

Whence and whither ‘modern medical law’?

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Abstract

Academic study of law relating to healthcare has flourished in the UK. Yet our field of study is often seen as ‘new’, both as an ‘area of importance in legal practice and as an academic discipline’. We argue that practical engagement between English law and medicine has a long history, a history revealing that claims of historic deference from one learned profession (the law) to another (medicine) is a myth. We further contend that ‘medical law’ as an academic discipline also enjoys a history. We explore these histories by looking back to the late medieval and early modern eras, and then show that crucial developments in more recent history have been overlooked in the emphasis on medical law as ‘new’. An appreciation of whence ‘medical law’ is crucial to assessing how future directions for law and scholarship in relation to the regulation of health may develop – whither it may go.

Keywords: medico-legal history; deference; regulation of health: future.

Introduction

In this paper – a first version of which was delivered by Margaret Brazier at the inspiring conference held to celebrate the inauguration of the University of Bristol’s Centre for Health, Law, and Society – we explore the past and speculate on the future of the relationship between English law and health. This paper derives from a series of conversations between the authors, conversations which may pose more questions than answers.

In 2000, Andrew Grubb contended that what he and Ian Kennedy described as ‘medical law’ was ‘still a comparatively young subject’, and only late in the twentieth century had it emerged in English law ‘as a distinct subject, both as an area of importance in legal practice and as an academic discipline’.¹ Insofar as there was any history of engagement between law and medicine, the assumption was made that judges had from time immemorial deferred to their medical brethren.² We argue that practical engagement between English law and medicine has in fact a long history, a history which (inter alia)

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1 A Grubb (ed), *Kennedy and Grubb: Medical Law* (3rd edn, Butterworths 2000) 3.

2 H Teff, *Reasonable Care: Legal Perspectives in the Doctor/Patient Relationship* (Clarendon Press 1994) 69.

reveals that the claim of historic deference from one learned profession (the law) to another (medicine) is a myth, and a myth that retarded the development of the law. Slightly more tentatively, we further contend that ‘medical law’ as an academic discipline also enjoys a history, albeit a neglected one. We first explore these histories by looking back several centuries to the late medieval and early modern eras. We then show that some crucial developments in more recent history (the 1940s–1980s) have been overlooked in the emphasis on medical law as ‘new’. Some appreciation of the history of ‘medical law’ is crucial to assessing how future directions for law and scholarship in relation to the regulation of health may develop, and to prevent us making the same mistakes again and again. We argue that there are enduring themes that enable us both to understand better the continuity between the emergence of medical law as a discrete subject and its antecedents and also to identify key issues for the future. We end by considering possible future directions, informed by our historical analysis, but also recognising that now and in the future there will always be contemporary pressures arising both from developments in biomedical science and social change that we and our ancestors have not yet encountered.

‘Modern medical law’

Ian Kennedy’s Reith Lectures published in 1981 as *The Unmasking of Medicine*³ are often cited as marking the birth of medical law in the UK.⁴ *The Unmasking of Medicine* and the creation in the mid-1980s of academic centres dedicated to the study of medical ethics and law⁵ may rather be seen as marking the beginning of the rebirth, for some a ‘renaissance’,⁶ of medical law, not its birth. We will describe this rebirth as ‘modern medical law’.

We do not question the evidence that this rebirth has witnessed the rise of a sub-discipline of scholarship to be variously named ‘medical law’, ‘healthcare law’ or ‘health law’. The nomenclature of the subject of study has provoked sharp differences of opinion among scholars.⁷ What may be more readily agreed is that, as the sub-discipline grew up, its adherents sought to research and critique the relationship between law and the practice of medicine, the provision and regulation of healthcare and the amazing developments in biomedical science. The debate over the naming of the subject area will continue, but we have concluded that it can be a distraction, and that understanding where this burgeoning area of legal practice and academic enquiry came from is an important guide to where it might go to in the next three decades. In this paper, we concentrate on this issue rather than seeking to defend a particular label.

The development of scholarly study of ‘modern medical law’ in the past 30 years cannot be divorced from at least three other key developments affecting the law as it applied to health matters. (1) At the same time that academic enquiry developed in this field in the last quarter of the twentieth century, English judges began to abandon their apparent prior deference to ‘medical men’, patients became less patient, and the courts as well as academe became much more engaged with questions of healthcare practice.

3 I Kennedy, *The Unmasking of Medicine* (Allen & Unwin 1981).

4 D Wilson, *The Making of British Bioethics* (Manchester University Press 2014) 105–39.

5 Ibid 196–209.

6 See J Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship* (Hart 2001) 33–54, on a medical ethics ‘renaissance’.

7 See J Montgomery, *Health Care Law* (Oxford University Press 1997) 1–4; J Coggon, *What Makes Health Public* (Cambridge University Press 2012) 86–91; T Hervey and J McHale, *European Union Health Law: Themes and Implications* (Cambridge University Press 2015) 10–29.

Medical law swiftly became an area of importance in legal practice. (2) Closely linked, if not conjoined to the growth of law in relation to healthcare, are profound changes in the older tradition of medical ethics, first in Gillon's emphasis on 'critical ethics'⁸ and then in the evolution of bioethics,⁹ culminating in a sometimes uneasy sibling relationship between law and bioethics.¹⁰ (3) Finally, the development of research in law, ethics and healthcare was swiftly mirrored by a proliferation of undergraduate courses in UK law schools on medical or healthcare law and ethics and the creation of specialist Masters' and PhD programmes focused on law, ethics, medical science and healthcare.

The pace and extent of these developments might be seen as proof that claims of something 'new', in academe in particular, were right. Travel back in time to the 1960s and tell the Dean of a Faculty of Law that his undergraduates and postgraduates should study medical law or law and healthcare, whatever name you chose for your proposal, and the likelihood is he would respond with a derisory laugh. Announce an intention to research law and healthcare and you might well meet the puzzled question: 'Surely this isn't legal scholarship?'. Legal scholars addressed the development of the common law, fundamental questions of obligations, contract and tort, property law, jurisprudence, international law. The study of Roman law marked a scholar out as a true intellectual, and legal history was respectable.

Family law was only barely respectable. In 1957, when Peter Bromley wrote a textbook on family law,¹¹ eyebrows were raised. What on earth was a good Oxford man like Bromley about? Applying, analysing, how law related to particular domains of human life was likely to be dismissed as quasi-sociology. It is not surprising that Kennedy and Grubb, doyens of 'modern medical law', described the field of academic study as 'comparatively new'. That claim must, however, be considered in the light of evidence that before the 1970s not only was research carried out in law faculties in the UK limited in scope, but not much research as we would understand it today was done at all.¹² Many law teachers combined teaching with professional practice. Publications tended to be textbooks and contributions to works designed to assist practitioners. So, if there was little research into healthcare law it is unsurprising, as there was little research at all.

What of practice? When Kennedy and Grubb first applauded the novelty of medical law there were relatively few twentieth-century cases troubling the law courts. As Kennedy put it later:

Medical law used to be fun. All you had to do was read a lot of strange American cases, the odd Commonwealth decision and maybe some English nineteenth-century cases on crime then you could reflect that none of these was relevant and get on with the fun of inventing answers. Suddenly, 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. Medical lawyers are having to do homework.¹³

For a legal scholar coming to medical law in that era, it felt new.

8 R Gillon, *Philosophical Medical Ethics* (John Wiley & Sons 1986).

9 Oxford University Press launched a Studies in Bioethics series in 1984 with the first volume, P Singer and D Wells, *The Reproduction Revolution*.

10 Wilson (n 4); and see D Wilson and R Chadwick; 'The Emergence and Development of Bioethics in the UK' (2018) 26 *Medical Law Review* 183; A Grubb, 'The Emergence and Rise of Medical Law and Ethics' (1987) 50 *Modern Law Review* 241.

11 P M Bromley, *Family Law* (Butterworths 1957).

12 G Wilson, 'English Legal Scholarship' (1987) 50 *Modern Law Review* 818.

13 I Kennedy, 'The Patient on the Clapham Omnibus' in *Treat Me Right* (Oxford University Press 1988) 175; originally (1984) 47 *Modern Law Review* 454.

Insights from history: the past is not so foreign a country¹⁴

In the absence of evidence of much late nineteenth to late twentieth-century engagement between law and medicine, seeking to go further back in time to Tudor England and before might seem pointless. One might assume that there was little healthcare available to most people, few doctors, and that what medical remedies there were, such as blood-letting and leeches, have little relevance today. If there was no pertinent healthcare then it would follow there was not much to take to the law courts or to trouble the legislature. Add to these factors the myth of deference suggesting that if a patient went to court a judge would just back the doctor and the case for the existence of robust medico-legal history looks thin.

The premises on which the case looks thin are simply wrong. The medical historian Margaret Pelling¹⁵ has demonstrated that the assumption made by older historians that ‘most of the population before the nineteenth century had no access to medical services worthy of the name’ and that ‘medical care was necessarily confined to the rich’¹⁶ was plain wrong. Nor was access to healthcare limited to residents of London alone.¹⁷ In common with their descendants, Pelling declares ‘early modern people were obsessed with health, with its fragility and with the means of preserving it’.¹⁸ The very importance of health to people well before the nineteenth century created a space for law and lawyers. And as today, there is evidence that laypeople, the consumers of healthcare, have long sought ‘rights over their own lives and bodies’.¹⁹ Moreover rather than there being very few ‘doctors’ in Tudor and Stuart England, there were too many healers, many men and some women, who fought over their share of the healthcare market. Courts were regularly resorted to in disputes between patients and doctors and between the different sorts of doctors.²⁰ Legislation relating to medical practice was common. The law engaged with medicine on a regular basis.

For much of the last quarter of the twentieth century it may be argued that, with some exceptions, judges distorting the direction of McNair J in *Bolam*²¹ allowed the medical profession to dominate the legal framework of medical practice and to define medical ethics.²² As the twentieth century gave way to a new millennium, ‘modern medical law’ might be characterised as a battle against *Bolam*. The dominance of the medical profession in defining what constituted ethical and lawful practice was challenged.

AREA OF IMPORTANCE IN LEGAL PRACTICE?

In seeking out a forgotten history, let us take first the question of legal practice. Engage with the primary sources and guided by the work of medical historians and there will be discovered a rich history of the relationship of law and healthcare in England stretching

14 We allude to the opening of *The Go-Between* by L P Hartley (Hamish Hamilton 1953): ‘The past is a foreign country; they do things differently there.’

