RESEARCH ARTICLE

The Compleat Lawyer - Medical Law as practical reasoning: doctrine, empiricism and engagement

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ABSTRACT

Margot Brazier modelled the relationship between legal scholarship and health care practice - an evidence based approach to doing good in the real world through the application of the discipline of law. No ivory tower academic, but a good citizen. This paper explores the expression of that comprehensive contribution in an academic paper and a policy review.

She showed how law needs take into account the realities of the clinic when considering the plausibility of various claims for the doctrine of informed consent. Also how discipline could be brought to bear on policy-making, where in the Surrogacy Review she prioritised empirical evidence over preconceptions: evidence-based policy not policy-based evidence as modern consultation documents too often elicit.

Margot also provided a role model for academic lawyers' contribution to the public good; not only through ensuring the proper administration of the law (as chair of the Animal Procedures Committee for the Home Office), but also in shaping a cathartic response to public concerns as Chair of the Retained Organ Commission. She did not set out to establish a grand theory of medical law, but rather built an approach that has enriched its practice and has had a lasting impact on those working in the field. In her hands, law is a tool for improving the practice of health care.

> 'Efficient practice precedes the theory of it; methodologies presuppose the application of the methods, of the critical investigation of which they are the products. It was because Aristotle found himself and others reasoning now intelligently and now stupidly and it was because Izaak Walton found himself and others angling sometimes effectively and sometimes ineffectively that both were able to give their pupils the maxims and prescriptions of their arts.'[1]

Introduction

[1] Gilbert Ryle, *The Concept of Mind* (Harmondsworth, Penguin 1949) p 31. Ryle refers to Izaak Walton's *The Compleat Angler* (first published 1563, with many subsequent editions).

This paper explores the approach of Margot Brazier to the role and nature of medical and health care law in an important academic paper on informed consent and argues that it exemplifies a distinctive methodology that can be traced through into areas of her later public service work (in particular, the policy review into surrogacy law that she chaired). Margot avoided grand theorising in order to focus on practical issues. In doing so, she modelled the relationship between legal scholarship and the real world of health care practice - an evidence based approach to doing good through the application of the discipline of law. She was, thus, no ivory tower academic, but a good citizen.

Gilbert Ryle contrasted propositional knowledge ('knowing that') with 'know-how'.[2] He reflected on the fact that a person could learn to play chess without being expert in the formal rules: 'We learn *how* by practice, schooled indeed by criticism and example, but often unaided by any lessons in theory.'[3] He concluded that 'knowing *how*, then, is a disposition…. Its exercises are observances of rules or canons or the applications of criteria but they are not tandem operations of theoretically avowing maxims and then putting them into practice.'[4] There is something of this 'know how' approach in the method adopted by Brazier to the practice of law. As we shall see, her approach was firmly rooted in the practices that were being regulated and did not proceed by first establishing principles and then translating them into law. It is not that she ignored propositional knowledge. Indeed, she made significant contributions to the understanding of doctrine by both law students and legal practitioners.[5] However, she built her analysis around the practices of health care rather than principles of law or ethical theory abstracted from this context. Consequently, she put herself in a position to critique the disciplines of both law and medicine rather than merely to subject health professionals to the will of lawyers.[6] As Ryle suggests with Aristotle and Izaak Walton, she proceeded by identifying the intelligent and effective practice of law, so as to derive the maxims and prescriptions from such practice. She did not dictate to practice on the basis of theory.

Something of the flavour of Margot's approach can be seen by comparing the opening of her article on informed consent, following the *Sidaway* decision, with that of the leading exponent of a more principle-based approach, Ian Kennedy. The main protagonists in Margot's opening paragraph are patients. They are said to have rarely sued until recently, received 'scant sympathy from Her Majesty's judges', be 'less and less willing to accept without complaint the results of injurious treatment.

