary Lobjoit who was fantastic pioneer insisting that we should teach medical ethics to medical students. So combination of these things got me interested in medical law.

2. The Surge in academic interest in Law and Medical Ethics post 1980

a. How did you develop an interest in law and medical ethics?

MB: [answer: same as above)

b. Did you encounter any challenges as you embarked upon publication of your research in this new area of the law?

MB: It was made easier by the fact that I was not taken seriously by the law school at the time as was expected to go part time after having a baby. I had people who supported me; Professor Bromley who had similar experience with family law. I did the first edition of my book in 1987. The hard aspect was incorporating teaching medical law in the LLB teaching. We set up a Masters degree aimed at medical profession and possibly lawyers. I wanted to teach medical law to undergraduates; there was debate in the faculty board which I won by 1 vote. A number of people said it was not a proper subject; but now it is taken for granted and is a popular subject with students. I didn't have difficulties with publishers.

c. Can you explain if there was particular objective (s) which you wanted to pursue by focusing your academic interest towards this area of the law?

MB: Medicine is such important part of human life. Whatever we do all of us have contact with medical profession all our life. With medical care you can lose your life or your life can be made so valueless that you can do nothing for your life. I was interested in consent; information disclosure; new technologies coming. I had much in mind to do work resulting in law and policy to be better. Managing and negotiating difficult balance between rights of patients. Recognising that doctors are not machines and that they do their work in circumstances quite different from other professionals. The way Bolam was interpreted that if a doctor said is ok that is ok was wrong. But if a trainee solicitor makes a mistake something is wrong in the firm; if he gets up in the night he can say I will fix it tomorrow. If a trainee surgeon gets something wrong, the consequences are disastrous; medics don't have the same control of their working conditions so you cannot say that you are really too tired I

am not going to that operation or anaesethetise the patient; if there is nobody else to do that you have to do it. So in framing principles of medical law you have to think of patient as the Centre of what you are doing and also the professional who works in unique circumstances from other professionals.

d. Do you consider that there was surge in academic interest in law and medical ethics post 1980? If you consider there was a surge, please can you explain why you think this happened?

MB: There is so much to do. All things you have talked about before changes. Changes in medicine, technology and society. So it needs lots of people to address all those questions. More and more academic lawyers and professional practitioners became much more socially aware much more interested in the kind of law not much more akin to property law, contract etc. The influx of women into academia made quite a lot of difference. Of the younger generation of medical lawyers I will say two thirds are women and I think they are the very successful ones. For what I am going to say I have to be cautious because of my feminist colleagues but I think just as in medicine you see women becoming pediatricians so in medical law lots of women came in; although there are women who are wonderful commercial lawyers and similarly male colleagues who are wonderful medical lawyers. The subject matter attracted women. One of the things medical law does for academics in way not all other areas of law does; it offers opportunity for you to do things outside the university system. You get opportunity with Department of Health, medical profession; Ministry of Justice.

3. The courts, legal profession and the emergence of a distinct body of health care law.

a. How would you describe the posture of the courts and legal profession generally toward this field of law?

MB: Within the profession itself the evolution of medical law practitioners more or less parallel medical law academics. For instance, in the late 1980 there were relatively few people who were skilled medical law solicitors or barristers but now there are lot; and there is lot of interaction between academic and medical law practice too. In terms of judges it is trite changes in judicial attitude in 1950s that doctors could never been wrong to change in *Chester v Afshar*. we have seen the evolution of a cohort of judges who although they don't exclusively do medical law because that is not how the judiciary works, predominantly do

medical law cases: eg Mr Justice Hedly, who has taken most of the surrogacy cases family and medical law, Lord Thorpe Shaw in the court of appeal, Baroness Hale who was a distinguished mental health lawyer as academic and is now in the Supreme court. In many of the earlier cases judges were dismissive of patient with the apparent reason that medicine is too complicated we cannot make judgement on that; but they did it on engineering and will quite happy to work through complicated engineering evidence; but that is all changed judges will now go through medical evidence in equal measure.

b. Do you think that the courts and the legal profession could have contributed towards the development of this area of the law differently? Please explain.

MB: Well, I think we have seen on a couple of occasions, folks try to turn the clock back towards conservative approach, one example is MacFarlane case. There could be tension at the moment within judicial system, some people pulling back because of all the worry over compensation culture and worry over NHS; on the issue where medical law interact with social values or morals again there is tension; between very conservative judgement and hands off judgement like Mr Justice Munby on the morning after pill saying that the law has no business here. The increasing difficulty in bringing claims; abolition of legal aid so ordinary medical negligence case is going to become very difficult. Government wants to make it much more difficult to bring claim to judicial review so cases in which people challenge allocation for health care resources are going to be much more difficult.