15 M Pelling, *The Common Lot: Sickness, Medical Occupations and the Urban Poor in Early Modern England* (Routledge 1998).

16 *Ibid* 5.

17 R S Roberts, ‘The Personnel and Practice of Medicine in Tudor and Stuart England: Part I The Provinces’ (1962) 6 *Medical History* 363.

18 Pelling (n 15) 5.

19 *Ibid* 8.

20 Roberts (n 17) 363–4.

21 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

22 Miola (n 6).

back to the medieval era.²³ Until the Reformation, the canon law of the Roman Catholic Church promulgated laws across Western Europe governing many matters that constitute healthcare law today.²⁴ Successive Councils of the Church addressed (inter alia) the ethics of medical practice, consent to treatment, questions of reproduction (including but not only abortion), the limits of what we may do to and with our living bodies, the care of the dead and much more. The Church also delivered much of the healthcare available to the sick and played a major role in the control of communicable diseases, such as leprosy and the plague.²⁵ Medieval canon law can be characterised as 'Western European health law' long before the European Union was ever thought of. Questions we struggle with today, canon law considered centuries ago.

In the sixteenth century and in particular post the Reformation, the legislature and secular courts began to play a larger role in relation to medicine and healthcare.²⁶ It should be noted though that the reformed Church of England continued to be responsible for licensing surgeons and midwives outside London until well into the eighteenth century.²⁷ The reign of Henry VIII saw a series of Acts of Parliament and Royal Charters addressing the regulation of medicine, legislation often claimed to be for the protection of the people.²⁸ The creation of the College of Physicians in 1518 signalled the start of a vicious war between the three sorts of medical practitioners who saw themselves as 'orthodox professionals': the physicians, the surgeons and the apothecaries.²⁹ The College sought domination over the 'lower' orders. Its members perceived themselves to be educated gentlemen, while the surgeons and the apothecaries regulated in Tudor England within the craft Guilds (the Barber-Surgeons³⁰ and the Grocers Companies)³¹ were mere tradesmen. It was a war often fought in the courts. The power of the College was challenged in a range of court battles in the Courts of King's Bench,³² Common Pleas³³ and even Star Chamber.³⁴ The physicians fought with the surgeons and the apothecaries, suffering a significant defeat in 1703 in *Rose v College of Physicians*.³⁵ All three 'orthodox' groups of licensed medical practitioners agreed on one

23 See generally C Rawcliffe, *Medicine and Society in Later Medieval England* (Sandpiper Books 1999); O Grell, 'Medicine and Religion in Sixteenth Century Europe' in P Elmer (ed), *The Healing Arts: Health, Disease and Society in Europe 1500–1800* (Manchester University Press 2004) 85.

24 C Rawcliffe, *Leprosy in Medieval England* (Boydell Press 2006) 9.

25 Ibid.

26 T Gelfand, 'The History of the Medical Profession' in W F Bynum and R Porter (eds), *Companion Encyclopaedia of the History of Medicine* (Routledge 1993) 1119.

27 J R Guy, 'The Episcopal Licensing of Physicians, Surgeons and Midwives' (1982) 56 *Bulletin of the History of Medicine* 582.

28 See T Cunningham, *Physicians, Surgeons and Apothecaries containing All the Statutes, Cases at Large, Arguments, Resolutions and Judgments against them compiled at the Desire of a Great Personage* (W Griffin of Catharine Street in the Strand 1767).

29 M Brazier, 'The Age of Deference – A Historical Anomaly' in M Freeman (ed), *Law and Bioethics* (Oxford University Press 2008) 465.

30 The surgeons gained independence from the Barbers in 1745 becoming the Company of Surgeons, and in 1800 received a Royal Charter to become the Royal College of Surgeons.

31 In 1607, apothecaries were granted a discrete status within the Grocers Company and in 1617 the Society of Apothecaries was established by Royal Charter.

32 It is known that there were proceedings in *Bonham's Case* in the Court of Kings Bench, but to our knowledge no full records have as yet been found: see H J Cook 'Against Common Right or Reason: The College of Physicians Versus Dr Thomas Bonham' (1985) 29 *American Journal of Legal History* 301.

33 *Dr Bonham's Case* (1609) 77 ER 646.

34 See the account of the criminal libel case of *Edwards v Woolton* STAC/8/130/12 (1607) in Roberts (n 17) 371.

35 *William Rose (Plaintiff in Error) v the College of Physicians* (1703) ER 857.

question and joined together in one enterprise – to drive out other healers, the empirics, later more often styled as ‘quacks’.

How to regulate medical practice was not the only medical law issue to engage the courts. Disputes between doctors and patients were common but, at first glance, look unlike the clinical negligence claims of today. What would now be a clinical negligence claim, might well in the sixteenth century be brought as a complaint by a patient to the Censors of the College of Physicians, which could result in a criminal prosecution for *mala praxis*.³⁶ Occasionally, aggrieved patients and competing healers sought indictments for witchcraft.³⁷ Clinical negligence suits hide in the Law Reports, often beginning as actions for debt brought by the doctor for breach of contract, i.e. non-payment of fees.³⁸ The defendant counterclaimed stating that no payment was due, rather that the doctor ought to compensate them. In the eighteenth and nineteenth centuries there was a series of prosecutions of unlicensed practitioners for gross negligence manslaughter – initiated by the orthodox professionals using the law in what proved to be a vain attempt to drive out other sorts of healer.³⁹

Discovering whence healthcare law is fun, but as one former Secretary of State for Education, Charles Clarke, said of any study of medieval history, should the taxpayer pay for it? Our first response would be that the pursuit of knowledge and scholarship is a good in itself. History helps us understand who we are and how our society evolved. The medical historians, led by Roy Porter,⁴⁰ use the focus of medicine to tell us much more about the society of the times. The sociology of health provision shows how societies organised themselves (creating categories of private and public care provision, paid and unpaid health labour) and managed their understanding of the world (developing the uses of concepts such as health and illness to transition from a theological to scientific understanding of the natural world).⁴¹ Developing research into medico-legal history adds to that picture.

We would go further and suggest that medico-legal history has lessons for law and medicine today. By neglecting history we waste time and effort and repeat the same mistakes. If we have only a vague notion of history, a notion unsupported by evidence, we may make bad laws today. Researching the history of medical law unearths enduring themes and some dangerous myths.

Enduring themes

Biomedical science has altered radically over time; human nature and desires have altered less. Many of our concerns about healthcare and science can be found to have been addressed by our forebears, giving rise to themes that permeate history. Perhaps the first and central theme is the enduring importance of health itself as both a private and public concern. Health was ascribed a value of high importance, justifying the engagement of the Crown and the legislature, both to protect the subject’s ‘right’ to healthcare and manifest the Crown’s responsibility for the health of the public.

36 See *Dr Groenvelt’s Case* (1697) 9 Will 3 BR.

37 See B Woolley, *The Herbalist* (Harper Perennial 2005) 213–15.

38 *Slater v Baker and Stapleton* (1797) 95 ER 860.

39 M Brazier, ‘The Criminal Process and Medical Practitioners: Shield and Sword’ in M Henaghan and J Wall (eds), *Law, Ethics and Medicine: Essays in Honour of Peter Skegg* (Wellington, Thomson Reuters 2016) 7.

40 R Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (Harper Collins 1997).

41 M Stacey, *The Sociology of Health and Healing* (Unwin Hyman 1988).

Our ancestors perceived healthcare, if not as a right, as a powerful claim generating obligations on others. Consider monastic healthcare in the medieval era. The Rule of St Benedict stated:

The care of the sick is to be placed above and before any other duty, as if indeed Christ himself were being directly served by waiting on them.⁴²

The monks were obliged to offer care to anyone in need who came to their doors. They were forbidden to act for gain. The 'Monastic Health Service' was in theory not free to pick and choose – not permitted to treat their guests as the common sort of persons who should be condescended to and patronised. They must be served as the monks or nuns would serve Christ. When the monks were driven out and the battling kinds of 'doctors' fought for their share of the market, all sought to claim that they would treat the poor for free.⁴³

Once healthcare was disaggregated from the rules of religious life, and no longer free save for the indigent poor, then a different and complex regulatory context emerged. Within London and its environs, the Crown, Parliament and the secular courts came to play a major role in regulation, albeit one that often entailed judging the claims of the respective kinds of practitioner. Outside London, the craft guilds undertook the task of regulating surgeons and apothecaries.⁴⁴ Regulation governing surgery might differ between London and Norwich or Norwich and York. Devolution of healthcare regulation is not new. Regulation, as it always has, determined disputes in ways that reflected the context, parties, and the fora that are empowered to resolve them. The diverse forms of regulation of medical practice in Tudor and Stuart England are a fertile field for scholars of regulatory theory.

Developments in medical science, even when that 'science' was rudimentary, also have common and ancient themes in legal debate. The several uses of the human body and human material have generated much academic debate and public controversy in 'modern medical law'.⁴⁵ How the dead are treated has given rise to bitter controversies, most recently in relation to organ retention. In 2000–2001, when the retained organs controversy hit the headlines, the medical historian Ruth Richardson could have said: 'I told you so'. In *Death, Dissection and Destitute*⁴⁶ she outlined the several attempts by the Crown, Parliament, and the anatomists in the fifteenth to nineteenth centuries to gain a sufficient supply of corpses to engage in dissection and research. She describes the huge public opposition and a chasm of misunderstanding between 'scientists' and much of the populace.⁴⁷ Crowds, who had cheered the executions, sought to snatch the bodies of executed criminals from the scaffold to save them from the surgeons. Battles over the Anatomy Act 1832 led to riots and the burning down of the anatomy school in Sheffield.⁴⁸ Above all, the nature of the debates and the language used by the elite to condemn those lower classes who stood in the way of science as superstitious and ignorant are echoed in the more modern controversy around organ retention.

Controversy around bodies highlights two further enduring themes: first, those surfacing when scientific developments appear to seek to change attributes of humanity. Thus, the actions of the anatomists in the sixteenth and seventeenth centuries embarking

42 Porter (n 40) 111.

43 *Rose v College of Physicians* (n 35); Brazier (n 29).