[2] Ryle chapter 2.
[3] Ryle at p 41.
[4] Ryle at p 47.
[5] Through, for example editing *Street on Torts* (1988-2003, 8th to 11th editions), a student text, and *Clerk and Lindsell on Tort* (1995, 17th ed, London: Sweet & Maxwell) in the Common Law Library – a mark of its canonical status for practitioners.
[6] Tony Hope has criticised the approach of some lawyers in these terms, R.A. Hope, 'The Birth of Medical Law' (1991) 11 OJLS 247-53.

They are more and more inclined to question their doctor's judgment.'[7] The picture she paints of the context of the litigation is one that needs to respond to patient activity.

The opening of Kennedy's piece does not mention patients at all. He begins with the following paragraph:

> '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.' [8]

His interest, and this was reflected the bulk of contemporary medical law writing, was in the law. His motivation, as his writing makes clear, lies in protecting the rights of patients in the face of an imbalance of power. He does little, however, to call into question the legitimacy of using the law to redress those imbalances. Nor does he devote space to exploring what actually happens in the clinic when the law comes into play.

The significance of these different approaches can be seen from a fuller comparison of Margot Brazier's work on *Sidaway* with other articles published in the law journals at the time. A picture of her method can be constructed and its distinctive features identified. The implications of this approach go beyond the enterprise of academic law, and an exploration of some of Margot's public service work will enable this to be drawn out, again with comparison to other ways of approaching similar issues. It will be contended that the example set by Margot provides a richer understanding of the role and nature of the law in health care and a more robust foundation for law reform than the work with which it is being compared. In this way, although her work avoids any attempt to construct a theory of health care law, it does provide a model for the methodology of scholarship in the field, including the wider role of legal academics in contributing to public life.

Informed Consent and the Role of Law

[7] M Brazier, 'Patient autonomy and consent to treatment: the role of law?' (1987) 7 LS 169-193, at 169.
[8] I Kennedy, 'The Patient on the Clapham Omnibus' (1984) 47 MLR 454.

The decision of the House of Lords in *Sidaway v Bethlem Royal Hospital Governors*[9] attracted considerable interest from commentators. Margot Brazier's contribution displayed some key characteristics of her approach:[10]

- a concern with the role of law in facilitating effective health care as well as protecting patients' rights;[11]
- an interest in the reliability of the assumptions made about the reality of clinical practice (so that policy was based on firm empirical foundations wherever possible);[12]
- a healthy cynicism about consequences of legal interventions, so that the coherence, feasibility and (possibly unintended) consequences of a legal doctrine of informed consent receive the same robust scrutiny as do the paternalistic claims of traditional medical practice;[13]
- an awareness of the need to develop tailored responses, which might need both to break the shackles of the traditional forms of action (negligence and battery) and also look more broadly to 'soft law' to 'supplement the stark legal rules'.[14]

The distinctiveness of this contribution can be demonstrated by a comparison of Margot's piece with the works of three scholars who published contemporaneously in the leading academic journals. Pieces by Andrew Grubb and Ian Kennedy illustrate what became an orthodox approach for medical lawyers but which neglected some important aspects of the methods developed by Margot Brazier. The comparison allows the characteristics of her approach to be seen more clearly. Other contemporary commentaries might also be noted, but their rather different focuses mean they are less interesting for the purposes of this piece. [15] Although Harvey Teff's article in the Law Quarterly Review shares some features with Margot's approach, it has a rather different focus overall. [16]

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[9] [1985] 1 All ER 634.

[10] M Brazier, 'Patient autonomy and consent to treatment: the role of law?' (1987) 7 LS 169-193. As well as being an analysis of the *Sidaway* decision, this piece should also be seen as a reflection on the report *Making Health Care Decisions* (President's Commission for the Study of Ethical Problems in Medicine. US Govt Printing Office 1982, available at http://bioethics.georgetown.edu/pcbe/reports/past_commissions/making_health_care_decisions.pdf, last accessed 30 August 2011) from which it draws extensively and whose methodology can be seen to be influential on the aspects of Margot's work explored in this paper.

[11] See p 170.

[12] See pp174-6.

[13] See especially pp 176-178.