4. The potential of English and Welsh health care law to be exported

a. Are there aspects of the body of health care law in this country which you think could and should be emulated by other jurisdictions?

MB: It is always useful to look at examples if your jurisdiction has not developed medical law. It is better where the legal systems are the same. Problem with comparative medical law is that we tend to compare only common law systems because of language barrier and difference in legal tradition. Things like laws on transplant can be adapted to suit your local circumstances. The HFEA is attractive as many people from abroad look at it as example. if a jurisdiction outside sees a problem it is useful to look critically at England and find out how good was it or bad was it and say we are going to take the good bit ; how do they apply to my country resources; religion are all important factors.

b. Which direction do you think English and Welsh health care law is currently facing - towards the patient or medical profession? Or something or someone else?

MB: In so far as the law is evolving by case law the courts generally think patients are centre of problem; I will say they are pro patients but not mindlessly. They are aware of what is being asked of doctors. So far law on health care has been developed through legislation, in that domain the medical profession still has pretty sound grip on what goes on in policy.

c. What advice will you give to a developing country with a common law tradition like Ghana, which is seeking to draw lessons from the experience of England and Wales in this field of law?

MB: in so far as the country is making its own particular advance in medical technology careful decisions need to be taken about allocation of resources. It worries me in this country we put enormous of money in reproductive technology and we still have one of the highest death rates in developed world. in my view if your country had extra money you could either develop pre-genetic diagnosis in Ghana or could put money into care of premature vulnerable babies. If you decide technology there are useful precedents to look at: transplant law etc. More generally the most important thing is to teach medical students properly. If we could produce in England and Ghana a generation of doctors who have good comprehension of the legal parameters in which they practice and train to reflect on ethics of what they do, then there will be less need for medical lawyers.

[Medical law cannot claim strictly any particular principles of law as exclusively its own but we have got foundational law which create the building blocks of the legal system; tort, contract, equity, land law. Then we have got next part of lawyers training which is to apply the law to a crucial area of human life which may be family law, medical law, employment law ; so we have got kind of the founding blocks and law and; so medical law is law and.

[One issue which is important is to think about is the breakdown of moral cohesion in this country. And there is a tension in relationship between religion and medical law ; that seems to me a fact that states have to account of religion.

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NAME OF INTERVIEWEE: KEN MASON (KM) AND GRAEME LAURIE (GL)

DATE: 15/10/2013 TIME: 19:00

MODE: SKYPE VIDEO CONFERENCE

Semi-structured interview Guide

- 1. Law and Medicine's relationship before 1980s**
 - a. How did the law relate to issues arising in health care during the long period before 1980s?**
 - b. Why did the law relate to medicine in the way it did.**
 - c. As an academic did you have research interest in matters relating to law and health care before the 1980s**

KEN MASON (KM):

There has always been medical law in so far as medicine has always been subject to the law. What you are referring to here is medical law as an organized discipline subject to it. If you are talking about medical law as a discipline then I have no doubt that it was the series of lectures given by Ian Kennedy which aroused people's minds and marked the start of the subject. The lectures aroused people's minds as to different views of medical law rather than just as a matter of medical negligence. It made medical law to be viewed also as a matter of medical ethics. If you like the lectures made people see medical law not just as negligence but rather a matter of medical ethics. At the same time and quite fortuitously, the subject was being developed in Scotland by Sheila McLean in Glasgow. She had also started writing on medical law in the small text and articles but not monographs as Kennedy did. She edited chapters of very small books. Nonetheless if you look back those writings were important. Kennedy published *The Unmasking of Medicine* in 1981. Kennedy is still the one who started the discipline of medical law.

It should be negligence. If people asked you what you mean about medical law, the answer would be the law of medical negligence. The way that medical law was being taught in the universities was by the Department of forensic medicine. Forensic medicine was a matter of pathology; I chose to follow it as medical practice. We call medical law here by the title, medical jurisprudence. I started teaching it around the 1980s. I taught it with Alexander McCall

Smith. Before 1980, you expected your doctor to behave in correct proper way and the effect of Kennedy was to question our original belief in doctors.