44 Roberts (n 17).

45 M Brazier, 'Retained Organs: Ethics and Humanity' (2002) 22 *Legal Studies* 550.

46 R Richardson, *Death Dissection and the Destitute* (2nd edn, University of Chicago Press 2000).

47 *Ibid* 3–29.

48 *Ibid* 263.

on research and unpicking some of the mysteries of the human body were received by many people with scepticism and fear.⁴⁹ A similar popular reaction can be seen again in the early years of artificial reproductive technologies (ARTS). Medical science even in its crude early forms was feared when it appeared to take control of human life; fears well evoked in Mary Shelley's horror novel, *Frankenstein*.⁵⁰ Those concerns are exacerbated when evidence of 'scandal' emerges. So, while there were many people who thought that dissecting dead bodies was wrong per se, opposition to dissection was further inflamed by the evidence of body-snatching and murder,⁵¹ 'crimes' in which the medical professions were complicit.⁵²

We have identified five enduring themes: the social organisation of healing; the sphere of regulation; the significance of human bodies; fear of science; and the impact of scandal. Analysis of the history of law and medicine based on these (and no doubt others) reduces the risk that contemporary developments are seen as more significant than they really are. We should be wary of overestimating discontinuity with the history of interactions between the law and health provision. We use these five dimensions to help us understand better the roles that legal engagement plays.

Dangerous myths

Another reason why we should consider whence 'modern medical law' derives from the importance of myth-busting. Coupled with the belief that medical law was new was the assumption that, when doctors did end up in court or the regulation of doctors was under consideration, English judges and the legislature had always endorsed a paternalistic tradition⁵³ and been unwilling to question medical practice. The evidence, at least until late in the nineteenth century, is to the contrary. Prior to the later decades of the nineteenth century, judges declined to offer any sort of privilege to a medical man of any persuasion, be they physician, surgeon or apothecary.

Given the competing groups of 'orthodox' professionals, not to speak of the many other sorts of healers, to whom would you defer? Until the creation of the General Medical Council in 1858⁵⁴ and the Medical Register any uncritical *Bolam* approach would have encountered difficulty. How would one identify the responsible 'medical man'?⁵⁵ It was only the organisational demarcations that the 1858 Act introduced which made 'responsible professional practice' a coherent and ascertainable concept.

One answer to the question of identifying the responsible medical man prior to 1858 might have been to defer to the licensed practitioners dismissing other groups of healers as 'quacks', and/or accept the College of Physicians' claim that it was the ultimate authority ruling over 'the whole domain of medicine'. Before 1858 and even later, judges showed little inclination to favour the licensed doctor be he physician, surgeon or

49 J Sawday, *The Body Emblazoned* (Routledge 1995).

50 Mary Shelley, *Frankenstein: or; The Modern Prometheus* (Lackington, Hughes, Harding, Mayor & Jones 1818).

51 Richardson (n 46) 52–72.

52 Ibid 55–57.

53 Teff (n 2) 69–93. And see I Goldrein, 'Bolam: Problems Arising out of "Ancestor" Worship' (1994) 144 New Law Journal 144.

54 M Davies, *Medical Self-regulation* (Ashgate 2007) 15–17.

55 The popular belief that there were only medical 'men' who had ever practised medicine in England is another myth. Elizabeth Garrett Anderson was not the first woman to practise medicine in England. In the 1500s to 1700s there were women surgeons and apothecaries benefiting from Guild laws that allowed widows and even daughters to take over the family business: See M Green, 'Women's Medical Practice and Health Care in Medieval England' (1989) 14 Signs 434.

apothecary. In *Bonham's Case* in 1610, finding in favour of Dr Thomas Bonham's challenge to the College of Physicians, Sir Edward Coke CJ was unimpressed by the College's claim to determine who practised 'physic' and what constituted good practice. Harold Cook, in a masterly analysis of the complex litigation now known simply as *Bonham's Case*,⁵⁶ commented that Coke removed from the College the unfettered power it claimed to judge what constituted good or bad practice:

The College was not to be the only expert judge of medical practice – or rather any judge with a university education could find whether a medical case had been handled correctly or not.⁵⁷

Two centuries later the founder of *The Lancet*, Dr Thomas Wakley, led a campaign by the licensed practitioners to drive out the quacks by instigating prosecutions for manslaughter whenever a patient in the care of an unlicensed healer died within three days of receiving treatment.⁵⁸ Ironically, they invoked a dictum from Coke⁵⁹ that there was a presumption that if an unlicensed practitioner treated a patient and she died within three days he was guilty of manslaughter. The judges rejected such arguments saying that whether the practitioner was licensed or unlicensed, to be convicted of homicide it must be shown that he acted with gross negligence, out of grossest ignorance, or the most criminal inattention. What is notable is that the language of the judgments dismissing the arguments put forward at the instigation of the licensed medical professionals resonated with undeferential scorn. To give just one example, Park J said that it mattered not:

[W]hether the individual consulted the president of the College of Physicians, the president of the College of Surgeons or the humblest bone-setter in the village.⁶⁰

Claims to deference based on medical professional status cut little ice with sceptical judges. Lack of deference to doctors before the late nineteenth century should not perhaps surprise us. Medicine did not share the mantle of a learned profession suitable for a gentleman until well into the nineteenth century. Medicine was an occupation, a business, not much different to the trade of the master baker or farrier.

Bolam is not the only dangerous myth. Another example relates to leprosy and communicable diseases and illustrates the dangers of a 'little knowledge'. In the nineteenth century, colonial administrators who were dealing with leprosy in the British empire and public health doctors drafting public health legislation on communicable diseases in England believed that it was draconian laws imposing a stringent regime of isolation of and quarantine which brought about the decline in leprosy in medieval England. Thus, Victorian laws were drafted which were thought to be based on sound medieval precedent. In *Leprosy in Medieval England*⁶¹ Rawcliffe provides conclusive evidence that the 'laws' on which the nineteenth-century lawmakers relied were of as dubious provenance as the medical 'evidence' relating to the decline of leprosy. Rawcliffe warns of:

56 Albeit it involved at least three sets of related proceedings,

57 Cook (n 32) 317.

58 Brazier (n 39).

59 *Coke's Institutes* 4 Inst 251 (1644).

60 *R v John St John Long* (1831) 172 ER 172; and see *R v Van Butchell* (1829) 172 ER 576.

61 Rawcliffe (n 24).

[F]antasies and misapprehensions about ‘the medieval leper’ propagated during a period when microbiologists, colonial administrators and evangelicals turned to the past for evidence to support their own campaign for mandatory segregation.⁶²

The ‘leprosy’ myth still affects public health law today in that (although heavily amended) modern legislation on communicable diseases remains modelled on the old Victorian laws.⁶³ Moreover, the initial response to the HIV epidemic was again influenced by the enduring myths around the law and leprosy.⁶⁴ Knowing a very little about history is as dangerous as knowing nothing.

AN ACADEMIC DISCIPLINE?

While we can claim that law’s engagement with medicine has a long history as an important area of legal practice, the question of its longevity as an academic discipline cannot be answered without bearing in mind the way in which it has been manifest. The emergence of ‘modern medical law’ scholarship needs to be considered alongside the ways in which academic legal writing in England developed more generally in the latter parts of the twentieth century. The explosion of activity relating to law and medicine in the past 30 years is as much a change in the form of legal scholarship generally as a discovery of a new area of legal scholarship.

There is evidence from at least three centuries ago of legal writing, what might be described as legal scholarship, addressing issues that count as medical/health law today. The ‘fathers’ of the common law, including Bracton, Coke and Hale, all addressed matters of law and medicine. In 1768, Blackstone gave as an example of a private wrong: ‘the unskilful management of his physician, surgeon, or apothecary . . . *Mala praxis* is a great misdemeanour [*sic*] and offence at common law, whether it be for curiosity and experiment, or by neglect; because it breaks the trust which the party has placed in his physician’.⁶⁵

The commentaries of the legal giants of the past were comprehensive analyses of the laws of England in their entirety. It could be argued that they no more identified an area of study relating to medicine than they did blacksmiths’ law. Doctors were just one illustrative example of the application of criminal law and/or the law of torts. Yet it is clear that the judges made some allowance for the special nature of the doctor–patient relationship exemplified by what Blackstone says about trust. The commentaries were written predominantly by legal practitioners and judges, not academics. Such was the tradition of the times. Blackstone was, prior to his appointment to the Bench, the first Vinerian professor of English law at the University of Oxford. Legal scholars of the kind we know today did not exist.

In addition to the inclusion of analyses relating to medical practice in the writings of iconic judges, a number of books from the eighteenth and nineteenth centuries focus expressly on laws relating to medicine. We note two examples. (1) In 1767, Timothy Cunningham, a barrister, published *Physicians, Surgeons and Apothecaries containing All the Statutes, Cases at Large, Arguments, Resolutions and Judgments against them compiled at the Desire of*

62 Ibid 5.

63 Public Health (Control of Diseases) Act 1984, despite the amendments made by the Health and Social Care Act 2008.

64 Rawcliffe (n 24) 17, 90.

65 *Commentaries on the Laws of England* vol 3 (1768), ch 8, s 4, 122, in the facsimile edition published by University of Chicago Press 1979. He goes on to observe that the civil law (as well as the common law) recognised an action for ‘neglect or want of skill in physicians and surgeons’.

a *Great Personage*.⁶⁶ (2) In 1814, Robert Masters Kerrison⁶⁷ published *An Inquiry into the Present State of the Medical Profession in England containing an Abstract of all the Acts and Charters granted to Physicians, Surgeons and Apothecaries and a Comparative View of the Profession including the Need for Reform and an Analysis of Medicine in Classical Times*. Both books attest to the existence of a discrete focus on the medical professions and healing.

Cunningham's book if assessed by today's classification of legal writing might resemble a text and materials book; Kerrison is much more a critical work – a monograph on the regulation of medical practice. However, Kerrison was neither a lawyer nor an academic but practised as a surgeon–apothecary, later becoming a licentiate of the College of Physicians. Both works have an additional mission over and above critiquing the law. Cunningham argued for the importance of laws that prevent and punish 'quackery'. Kerrison's work seeks to advance the case for the Bill before Parliament which became the Apothecaries' Act 1815. Neither the medical authorship of the work nor the campaigning role of both books disqualifies them from being seen as proto-medical law scholarship. J K Mason's work is not ruled out of the canon because Mason was a medical professional. Much of modern scholarship in our field is campaigning too.