[14] See 192.

[15] See also C Newdick, 'The doctor's duty of care under Sidaway' (1985) 36 NILQ 243-250, a careful and subtle analysis of the differences between the speeches in the case. J Shaw 'Informed consent: a German lesson' (1986) ICLQ 864-890 discusses Sidaway briefly in a comparative context but is principally concerned to explain the nature of the German doctrine. See also, in a practitioner journal, D Brahams, '"Informed" Consent – the Thin End of the Wedge' (1985) NLJ 201-202, 215-6.

[16] H. Teff, 'Consent to medical procedures: paternalism, self-determination or therapeutic alliance' (1985) 101 LQR 432-453, see below.

Lawyers' Law?

Andrew Grubb, writing within the constraints of the Cambridge Law Journal's case note tradition, was able to do little more than set out what was decided in the case, what was left open by the judges and what doctrinal problems the decision created.[17] However, even here the pattern emerges. The focus is on the arguments as presented by the courts, analysed for consistency and found wanting. Grubb notes that the Court of Appeal's argument was built on a non-sequitur when it concluded that because the identification of risks must be a matter for the medical profession it followed that which risks should be disclosed was also a matter for professional judgement.[18] When the policy issues are considered, the presentation in the case note is of assertion and counter-assertion, with no basis offered for showing which is the more convincing. Thus, Grubb contradicts Browne-Wilkinson LJ's suggestion that full disclosure would undermine the relationship of trust and confidence between doctor and patient by saying that the opposite was in fact the case as 'Secrecy undermines such a relationship; it does not enhance it'. [19] Grubb then speculates as to what most patients will want, but without reference to any empirical evidence to show whether his assessment was based on evidence or assumption. [20] Turning to the use by Browne-Wilkinson LJ and Dunn LJ of the 'spectre of "defensive medicine"' ('like all ghosts, it disappears on closer examination') [21] Grubb asserts reasons for rejecting their concerns, but cites no empirical evidence. This is understandable in a journal that permits no footnotes and little space for its case notes, but it makes it hard to determine the force of arguments that depend, at least in part on an assessment of the realities of clinical practice. Instead, the focus was the internal logic of legal doctrine, judged against unexplored policy assumptions (as it was of the judgments being analysed).

The primacy of ethics?

Ian Kennedy's contributions, a case note in the Modern Law Review on the ruling of Court of Appeal[22] and a later postscript on the decision of the House of Lords,[23] were less constrained by such journal requirements. However, his work displays a similar approach. Kennedy asserts the primacy of ethics over law, suggesting that 'informed

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[17] A. Grubb, 'Medical Law – Doctors' advice and the reasonable man: do we need a second opinion?' (1984) 43 CLJ 240-243; A. Grubb 'Medical Law – "Informed Consent" to Medical Treatment: Who decides – the Patient or the Doctor?' (1985) 44 CLJ 199-202

[18] (1984) 43 CLJ 240, 242.

[19] (1984) 43 CLJ 240, 243.

[20] (1984) 43 CLJ 240, 243. Although the US President's Commission (see above n. 2) did adduce empirical evidence to this effect and is possibly what Grubb had in mind.

[21] (1984) 43 CLJ 240, 243.

[22] I Kennedy, 'The Patient on the Clapham Omnibus' (1984) 47 MLR 454.

[23] I Kennedy , 'The Patient on the Clapham Omnibus' in *Treat Me Right: Essays in Medical Law and Ethics* (Oxford, Oxford University Press, 1988) pp 175-193 reprints the MLR note, with the postscript on the House of Lords speeches at 193-212. Page references in the subsequent footnotes are to this book version.