Graeme Laurie (GL): There are two books which Sheila McLean edited in the 1970s- Legal Issues in Medicine and Medicine Morals and the Law. Legal Issues in Medicine is interesting book because it is a collection of essays: a lot them talked about criminal law issues. Before 1980s the law engaged with doctors either in criminal context or negligence law. Indeed, McCall Smith came into medical law as a criminal lawyer and not tort of law. What we have seen is that in the post 1980s we have had less of criminal law as other areas of the law have grown up in broadening their perspectives on the law and medicine relationship. Britain and other European countries were taking a lot of lead from America so lot of it was around litigation but because UK was no very litigious we didn't have a body of law as such.it was something on the radar in UK until Kennedy and Mclean began to question authority of medical profession. I could not have had interested in medical law before 1980s as I was a child. I studied medical law from 1987 to 89. It was immediately after the Sidaway case; same time as the Gillick case; so I think it was very good time to study medical law because they landmark decision was laid down at the time I was interested in the subject; so lots of discussion we had in class was about deference of the court to the medical profession. My degree was in forensic medicine.

2. The Surge in academic interest in Law and Medical Ethics post 1980

a. How did you develop an interest in law and medical ethics?

KM: I was interested in the legal aspect of forensic medicine. I read a book by David Myers. It was very powerful book. When I read that I felt that was where I wanted forensic medicine to go. The book dealt with wide range issues. It was a lawyer speaking and not a doctor speaking. Our first book was in 1983. The book is now in 9th edition (2013).It was first and only book intended as comprehensive. There has been explosion in parliamentary intervention and case law which did not happen in the 1980s.

GL: A lot of it was either posed us negligence where we need significant deference of the courts to medical profession or it was a matter of criminal law; and we did not believe that there was place of law in the spaces between negligence and criminal law.

GL: I couldn't make a decision between becoming a lawyer and a becoming a doctor. I decided to take law and studied at Glasgow University which at the time specialised in medical law for two years. The degree was four years but two of which was used in studying medical law. It was unique in the 1980s to do that.

b. Did you encounter any challenges as you embarked upon publication of your research in this new area of the law?

KM: I was inspired after reading Kennedy and Myers book then I became interested. My original contribution was a book

GL: Challenges was ore about lack of legal precedents. So for example the first thing I ever wrote on this area was legal liability for transmission of HIV Aids. That was an article commissioned by the Journal of law Society. My problem was there was no real legal authority so I had to rely on reasoning by legal analogy. From the existing law you had to reason by analogy; there was undeveloped case law except in the established areas of medical negligence. Throughout the 1980s there were very few statutes so you had to look at the existing areas of law whether they are tort law or criminal law.

c. Can you explain if there was particular objective (s) which you wanted to pursue by focusing your academic interest towards this area of the law?

GL: After my undergraduate degree I did my PhD and I was interested in privacy and confidentiality; that is an area of the law which does not cover only health context but banking etc. I became interested in how the law reconginse privacy issues in health context so I did my PhD in privacy in genetics. The privacy of genetic information in family context was not addressed adequately by the law at the time. One thing about medical law is thinking about how law responds to confidential circumstances. So you take genetics, you can find something about a disease in a family it might affect many members of the family but who information is it ; does it belong to the family; should the doctors respect to respect confidentiality of the patient and not tell the brothers and sisters; does he owe duty towards other members of the family.

At the time I did not have any objective in mind but looking back I think medical law is interesting because it makes us deep questions about how much law can be an effective social tool. If you want to develop deep medical jurisprudence you need different discipline to work together; you need to ask when law should intervene in medicine and when is it appropriate to leave matters to medical discretion. So what I have been interested in is that question of limits of law in medicine.

d. Do you consider that there was surge in academic interest in law and medical ethics post 1980? If you consider there was a surge, please can you explain why you think this happened?

GL: In the 1980s there were not that many medical lawyers that you know about - Kennedy, Brazier, Grubb, McCall, Mason, Sheila. The real explosion was in the 1990s and after 2000. I think the passing of the HRA 1998 is an important date because that was the year in which

HL decided the Bolitho case- the first time that court began to say we need to control standard of care for medical profession.

Historically, medical law has been a marginal aspect of family law; human rights etc. There are still few chambers that specialize in medical law but that is changing. If you look at the court particularly the HC in E & W; over the last 50 years they have taken interest I particularly in certain core concepts but I am not sure that in itself is a good thing; I think the courts are becoming more paternalistic particularly if you look at the Judge Munby, now Lord President; He has a particular view of medical law which has been influential in shaping medical law in England and Wales. His contribution is open to critique; I think he has a very particular view on dignity, autonomy. If you expose those views to other disciplinary perspectives especially bioethicists and philosophers' they will have very much to say. I think he has very much driven the court's intervention in medical law.