No exact analogy can be made with modern scholarship. Rather, the history of medical or health law scholarship is as 'ancient' and persistent as many other fields of legal scholarship. It is only relatively recently that anything resembling legal scholarship today has existed at all. The infrastructure did not exist. The first law journal in England allowing ready dissemination of legal scholarship, the *Law Quarterly Review*, was first published in 1885. The first volume included an article on lunacy laws. In the third was a piece on 'moral mania' in which the views of Dr Maudsley (founder of the famous London hospital) were discussed. Academics were writing on mental health law as early as on other areas of scholarly inquiry. For the most part, however, until the 1970s or so legal research of any kind going beyond fundamental common law, legal history, jurisprudence and international law was rare. Work assessing how the law applied to human life, such as the family or the environment, began to flower only a little earlier than 'modern medical law'.⁶⁸ It may be true that 'modern medical law' lacks an extensive history as a conventional academic sub-discipline, but this is in common with many of the categories we use to organise legal scholarship today.

Labour pains in the birth of 'modern medical law'

And so to the rebirth, renaissance, of modern engagement between law medicine and healthcare and whither tomorrow. We noted at the start of this paper that Kennedy's Reith Lectures may be seen as marking this rebirth and triggering the public emergence of 'modern medical law'. In practice, however, events before the 1980s demonstrate that, at the very least, matters of 'modern medical law' and healthcare were being gestated some years before any announcement of a 'birth'. One factor may have been that a focus on judicial activity obscured important legislative interventions (a blinkered view that reflected a widespread belief in law schools that only the common law was really worthy

66 Cunningham (n 28).

67 Robert Masters Kerrison, *An Inquiry into the Present State of the Medical Profession in England containing an Abstract of all the Acts and Charters granted to Physicians, Surgeons and Apothecaries and a Comparative View of the Profession including the Need for Reform and an Analysis of Medicine in Classical Times* (Longman, Hurst, Rees Orme and Brown 1814).

68 See W Twining, 'Professionalism in Legal Education' (2011) 18 *International Journal of Legal Education* 165. And for an account of English law schools more generally, see W Twining, *Blackstone's Tower: The English Law School* (Stevens & Sons 1984).

of attention). Another may have been that the connections that most early medical law scholars made between their new subject and bioethical concerns. An early critic of these developments, Joe Jacob of the London School of Economics, suggested that this concern with the ‘untoward’ obscured the realities of most clinician work.⁶⁹ It is necessary to assess these issues in order to characterise more accurately where the birth of medical law belongs in the historical succession of scholarly reflection.

The National Health Service Act 1946 and the creation of the National Health Services (separately for England and Wales, Scotland and Northern Ireland) in 1948 radically altered the way in which health services were provided and regulated, opening them up to the growing potential for public law scrutiny. The Act, however, also consolidated medical power in decision-making,⁷⁰ creating perhaps a context in which the medical profession was or could be seen as the dominant voice as to what constituted good practice. The relief and gratitude with which many patients greeted healthcare free for all may have contributed to a culture of deference to doctors providing that care. The withdrawal of healthcare for the most part from the market changed expectations from a degree of scepticism about what your doctor was ‘selling’ to one of ‘trust’ in what patients were being given.

The creation of a publicly funded and publicly managed service took medical law into the framework of public law.⁷¹ Legal writing on ‘NHS law’ was also to be found in Speller’s *Law relating to Hospitals and Kindred Institutions*,⁷² although it was said that this was ‘not intended to be a reference book for members of the legal profession’.⁷³ The NHS legislation represented both an affirmation of the value placed on health and access to healthcare and a further episode in the relationship of regulation and healthcare. A newly constituted sphere of regulation – NHS law – came into being. Its potential to trigger critical scholarship and place ‘modern medical law’ more firmly in the domain of public law took a number of years to realise,⁷⁴ but it showed how changes to the social organisation of healthcare prompted new forms of legal engagement.

What of other legislation before 1981? Primary legislation on matters of medical ethics was scant and rarely the subject of much academic debate at the time of enactment, but our enduring themes of embodiment, scientific advance and scandal brought some issues into the legal arena. The 1960s saw the passing of the Human Tissue Act 1961 and the Abortion Act 1967. In part, both legislation⁷⁵ and its avoidance⁷⁶ was the product of the manipulation of law-making by campaigners, with the medical profession constituting a major stakeholder in the legislative process.⁷⁷ As was the case in relation to judge-made law and the dominance of *Bolam*, from 1957 to the 1980s, so the legislature seemed

69 J Jacob, *Doctors and Rules: A Sociology of Professional Values* (Routledge 1988) 166; see the review article J Montgomery, ‘Medical Law in the Shadow of Hippocrates’ (1989) 52 *Modern Law Review* 566.

70 R Klein, *The New Politics of the NHS* (3rd edn, Longman 1995) esp 49–52.

71 Or perhaps, better, back to the sphere of public law, given the long tradition of the poor laws in public provisions of care. See K Price, *Medical Negligence in Victorian Britain: The Crisis of Care under the English Poor Law c 1834–1900* (Bloomsbury Academic 2015).

72 S R Speller, *Law relating to Hospitals and Kindred Institutions* (HK Lewis 1947); and see *The National Health Service Act 1946 Annotated* (HK Lewis 1947).

73 Review in the [1948] *Cambridge Law Journal* 161.

74 D Longley, *Public Law and Health Service Accountability* (Open University Press 1992).

75 S McGuinness and M Thomson, ‘Medicine and Abortion Law: Complicating the Reforming Profession’ (2015) 23(2) *Medical Law Review* 177.

76 P Lewis, ‘Legal Change on Contraceptive Sterilisation’ (2011) 32 *Journal of Legal History* 295.

77 M Latham, *Regulating Reproduction: A Century of Conflict in Britain and France* (Manchester University Press 2002).

content to regard the medical profession as the principal arbiter of good practice in matters of ethics, as well as clinical practice.

The picture was different, however, in mental health law. Here both legal involvement and lack of deference to medicine began much earlier. Legalism was said to have 'triumphed' in the late nineteenth century and a series of statutory reforms followed, including those based on human rights litigation during the 1980s.⁷⁸ Some thought the law was being too assertive, not deferential.⁷⁹ This view was largely neglected in the general acceptance in the academy of the 'Bolamisation' thesis and the less deferential approach seemed anomalous.

There were some significant developments in twentieth-century malpractice law and associated scholarship before 1981 too. In 1957, Lord Nathan published the first modern textbook in the field, *Medical Negligence*, addressing the phenomenon of apparently increasing litigation following the creation of the NHS, which he attributed to three factors.⁸⁰ First, 'a subtle change in the relationship between the medical man [sic] or institution and the patient' that he suspected had arisen because healthcare had become a matter of right rather than beneficence, or in return for a voluntary contribution to an association. Second, legal aid reforms made it possible for impecunious patients to sue. Third, developments of legal doctrine in relation to vicarious liability assisted plaintiffs⁸¹ to sue the hospital.

Nathan's book is little known today, despite the fact that his analysis was prescient. The issues he identified resurfaced later. Litigation to enforce rights to healthcare began to be explored in the 1980s in relation to kidney dialysis and access to fertility services.⁸² The availability and subsequent withdrawal of legal aid funding, apart from that relating to children, was said to have played a significant factor in changes to clinical negligence litigation rates.⁸³ The shift from vicarious to direct liability has played a further important role in litigation, something that is currently being worked out in the Supreme Court.⁸⁴

Nathan espoused much the same critical assessment of liability for medical negligence as did later legal academics condemning *Bolam*.⁸⁵ He thought that health practitioners were more vulnerable to litigation than lawyers; counsel were then by law immune from the consequences of their negligence, and solicitors could in practice secure such immunity by seeking counsel's opinion.⁸⁶ In contrast, the physician, surgeon, nurse or

78 C Unsworth, *The Politics of Mental Health Legislation* (Oxford University Press 1987). Few of the pioneers of 'modern medical law' covered this area, although see B Hoggett (now Lady Hale P), *Mental Health Law* (1st edn, Sweet & Maxwell 1975). Practitioners were better served, see the loose-leaf text, *Mental Health Services, Law and Practice* (Shaw & Sons 1986).

79 N Rose, 'Unreasonable Rights: Mental Illness and the Limits of the Law' (1985) *Journal of Law and Society* 199.

80 Lord Nathan PC (in collaboration with A R Barrowclough), *Medical Negligence: Being the Law of Negligence in Relation to the Medical Profession and Hospitals* (Butterworth & Co 1957) 5.

81 As claimants were then styled.

82 G Morris, 'Enforcing a Duty to Care: The Kidney Patient and the NHS' [1983] *Law Society Gazette* 3150; R Singh, 'Infertility Treatment and the Courts' [1988] *Family Law* 299.

83 P Fenn and C Whelan, 'Medical Litigation: Trends, Causes, Consequences' in R Dingwall (ed), *Socio-legal Aspects of Medical Practice* (Royal College of Physicians 1989); P Fenn, A Gray, N Rickman and D Vencappa, *Funding Clinical Negligence Cases: Access to Justice at Reasonable Cost?* (Nuffield Foundation 2016).

84 *Darnley v Croydon Health Services NHST* [2018] UKSC 50, [14]–[21]. See also *Poole BC v GN* UKSC 2018/0012 which was argued in July 2018.

85 See e.g. M Jones *Medical Negligence* (5th edn, Sweet & Maxwell 2017)

86 Nathan (n 80) v.

hospital was required by the law to 'stand or fall by what they do, or fail to do'.⁸⁷ Most pertinently, Nathan suggested that there was no special law of negligence for medicine, only the application of the general principles. He noted that there would inevitably be cases in which:

... the standard of skill and care exacted by the judges may appear to the medical profession to be excessively high; but isolated cases of that sort ought not to blind the profession to the fact that the standard of measurement always used is the reasonably careful and skilful practitioner.⁸⁸

On his analysis, there was respect for professional skill, but little deference. It is ironic that Lord Nathan signed off his 'Preface' in October 1956, slightly more than four months before the direction of McNair J and decision of the jury in *Bolam v Friern Hospital Management Committee*⁸⁹ instituted a period of the very deference to which Nathan was opposed. In the long arc of history, Nathan's analysis is the orthodox one, and *Bolam* looks to be an anomaly.

We have noted the claim that there was relatively little academic debate on medical law before the 1980s. Yet in 1958 Glanville Williams published *The Sanctity of Life and the Criminal Law*, covering legal and ethical issues in reproductive medicine (including control of conception, sterilisation, artificial insemination, abortion, suicide and euthanasia).⁹⁰ Norman St John-Stevas wrote his *Life, Death and the Law* as he ended his career as a law lecturer (prior to entering journalism and then Parliament).⁹¹ Like Williams, he concentrated on the control of fertility and on the ending of life. These were matters with which the Church of England had also engaged during the middle of the twentieth century. The Archbishop of Canterbury had commissioned a report on *Artificial Insemination* in 1948.⁹² A working party on euthanasia reported in 1975, following on from earlier work in the 1960s, considering the case for law reform (which it concluded was not justified).⁹³ Laws relating to abortion and euthanasia were noted by H L A Hart and Lord Devlin in their celebrated debate on the enforcement of morals⁹⁴ and explored by the Oxford theologian Basil Mitchell in his consideration of their positions (described by J R Lucas in the *Dictionary of National Biography* entry on Mitchell as 'a counter-blast to H L A Hart's influential' book).⁹⁵

It is evident that the twentieth century before 1981 was not wholly free of case law, legislation and commentary touching on the law, medicine and health. Well before 1980, new if sparse legal literature emerged to reflect changes in the organisation and doctrinal context in which healthcare was being delivered, much as it always had. Should we adjust the date for rebirth, taking it back to 1946 or forward perhaps to 1998 and the decision

87 Ibid.

88 Ibid 5.

89 *Bolam* (n 21).

90 (Faber & Faber 1958).

91 *Life, Death and the Law: A Study of the Relationship between Law and Christian Morals in the English and American Legal Systems* (Eyre & Spottiswoode 1961).

92 Discussed in Glanville Williams (n 90) ch 4 and St John-Stevas (n 91) ch 3.

93 *On Dying Well: A Contribution to the Euthanasia Debate* (Central Board of Finance for the Church of England 1975; 2nd edn with revisions 2000); Church Information Office, *Decisions about Life and Death* (Church Information Office 1965).

94 H L A Hart, *Law, Liberty and Morality* (Oxford University Press 1963) 25; P Devlin, *The Enforcement of Morals* (Oxford University Press 1965) 125, 139.

95 Basil Mitchell, *Law, Morality and Religion in a Secular Society* (Oxford University Press 1967) 80–2, 108–10.

in *Bolitho*?⁹⁶ This would be a mistake. Starting in the 1980s, the pace of and diversity of litigation and the intrusion of legislation were to pick up speed in the following decades; recall Kennedy's quip in 1988 about medical lawyers having to do their homework.⁹⁷ The Human Fertilisation and Embryology Act 1990, derived from the Warnock Report of 1984,⁹⁸ was the first of a new type of regulatory intervention that could not have been conceived without the explosion of bioethical and legal concern.⁹⁹

What was 'new' in the 1980s was not so much medical law in practice, although its importance within legal practice did grow. Nor was it new to see academics writing about medical law and ethics. What was more clearly 'new' was the way in which scholars (and to some extent practitioners) came to define their activity as a discipline – a specialism – 'medical law', a unified area of law, not just the application of conventional principles of tort, public law, criminal law, family law etc. to medical practice and ethics.

In its emergence as an academic discipline, 'modern medical law' soon to be rechristened 'healthcare law' by many of its scholars, echoed what had happened earlier with family law.¹⁰⁰ Writing on the law relating to husband and wife became organised around the label 'family law', something that seemed obviously wise as divorce became more widely available at the end of the 1960s and the law was democratised. It was reshaped again in the 1970s as child law developed and divorce procedures were simplified. Student interest promoted the creation of textbooks in the modern form. A programme of socio-legal studies emerged, attracting increasing numbers of doctoral students. The burgeoning scholarship focused on the relationship between law and medicine developing contemporaneously with greater judicial and legislative activity in the 1980s makes 1981 a useful marker for the rebirth of medical law. The 'child' may have been gestated in the sea changes of the NHS Act and the writings of Nathan, Williams and others. 1981 welcomed the 'child' on the public stage. The failure to recall much of either the 'ancient' or more modern history impeded the development of practice and discipline.

These processes of demarcation and definition of the 'new' academic discipline were not neat and tidy, but it is clear that something significant occurred. In terms of quantity, academic healthcare law has generated a vast scholarly literature. In terms of textbooks designed for students published in England, we can identify at least 12 substantive books on the market compared to four in 1987. The first edition of Mason and McCall Smith's *Law and Medical Ethics* (now in its 10th edition) published in 1983 comprised 275 pages, including appendices. The first edition of *Medicine Patients and the Law* (now in its sixth edition) published in 1987 was 375 pages. The latest editions are respectively 740 and 617 pages. In terms of research, we estimate that around a hundred books a year published in the UK relate to healthcare law and ethics (excluding books which are primarily ethics-focused). Articles in the field are regularly to be found in generalist legal journals, and there are now at least three specialist law journals dedicated to our domestic law, the *Medical Law Review*, *Medical Law International* and the *Journal of Medical Law and Ethics*. These have somewhat eclipsed the older titles that were generated more by interested doctors

96 *Bolitho v City and Hackney Health Authority* [1998] AC 232 HL.

97 Kennedy (n 13).

98 *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (Department of Health and Social Security, Cmnd 9314 1984).

99 J Montgomery, 'Rights, Restraints and Pragmatism' (1991) 54 *Modern Law Review* 524.

100 S Cretney, *Family Law in the Twentieth Century* (Oxford University Press 2005); C Bridge, *Family Law towards the Millennium: Essays in Honour of Peter Bromley* (Butterworths, 1997); M Freeman, 'Towards a Critical Theory of Family Law' (1985) 38 *Current Legal Problems* 153.

than legal scholars – the *Medico-Legal Journal and Medicine, Science and the Law*. Academic centres devoted to the study of law and healthcare are now established at many leading universities.

Rapid expansion of judicial and legislative activity in relation to healthcare and biomedical science and the rebirth of a broad scholarly and popular interest in the subject paid little attention to the area's history. Medical law in the courts in the 1980s was typified by the process of Bolamisation. With rare exceptions,¹⁰¹ judges abdicated responsibility for scrutiny of medical decisions.¹⁰² For the senior judiciary in the 1980s, in the context of medical negligence¹⁰³ and consent,¹⁰⁴ ceding 'jurisdiction' to the medical profession seemed to be driven by a combination of seeking to resist what they perceived as the American nightmare of excessive litigation and defensive practice and a settled belief that doctors were better placed to judge the interests of their patients than the patients themselves,¹⁰⁵ or the courts. In the context of the many other areas of healthcare which gradually became *Bolamised*, such as decision-making on behalf of mentally incapacitated patients¹⁰⁶ and withdrawing artificial life support,¹⁰⁷ judges conflated clinical and other interests and again determined that doctors 'knew best'. For academics engaging in this purportedly 'new' arena of legal practice and scholarship, Bolamisation exemplified what was wrong with the law.

The early years of 'modern medical law' in the academy might be summed up as 'the battle against *Bolam*'. What all parties seemed to take for granted was that the judges, even if wrong in their deference to the medical profession, based their judgments on longstanding tradition. Yet what was taken to be a tradition of judicial deference was an aberration based on myth, one that the sturdy advocate of the common law, Edward Coke, would have deplored.¹⁰⁸ The rebirth of medical law initially marked a revival of engagement between the law and medical practice and biomedical science. It failed to rediscover 'ancient' learning, or fully appreciate the tradition in which it sat. 1981 might mark renewed focus on law and medicine but not at that point a renaissance.

As the old millennium drew to a close and in the early years of the 2000s, judges gradually pulled back from Bolamisation, reasserting (inter alia) that the courts, not doctors, are the ultimate arbiters of the standard of care, that competent patients have the right to make their own choices and that, when the law requires that the best interests of an incapacitated person be assessed, those interests encompass much more than medical judgment. Culminating in the decision of the Supreme Court in *Montgomery v Lanarkshire Health Board*,¹⁰⁹ the judiciary now endorses the view that patients should be regarded as 'persons' holding rights rather than the 'passive recipients of the care of the medical profession.'¹¹⁰ At least in the courts, the battle against *Bolam* appears to have been largely won.¹¹¹ Bolamisation should be seen as an instructive episode in the history of

101 *Hucks v Cole* (1968) reported in [1993] 4 Medical Law Review 393.

102 *Miola* (n 6) 10–15.

103 *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635, HL.

104 *Sidaway v Royal Betslem Hospital* [1985] AC 871, HL.

105 See in particular the speech of Lord Diplock in *Sidaway*, ibid.

106 *F v West Berkshire HA* [1989] 2 All ER 545, HL.

107 *Airedale NHS Trust v Bland* [1993] AC 789, HL.

108 See *Bonham's Case* (n 33).

109 [2015] UKSC 11.

110 *Ibid* [75].

111 Although this does not mean that the implications are yet clear, see J Montgomery, 'Patient No Longer? What's Next in Health Care Law?' (2017) 70 *Current Legal Problems* 73.

law's engagement with healthcare, an episode that marked the rise and fall of a very short age of deference.¹¹²

W(h)ither this area of law?

We have identified earlier five enduring themes: the social organisation of healing; regulation; the significance of human bodies; fears of science; and the impact of scandal. Reflecting on the current context, in the light of those themes (and we have by no means identified all such themes), sheds light on how the law, and legal scholarship, might be expected to adapt its concerns in the next phase of its history. We therefore turn our consideration to how medical law should now be examined in the light of those themes and bearing in mind the context of a much broader conception of law, health and biomedical science.