Media has been actively reporting on medical law; there has been number of parliamentary intervention. So the profile of medical law has been raised for bad reasons: so that medical law has to come in a very reactive way. There are also number of scandals - organs; tissues etc. In a positive sense I think law schools have come to realise that actually human health is such a fundamental part of the human condition that we have got to engage with the role of law in protecting and promoting human health and wellbeing; and actually medical has been seen as a very marginal area but if you look at the discipline you have to involve almost all areas of the law- private law; judicial review; public law; international law- thus medical law is incredibly rich and multi-dimensional.so medical law has progressed from being marginal area at the edges to the centre of law's role in society and teaching.

Q: Can we say medical law is not a discrete field?

3. The courts, legal profession and the emergence of a distinct body of health care law.

a. How would you describe the posture of the courts and legal profession generally toward this field of law?

KM: How strong was the impact of criminal thinking in the 1980s; the impact of some of the cases and how did that replace when the civil courts began to reflect more critical lee about the medical profession. Although we have always had criminal law but civil law engagement of medicine has increased during the last 30 years. There are core concepts and values that hold the different aspects of medical law together: the notion of autonomy; human health' dignity ' wellbeing; best interest; caring. These all require particular consideration of how law actual operates to protect human being and their health. We have developed rich

conceptualisation of dignity and autonomy; necessarily to lawyers and the courts but through the multi-disciplinary working we have come to appreciate far better what these concepts mean for human flourishing so I think these concepts sew medical law together rather than saying it is just aspect of contract; tort or any other areas of the law.

b. Do you think that the courts and the legal profession could have contributed towards the development of this area of the law differently? Please explain.

GL: if you look at the court and legal judgment we are only getting part of the picture about patients' experience in health care and health care professionals. Obviously cases that come to court are cases where the relationship broke down; patients' right was not respected. So they are the bad cases; we have to remember that the cases that we read are very small part of people's experience of caring relationship or how they think that the law support or ought to support them. The fact that we see recognition of autonomy; dignity and values that is important but we have got a long way together.

4. The potential of English and Welsh health care law to be exported

a. Are there aspects of the body of health care law in this country which you think could and should be emulated by other jurisdictions?

JM. Medical law in Great Britain is shaped by the culture of British society; so talking about Ghana in West Africa you need to know the culture of the society in which medical law is being developed. We cannot dissociate culture from medical law.

GL: One area interesting to examine is the way in which the courts have dealt with best interest test; for example best interest test in future treatment when they have to draw balance sheet about question on value of life and quality of life that comes close to what healthcare professionals have to deal with patients in terrible circumstances. There may be some assistance from legal analysis there to health the health professionals take very difficult decisions. That might be good area but I resist in being too dogmatic about the role of law in the development of medical jurisprudence.

b. Which direction do you think English and Welsh health care law is currently facing - towards the patient or medical profession? Or something or someone else?

JM & JK: Political rhetoric or agenda has made medical law more of patients focused. However, this over emphasis of rights means that it does not promote caring relationship; the more we assert patients' rights it means more responsibilities for doctors and that make doctors more oppositional and it thereby draws patients and doctor apart. The autonomy of patients cannot be sustained because of resources constraint. The notion of patient autonomy is a flawed concept since you cannot give every patient all the relevant information. [*This view is based upon a chapter we just worked on together*]

GL: it has definitely moved towards the patient but the consequence of that is the law is beginning to support patients' abandonment. For example patient is entitled to information; the doctors provide it but it does not promote a caring relationship.

c. What advice will you give to a developing country with a common law tradition like Ghana, which is seeking to draw lessons from the experience of England and Wales in this field of law?

JM: Part of the problem of provision of resources; what resources can you provide. There is no point in making law for something you cannot do if you have the money; the infrastructure, you could do. But don't start making law that you cannot implement. Allocation of scarce resources is an important chapter in the book.

GL: In England and Wales, the law drives the discipline of medical law. In Edinburgh we call it Medical jurisprudence because we see it necessarily as multidisciplinary area. What we have done in EW is that we have over legalise it; too much driven by the courts and parliament; but there is only so much that the law can do in developing caring relationship. One advice is don't ask too much of the law because the law is a crude tool to develop human relationship and core values. The courts have embraced core values of autonomy and dignity but the way that they interpreted that is very impoverished and is not something which is in the interest of doctor-patient relationship.

Considering my answer to previous questions; I think there are some concepts that you need to reflect in the law but be careful that the law does not have to drive you in the direction you need to go, the law has try to support care and necessary developing notion of patient rights which pulls the doctor and patient apart is not a good idea. It is good to protect autonomy; dignity but don't forget that at the end of the people are in vulnerable position and need to have good relationship with their healthcare professional.

JM: There is no point in keeping people alive, who will normally have died, if you cannot feed them. So the things I will say is that - what resources do you have and what do you want to achieve.

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