The social organisation of healthcare played a role in fostering what we say is the myth of medical dominance. Bolamisation enjoyed a degree of coherence while health services were delivered by a centrally organised NHS and a homogeneous medical profession, which in turn dominated the delivery of healthcare. It implied that accepted and proper practice could be integrated into the fabric of services if law, ethics and medicine worked in partnership.¹¹³ This picture is now far more fragmented. The Health and Social Care Act 2012 disaggregated the NHS into a deliberately unmanageable system of independent entities. Health provision is a mixed economy of public and private (sometimes, but not always for profit). In key sectors of health law concern, such as abortion provision and assisted reproductive services, non-NHS providers are the norm rather than the exception. Boundary work is underway in relation to practices such as aesthetic surgery and the sale of health supplements that sit uneasily between consumer law and health law. The importance of social care, as well as health services, is increasing and restores a holistic approach that was integral to the monastic health service that we have noted from earlier centuries.¹¹⁴ Public participation in service planning and also the creation of 'soft law' guidance has been substantially integrated in the work of the professions.¹¹⁵ When courts or the legislature address legal questions in the proto-market, regard must be had to this ever-changing picture of the way healthcare is organised, bringing issues of public law more to the fore.

Spheres of regulation are shifting too. The role of the Care Quality Commission (CQC) as the regulator of the right to provide services (through registration) and quality assurance has become more significant. Thus, the concerns expressed long ago by Lord Donaldson about the need for honesty about medical mistakes,¹¹⁶ and reiterated by Sir Robert Francis QC in the mid-Staffordshire Inquiry,¹¹⁷ have been addressed by the creation of duties of candour within the regulatory requirements policed by the CQC.¹¹⁸ The role of market regulation, including that achieved through EU law, has become more

112 Brazier (n 29).

113 J Montgomery, 'Law and the Demoralisation of Medicine' (2006) *Legal Studies* 185, 199–206, explores judicial assumptions of such integration as the hold of *Bolam* began to loosen.

114 Exemplified by the scope of the jurisdiction of the Court of Protection.

115 General Medical Council, *The Development of Treatment and Care towards the End of Life: Good Practice in Decision Making* (General Medical Council 2010).

116 *Lee v South West Thames Regional Health Authority* [1985] 1 All ER 385, CA.

117 *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry* (The Stationery Office, HC 898 2013).

118 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936, reg 20.

important.¹¹⁹ Even after Brexit, the pressure to respect principles of harmonisation to facilitate the global health markets will remain. International bodies are also increasingly significant in relation to tobacco control, public health, the migration of health professionals, bioethics norms and individual health rights. Transnational health activities are increasing too, so-called ‘health tourism’, demanding regulatory responses.¹²⁰ The centrality of the doctor–patient relationship that dominated post-1981 ‘modern medical law’ will diminish.¹²¹

Fascination and fears relating to human bodies, dating back to the popular concerns about anatomical dissection, are unlikely to diminish. One current example of the challenge of transnational regulation is the international market in body parts for transplantation.¹²² A failure to dispose of clinical waste (including some human anatomical waste) respectfully and in a timely manner remains a matter of public scandal.¹²³ Debates about the enhancement of humans, even the possibility of a new ‘transhuman’ race are heated.¹²⁴ On a micro-level, human genome editing is raising concerns across the world, drawing attention to the mobility of science and demanding that traditional bioethics norms are revisited. In different ways, these illustrate the continuing centrality of human embodiment to our sense of what is proper, and the need to respect biological identities. There is little doubt that legal regulation will be required in these areas. However, it is less obvious that increased legal regulation necessarily allays fears,¹²⁵ or that the vehicle will be a discrete subject area of medical or health law.

There remains considerable anxiety about scientific advance, with the language of ‘unnatural’ interventions remaining powerful in public discourse.¹²⁶ While it is incoherent and unhelpful as an analytical tool, it reminds us of the importance of recognising public fears and the need to reflect upon and address the ‘wisdom of repugnance’.¹²⁷ However, there are differences as well as similarities between these modern concerns and the ones we have seen in the past. The increasing importance of data (including genomic data) in addressing health needs has raised concerns about privacy and led to recognition of the importance of improved public deliberation if confidence is to be maintained.¹²⁸ Developments in data science have been driven outside health and led to plans for

119 T Hervey and J McHale, *European Union Health Law: Themes and Implications* (Cambridge University Press 2015); G Bache, M Flear and T Hervey, ‘The Defining Features of the European Union’s Approach to Regulating New Health Technologies’ in M Flear, A-M Farrell and T Hervey (eds), *European Law and New Health Technologies* (Oxford University Press 2013) 745.

120 D McMahon, *Medical Tourism and Cross-border Care* (Nuffield Council on Bioethics 2013) <http://nuffieldbioethics.org/wp-content/uploads/Forward_look_background_paper_on_medical_tourism_and_cross-border_care.pdf>.

121 J Montgomery, ‘Time for a Paradigm Shift? Medical Law in Transition’ (2000) 53 *Current Legal Problems* 363.

122 S McGuinness and J McHale, ‘Transnational Crimes Related to Health: How Should the Law Respond to the Illicit Organ Tourism?’ (2014) 34(4) *Legal Studies* 682.

123 ‘Human Body Parts “Pile up” in NHS Waste Backlog’ (*BBC News*, 4 October 2018) <www.bbc.co.uk/news/health-45750389>.

124 D Lawrence and M Brazier, ‘Legally Human: “Novel Beings” and English Law’ (2018) 26 *Medical Law Review* 309.

125 O O’Neill, *A Question of Trust?* (Cambridge University Press 2002).

126 Nuffield Council on Bioethics, *Ideas about Naturalness in Public and Political Debates about Science, Technology and Medicine* (Nuffield Council on Bioethics 2015).

127 L Kass, ‘The Wisdom of Repugnance’ (1997) 216 (22) *New Republic*, 2 June, 17.

128 O Leyser, *Data Management and Use: Governance in the 21st Century* (British Academy and Royal Society 2017).

enhanced regulation (another new sphere) that will encompass health uses but will not be driven or limited by them.¹²⁹

Scientific advance provokes excitement as well as fear, and scholarship will need to show how regulation can avoid being either too restrictive or failing to protect against abuse. Legal intervention is not automatically popular with the public. The drive for innovation has brought campaigners for the 'right to try' into conflict with the pharmaceutical regulation that emerged in the 1960s to address the thalidomide scandal.¹³⁰ The rise of citizen science and bio-hacking challenge regulatory norms.¹³¹

Scandal remains an important theme too in informing the development of law and regulation. The emergence of mitochondrial replacement therapies has seen scientists flout regulation by taking their work abroad to countries where it is either unregulated or regulation is poorly enforced.¹³² The continuing need for robust research regulation has been exposed by abuses in regenerative medicine, including the Paulo Macchiarini scandal¹³³ that spanned countries and institutions (again drawing attention to the need for health law to work across jurisdictions). Concerns about conflicts of interests and research integrity (or the lack of it) have attracted public, academic and parliamentary attention.¹³⁴ There is no lack of scandalous prompts for health law scholarship, to which we will need to respond without distorting our priorities.

The themes that we have identified over several centuries endure, but, as in earlier phases of the history of medico-legal engagement, the response that is now needed should have regard for history but also develop a particular shape that reflects the specific context of the times in which we find ourselves. History can warn us of dangers but cannot prescribe how problems in today's and tomorrow's world should be resolved. In looking forward, we consider that there are a number of features that are salient to the development of the law and that will need to be taken into account in legal practice and the academy.

We flag for attention three areas that we anticipate will characterise the next phase of scholarly work: doctrinal development; jurisdictional matters; and the impact of transnational activity. We shall see that there appears to be a rich feast of new directions in health law for scholars to enjoy. However, we also have concerns about the challenges that the current environment presents. We therefore draw attention to the need to take steps to preserve a vigorous scholarly community if we are going to maintain the

129 Ada Lovelace Institute <www.adalovelaceinstitute.org>; Department for Digital, Culture, Media and Sport, Data Ethics Framework <www.gov.uk/government/publications/data-ethics-framework/data-ethics-framework>.

130 D Meyerson, 'Medical Negligence Determinations, the "Right to Try," and Expanded Access to ITs' (2017) 14(3) *Journal of Bioethical Inquiry* 385; D Carrieri, F Paecatori and G Boniolo, 'The Ethical Plausibility of the "Right to Try" Laws' (2018) 122 *Critical Reviews in Oncology/Hematology* 64–71; J Miola, 'Bye-bye Bolitho? The Curious Case of the Medical Innovation Bill' (2015) 15(2) *Medical Law International* doi: 10.1177/0968533215605667.

131 E Vayena et al, 'Research Led by Participants: A New Social Contract for a New Kind of Research' (2016) 42 *Journal of Medical Ethics* 216.

132 S Chan, C Palacios-González and M Medina-Arellano, 'Mitochondrial Replacement Techniques, Scientific Tourism, and the Global Politics of Science' (2017) 47(5) *Hastings Center Report* 7.

133 *Karolinska Institutet and the Macchiarini Case: Summary in English and Swedish* <https://ki.se/sites/default/files/karolinska_institutet_and_the_macchiarini_case_summary_in_english_and_swedish.pdf>; S Wigmore, *Special Inquiry into Regenerative Medicine Research at UCL* (University College London 2017).

134 See <www.parliament.uk/business/committees/committees-a-z/commons-select/science-and-technology-committee/inquiries/parliament-2017/research-integrity-17-19>.

symbiotic relationship between legal practice and academic reflection that we have identified throughout the legal history that we have presented.

LEGAL DOCTRINE: THE ROLES OF THE COURTS AND SCHOLARS

First, there is a resurgence of the importance of judicial oversight and the recrafting by the senior judiciary of the constitutional foundations of health law. In the same way as the period of Bolamisation was ushered in by a cluster of House of Lords' decisions, so the new phase of the law has been inaugurated by the Supreme Court in a series of important cases. The courts have exhibited greater confidence in the value of judicial scrutiny of clinical judgments, exemplified in the *Montgomery* decision,¹³⁵ and also a reminder of the constitutional constraints that are placed by the law on policy-making, illustrated in *Nicklinson*.¹³⁶

As the judges leave *Bolam* behind, they will need to develop common law doctrine, either by applying more general principles to health cases or as a specific field with its own coherence. The more attractive option seems to be to promote the integrity of the common law. During the period of deference, clinical negligence became unduly detached from developments in tort law. We can already see examples of how a more orthodox approach is being applied to determining the standard of care in hospitals. The Supreme Court has recently pointed out that inaccurate statements that cause harm are as much an actionable misstatement when they occur in an accident and emergency unit as they would be in any other setting.¹³⁷

One of us has argued that the common ground of these recent Supreme Court decisions lies in the application of human rights thinking.¹³⁸ This can illustrate the point we are making, which is essentially about rigour.¹³⁹ Developing a doctrine underpinning the law relating to health founded on 'human rights' will require intellectual discipline. Early pronouncements on human rights and medicine were too often unclear about the differences between human rights law and human rights as a political slogan.¹⁴⁰ Scholarship needs to address both the health-specific rights in international law¹⁴¹ and also the implications of general human rights in the health context.¹⁴² The impact of positive rights under Article 8 of the European Convention on Human Rights seems particularly important in crafting a mature account of the power of human rights to reshape the relationship between citizens and the state to enable human capabilities to be realised.¹⁴³

135 [2015] UKSC 11.

136 R (*Nicklinson*) v *Min Justice*; R (*AM*) v *the Director of Public Prosecutions* [2014] UKSC 38.

137 *Darnley* (n 84).

138 *Montgomery* (n 111).

139 For concern about the lack of rigour in the *Montgomery* Supreme Court decision, see J Montgomery and E Montgomery, 'Montgomery on Informed Consent: An Inexpert Decision?' (2016) 42(2) *Journal of Medical Ethics* 89.

140 Representative examples of discussion at this stage would include: I Kennedy, *Treat Me Right* (Oxford University Press 1988) ch 20; and S Lee, 'Judges, Human Rights and the Sources of Medical Law' in P Byrne (ed), *Health, Rights and Resources* (King Edwards Hospital Fund for London 1987) esp 36–7. S Maclean, *Old Law, New Medicine: Medical Ethics and Human Rights* (Pandora 1999) recognises the programmatic nature of the human rights agenda.

141 J Tobin, *The Right to Health in International Law* (Oxford University Press 2011); T Murphy, *Health and Human Rights* (Hart 2013).

142 European Court of Human Rights, *Research Report: Bioethics and the Case-law of the Court* (Council of Europe 2016) <www.echr.coe.int/Documents/Research_report_bioethics_ENG.pdf>.

143 R Scott, 'Risks, Reasons and Rights: The European Convention on Human Rights and English Abortion Law', (2016) 24 *Medical Law Review* 1; I Black, 'Refusing Life-prolonging Medical Treatment and the ECHR' (2018) 38(2) *Oxford Journal of Legal Studies* 299.

As the UK (probably) disentangles itself from the EU, the human rights tradition is likely to become even more significant. This might be as part of the redefined framework of solidarity with the continent's value tradition, as Prime Minister Theresa May promised in her letter invoking Article 50 of the Treaty,¹⁴⁴ or as a result of the senior judiciary taking on a more assertive role as guardians of the rights protected under the Human Rights Act 1998. We anticipate that this is particularly likely in the face of perceived reductions in government commitment to its international human rights obligations and concerns that Parliament is unduly distracted with Brexit-related matters. High quality scholarship will have an important role to play. A focus on rights should not obscure the importance of addressing responsibilities.¹⁴⁵

Taking forward the promise of human rights will require some important partnerships to be cultivated outside academia too. Test case litigation has already played a significant role in developing the law in some key areas of medical law and bioethics.¹⁴⁶ This has brought together activists, practising lawyers and academics to bring issues before the courts in relation to mental health law,¹⁴⁷ end of life care,¹⁴⁸ assisted conception¹⁴⁹ and abortion.¹⁵⁰ There is scope for this to go well, but also to be an abuse of legal processes as the judicial criticisms of the role of the Christian Legal Centre in the Alfie Evans case highlighted.¹⁵¹

Amongst the duties of legal scholars is stewardship of the rule of law. Its principles must be articulated, defended and the risks to them exposed to enable scrutiny. These include important values such as accessibility, due process, precision and clarity, due regard for the separation of powers, the disciplined recognition of fundamental human rights and equality of arms before the law. As Nathan identified, the availability of public funding for litigation is a crucial piece of the jigsaw, and the withdrawal of legal aid needs to be a continuing focus of scholarly attention. The *Purdy* case drew attention to the importance of legal clarity,¹⁵² but also the complexity of enforcement mechanisms in its examination of the role of prosecutorial discretion, and raised concerns about the proper separation of powers.

Professionalism and activism need to be complementary and consistent. There may also be a need to explore the sort of rule of law concerns that relate to the 'inner morality' law – the conditions for effective and stable law to govern activity and the characteristics of effective law-based governance.¹⁵³ The time when it was thought unnecessary to

144 J Montgomery, 'Bioethics after Brexit' (2018) 18 *Medical Law International* 135.

145 M Brazier, 'Do No Harm: Do Patients Have Responsibilities Too?' (2006) 65 *Cambridge Law Journal* 397; J Coggon, 'Would Responsible Medical Lawyers Lose their Patients?' (2012) 20(1) *Medical Law Review* 130.

146 J Montgomery, C Jones and H Biggs, 'Hidden Law-Making in the Province of Medical Jurisprudence' (2014) 77(3) *Modern Law Review* 343.

147 L Gostin, *A Human Condition: The Mental Health Act from 1959 to 1975 – Observations, Analysis and Proposals for Reform* (Mind 1975), see also the discussion in Rose (n 79).

148 *Nicklinson* (n 136) saw a number of interventions including from Dignity and Choice in Dying and Care Not Killing.

149 See, for example, R (*Quintavalle*) v *Sec State for Health* [2003] 2 AC 687; *Quintavalle v Human Fertilisation and Embryology Authority* [2005] UKHL 28; R (*Quintavalle on behalf of Pro-Life Alliance*) v *Sec State for Health* [2001] EWHC Admin 918; (*On the application of Quintavalle and CLC*) v *HFEA* [2008] EWHC 3395 (Admin).

150 *Jepson v Chief Constable of West Mercia Constabulary* [2003] EWHC 3318 (Admin); *British Pregnancy Advisory Service v Secretary of State for Health* [2011] EWHC 235 (Admin).

151 *Evans v Alder Hey Children's NHSFT* [2018] EWCA Civ 805, [42]–[45].

152 R (*Purdy*) v *DPP* [2009] UKHL 45.

153 L Fuller, *The Morality of Law* (Yale University Press 1969) articulated this in his parable of Rex the failed law-maker.

consider the sanctions for non-compliance with legal norms, as seen in the Human Tissue Act 1961, is long gone. Consideration of the assumptions on which laws are based can demonstrate whether they continue to justify their provisions in the contemporary context.¹⁵⁴ A sound sense of history is vital to this process. It avoids repeating the mistakes of the past and also ensures that ill-informed perceptions of legal history do not lead to anachronistic revivals whose consequences leave considerable difficulties in their wake. We have seen this in relation to the inadequately reflective resurrection of the prerogative jurisdiction to deal with incapacitated patients, only corrected when the Law Commission brought about reform in the law relating to mental capacity.¹⁵⁵ Scholars have a crucial role in supporting lawmakers to be effective in their work. They are unconstrained by the limits that judges have of needing to wait for cases to be brought before them,¹⁵⁶ or the challenges of securing time for parliamentary debate.

JURISDICTION AND THE REGULATORY STATE

A second dimension that we see becoming more significant as medical/health law reshapes itself concerns the careful analysis of jurisdiction and its legitimacy.¹⁵⁷ The form of regulation will be a cause of concern, as well as its substance. It will be important to describe and justify the demarcation of the proper roles of Parliament, the courts and professional expertise. Both analytical and empirical work will be needed to understand better the interfaces between legal and administrative norms and structure. The context for the law is now less the care provided by individual health professionals or a particular hospital clinic than the complex health system in which patients will encounter many different service providers (not all within the NHS) as they receive their treatment.

The demarcations between health and consumer regulation will be of growing importance; including where practices such as body modification, the marketing of health supplements, and fertility services belong. Although consideration of a consumerist future has long been a characteristic of academic healthcare law discussion in the UK,¹⁵⁸ it has usually assumed the continuation of almost monopolistic public provision of services and that health professions remain centrally involved. The Lansley reforms of 2012 inscribed into law an expectation of an unmanaged NHS, with the extension of a much more mixed provider market. This increases the significance of market regulation for the future of health law.

The increasing plurality of health provision and the availability of services and products in non-health markets mean that health regulation and NHS law will increasingly diverge. The scope of regulated services under the CQC goes beyond public provision. The significance of this can be seen in the oversight of abortion services, now usually provided outside the NHS in England (even though mainly paid for from public funds). It was the CQC which was called in by Andrew Lansley in the 'moral panic' over suspected lax regulation by independent providers in 2012 (although it was NHS services

154 S Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016) 79 *Modern Law Review* 283.

155 B M Hoggett 'The Royal Prerogative in Relation to the Mentally Disordered: Resurrection, Resuscitation or Rejection' in M Freeman (ed), *Medical Ethics and the Law* (Stevens 1988) 85.

156 I Kennedy and J Stone, 'Making Public Policy on Moral Issues' in P Byrne (ed), *Ethics and Law in Health Research* (King's Fund 1990).

157 K Veatch, *The Jurisdiction of Medical Law* (Ashgate 2007); J Harrington, *Towards a Rhetoric of Medical Law* (Routledge 2017).

158 Kennedy (nn 3 and 13); M Brazier and N Glover, 'Does Medical Law Have a Future?' in D Hayton (ed), *Law's Future(s)* (Hart 2000) 371; Montgomery (n 113).

that were found more likely to be at fault).¹⁵⁹ It was the CQC's regulatory powers that addressed quality concerns at Marie Stopes International.¹⁶⁰

We are already seeing greater use of health and safety legislation in relation to systems failures in health and significant fines have been administered for health and safety breaches in NHS organisations.¹⁶¹ This should be seen as part of a pattern that emphasises the similarities between health and other industries rather than carving out a special framework. This is a further move away from Bolamisation, but also an alignment of health law with regulatory laws more generally.

Scandals, alas, are unlikely to fade away and the causes and responses must continue to be critically addressed. Responses may be administrative measures rather than, or as well as, litigation or legislation, and such extra-legal mechanisms deserve more academic attention than they have received. New law, more law is not always the answer. Thus, the consequences of the retained organs scandal in terms of the legislative response in the Human Tissue Act 2004 and the continuing debates about the role of consent (actual, deemed or presumed) have received more academic attention than the difficulties facing class actions as a mechanism of redress or the role of the Retained Organs Commission as a means towards 'truth and reconciliation'. The scholarship of the future will need to pay more attention to the range of tools available to the regulatory state and to developing frameworks for critical analysis of the uses to which they are best put.

Complex constitutional issues arise too, no doubt exacerbated through Brexit and its disturbance of the devolution settlements. The Supreme Court has already had occasion to examine the jurisdiction of the Northern Ireland Human Rights Commission in its oversight of abortion law,¹⁶² where international human rights watchdogs are also crucial and sometimes critical of the UK's approaches.¹⁶³ This leads us to a third element of the agenda that we see for the future.

DOMESTIC, TRANSNATIONAL AND INTERNATIONAL LEGAL NORMS

'Modern medical law' tended to be largely focused on domestic law, using comparative law as a guide (and sometimes a selective one) to local reform. The governance of healthcare, bioethics and our bodies, and the oversight of scientific advances need to become more internationalised if they are to keep up with the patterns of contemporary life and testify to the claims of a right to health. Our concerns about bodies cannot be geographically limited. Body parts and their products have become a global industry.¹⁶⁴ Through

159 Z Kmiotowicz, 'Pre-signing of Forms Found in 14 out of 249 Abortion Clinics in England' (2012) 245 *British Medical Journal* e4784.

160 CQC, *Marie Stopes International: Quality Report* (CQC 21 July 2017) <www.cqc.org.uk/sites/default/files/new_reports/AAAG6589.pdf>.

161 Fines have now been levied against NHS organisations for supervisory failures, 'Southern Health Fined £2m over Deaths of Two Patients' (*BBC News*, 26 March 2018) <www.bbc.co.uk/news/uk-england-43542284>. Much as the removal of crown immunity reduced special treatment for state hospitals, this signals an alignment of regulatory expectations between health and other industries.

162 *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27.

163 Committee on the Elimination of Discrimination against Women, *Report of the Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under Article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women* (Committee on the Elimination of Discrimination against Women, CEDAW/C/OP8/GBR/1 2018) <https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/GBR/INT_CEDAW_ITB_GBR_8637_E.pdf>.

164 D Dickenson, *Body Shopping: The Economy Fuelled by Flesh and Blood* (Oneworld 2008); N Pfeffer, *Insider Dealing: How Mortuaries, Medicine and Money Have Built a Global Market in Human Cadaver Parts* (Yale University Press 2017).

surveillance and research, our bodies have been transformed into data – the ‘digital me’ – and a whole new arena for breaching privacy has been opened up. This is no longer merely an issue about confidentiality in the patient–clinician interactions, though there is still much controversy about when disclosure is justified in the interests of others.¹⁶⁵ Data is produced well beyond health services, compiled using multiple sources, and accessible across countries and legal jurisdictions. Medical or health law concerns are becoming minor features of a broader agenda rather than being able to take a lead.

International health law is not a new phenomenon. Leprosy never respected political boundaries. Trade brought with it the risks of disease transmission. A long process, beginning with the first International Sanitary Conference, held in Paris in 1851, led to what are currently the International Health Regulations.¹⁶⁶ In some areas, such as pharmaceuticals, globalisation has been long facilitated by harmonisation of requirements for market access.¹⁶⁷ Since the Nuremberg war-crime trials, globally recognised principles of research ethics have been codified through the World Medical Association’s Declaration of Helsinki (regularly amended). International initiatives have been launched around common standards for bioethics through UNESCO on a global level. The content and legitimacy of the Universal Declaration on Bioethics of 2005 has been criticised in the bioethics literature;¹⁶⁸ its relevance for domestic law has not been examined. Only one case in the LexisLibrary database cites it.¹⁶⁹ Scholars and practitioners seem a little more aware of the European Convention on Human Rights in Biomedicine (the Oviedo Convention) which is cited more often, even though the UK is not a signatory.

Future scholarship will need to pay more attention to global health governance.¹⁷⁰ The nature of the changes in service delivery, public choice on accessing care, the governance of scientific advances, all point towards international, transnational and global legal perspectives being much more important for the next phase of legal engagement with healthcare.

Our past may not be your future?

As the law in practice engages with these issues, and others that we have not identified, rigorous scholarship will be essential. Judicial and legislative interventions are generally reactive and vulnerable to pressures from the media and knee-jerk responses. Scholars have the luxury of looking at the horizon. So, although at the time of writing no womb transplant has yet taken place in the UK and ectogenesis remains in the laboratory, scholars and lawyers can analyse the issues dispassionately now, free of clamour either that such measures are ‘breaking God’s laws’ or heavily emotional pleas that person X must be allowed whatever s/he wants to have a child. Scholars will need to critique

165 *ABC v St George’s Healthcare* NHST [2017] EWCA Civ 336.

166 L Gostin, *Global Health Law* (Harvard University Press 2017) ch 6. See also the World Trade Organization Agreement on the Application of Sanitary and Phytosanitary Measures (1995).

167 M Flear, ‘Charting a Roadmap towards Membership and Formal Voice in Global Bioethics Standard-setting: Health Research and the Case of the International Council on Harmonisation’ (2018) *Medical Law International Online* First doi: 10.1177/0968533218804598; S Dagrón, *Global Harmonization through Public–Private Partnership: The Case of Pharmaceuticals* (IRPA GAL Working Paper No 2/2012, 29 January 2012) doi: 10.2139/ssrn.1995035.

168 See, for example, the contributions to the special issue: *Reflections on the UNESCO Draft Declaration on Bioethics and Human Rights* (2005) 5(3) *Developing World Bioethics* 179–279.

169 *Re HK (Serious Medical Treatment) (No 3)* [2017] EWHC 2991 (Fam), search conducted 15 October 2018.

170 A Krajewska, ‘Bioethics and Human Rights in the Constitutional Formation of Global Health’ (2015) 4(4) *Laws* 771; doi: 10.3390/laws4040771; C Clinton and D Sridhar, *Governing Global Health: Who Runs the World and Why?* (Oxford University Press 2017).

whether existing or proposed legal regulation can be trusted, and they will need to deploy empirical and normative methods to do so, in addition to traditional doctrinal scholarship. Scholarly analysis is needed to resist the attacks on the rule of law that are coming from populism and to rebut denials of the importance of trust. There is a crucial role here for law schools and legal scholars, and the future of health law in legal practice and in the academy lies within this challenging agenda.

We are aware that we have been somewhat casual in the use of names – medical, healthcare, health law. In our defence we plead that what we should be doing in relation to the role of law matters more than the naming of the subject. While there is a place for discussing the best label to apply to our discipline, it is of secondary importance. We have shown how the creation of a discrete named discipline, known originally as 'medical law', enabled the growth of a discrete specialism, although unfortunately serving to exclude key issues of the law's role, ignoring most health professionals who were not doctors and obscuring the important continuities with the legal scholarship and practice of the past. We should avoid falling into that trap again. Different labels such as healthcare law, health law, and public health law are useful in so far as they draw attention to neglected perspectives. However, labels too often obstruct our perception of the complexity of our work by constructing boundaries, or tempt us into unproductive rivalries in the pursuit of reputational dominance. Where lies the boundary between health law and certain issues in family law? Does it matter? The future vitality of our scholarship lies in addressing the enduring themes and future challenges.

Names do, however, have significance in the academy, marking the territory of particular groups of scholars. The power struggles of academic life cannot be ignored and are a source of considerable concern at this stage in the history of law's engagement with healthcare and whither our sub-discipline. The emergence in the UK of an area of legal scholarship focused on health resulted in part from radical changes in the nature and mission of law schools. Research as well as teaching became central to the academic's career, encouraging legal academics to engage in research in the same way as other colleagues in humanities and social sciences, and to write far more than in previous generations. Curriculum reform allowed new areas for undergraduate and postgraduate study to be consolidated and made more visible. The agendas of funders promoting more application of scholarly knowledge were one of the factors that encouraged the creation of academic centres of medical law in the 1980s.¹⁷¹ The impact agenda of the Research Excellence Framework (REF) has favoured scholars working in this area, who have played a substantive role in national policy-making more often than most legal academics.¹⁷²

While the 'impact agenda' remains strong, there are worries that the pendulum which promoted legal scholarship may be about to swing back. Law schools are once more urged to focus more and more on training and skills than attempting to instil scholarship into a law degree. Opportunities to offer undergraduate course units in health law may be reduced to make room for more practice-focused clinical legal education. Such changes are fuelled in part by the proposals of the Solicitors Regulation Authority and the death of the qualifying law degree.¹⁷³ Rather than necessarily protecting research, the REF is paradoxically leading to some universities reclassifying more staff as teaching-focused. It is possible that, save for a few leading research-based institutions, law schools may retreat

171 Wilson (n 4) 197–8.

172 *Research Excellence Framework 2014: Overview Report by Main Panel C and Sub-panels 16 to 26* (HEFCE 2015) 72 <www.ref.ac.uk/2014/panels/paneloverviewreports>.

173 <www.sra.org.uk/sra/policy/sqe/page>.

from the traditions of scholarship in which the authors have been lucky to thrive. There is cause for concern that legal scholars researching the law relating to health and biomedical science may thus become a less attractive prospect to some universities. Earning their bread on the basic curriculum and having boned up on procedure, they may have less and less time to develop research-led teaching, and students may well not want complex debates and challenging intellectual curiosity. Time for research may be at a premium.

There are perhaps two futures for the academic discipline focused on law and health: (1) scholars may enjoy the feast of developments calling for academic enquiry; or (2) scholarship may be squeezed out by radical and retrogressive changes in law schools. Fighting for the first future requires that we pay attention to the second. In this context, the establishment of new centres, such as that at Bristol, will be crucial to maintaining the integration of research scholarship and education. They enable the intellectual excitement of cutting-edge and interdisciplinary work to provide a platform for funded research that provides a buffer against the risk that legal education will become increasingly focussed on professional rather than societal needs.

In reflecting on societal needs, attention to the past is crucial. It shows us that familiar categories, and the concerns to which we have addressed our efforts over the past few decades, were understandable but contingent responses to the contemporary versions of the enduring themes that we have mapped out. We have shown how a mythology developed around Bolamisation that lost sight of history and has constrained the effectiveness of both legal practice and scholarship in keeping pace with developments in the engagements between health and law. We have suggested that we need to 'reboot' our thinking to ensure that the scholarship of the future maintains the proud tradition that we have shown goes back centuries. While 'modern medical law' was a specific twentieth-century phenomenon, the history of law and health provision is as old as the common law itself.