consent' belongs to the former discipline not the latter.[24] He roots it in the principle of respect for autonomy and sees it as essentially about power and its transfer to patients so as to 'create the optimal relationship between doctor and patient, which is the same as that between any professional and his client – namely a partnership of shared endeavour in pursuit of the client's interests.'[25] The law should be analysed to see how far 'it reflected and gave effect to good medical ethics…, having regard to matter such as evidence and the burden of proof and the extent to which these may give unfair advantage to one party or another.' [26] Kennedy then turns to address the policy endorsed by the court, which he submitted was 'both unjustified and inappropriate' because most patients and doctors did not want it and good medical practice would be 'sadly damaged'. [27] Little direct evidence was offered of what patients want from their doctors, although reference was made in general terms to the fourth chapter of the Report of the US President's Commission for the Study of Ethical and Legal Problems in Medicine and the empirical evidence that it generated.[28]

In part, this structure follows from Kennedy's conceptualisation of medical law as subservient to ethics. From this paradigm, philosophical and conceptual analysis is predominant.[29] Thus, Kennedy presents the US Commission's use of empirical work as a way of testing the principle of informed consent, as if it was a hypothesis, rather than building the desired legal model from what we understand about the realities of the doctor patient relationship. The Commission's report

> 'is a brilliant work, not least because two volumes are dedicated to examining, through careful research, the various anecdotes about informed consent, and to comparing the evidence with the myth.'[30]

The conceptual structure comes first; the empirical issues follow.

Taking multi-disciplinary work seriously

Brazier's approach differs in a number of interesting ways. She begins from what life is like from the patient's perspective, and is open to the contributions from a wide range of disciplines to make sense of the law's role in their experiences. Out of this broad-based understanding of the world in which the law is operating, she then seeks to build a legal framework that meets the needs of society as she sees them. Legal scholars have not always taken seriously the need for rigour in building on

[24] At p 177.
[25] At p 178.
[26] At p 179.
[27] At p 179.
[28] At notes 12 and 62. See also his reference to an analysis of evidence in the *Bulletin of Medical Ethics* at note 38 of the postscript. For the US President's Commission, see n. 2 above.
[29] See similarly, S. McLean, 'The Right to Consent to Medical Treatment' in T Campbell, D Goldberg, S McLean and T Mullen (eds), *Human Rights: From Rhetoric to Reality* (Oxford, Blackwell 1986) pp 148-172.
[30] Kennedy p 176.

such a multi-disciplinary base and Margot Brazier's example here is an important one.

Brazier recognises the need to explore the strength of empirical evidence, rather than just the conclusions drawn from it by the President's Commission. Thus, she cites a number of the original studies and acknowledges the need to consider their methodological validity (although she does not explore this directly).[31] If the purpose of the law is, in part, to facilitate effective health care, then it is important to understand what will actually happen as a consequence of the legal rules being discussed. This is far more complex than might be imagined, and can be considered at a number of levels. Many commentators have noted the risks of proliferation of bureaucratic paperwork, with unsatisfactory results for both patients and health professionals.[32] This shows the need to understand how health care institutions will respond to particular legal incentives in order to judge the likely range of consequences, desired and undesired, of particular legal principles. Nor is it sufficient to consider the doctor-patient relationship out of its social and institutional context. This is recognised in the realisation that the economics of litigation, including the way in which lawyers and doctors get paid, are important factors in understanding the impact of informed consent.[33] In summary, using the empirical evidence to test pre-existing abstract conceptual positions, even those built on the rhetoric of patients' rights, rather than to illuminate the social practices that the law is regulating, is too narrow a view. Brazier's wider vision is crucial to a full understanding of health care law.

Constructing doctrine - court or clinic?

A difference of emphasis can be seen between Kennedy and Brazier's consideration of a subjective test for disclosure. That is, a requirement that doctors disclose those facts that the particular patient (as opposed to an objective 'reasonable patient') would regard as material. Kennedy observes that such a test 'would weigh the scales unfairly in favour of the complainant.' [34] This places the legal question in a forensic context – its effect on the balance of power in litigation. While Brazier notes the problem of self-serving testimony where a doctor is sued for a failure to counsel patients properly,[35]her main argument concerns the need for doctors to be able to understand their obligations. She argues that a 'particular patient' test provides doctors with greater certainty than a 'reasonable patient' test. [36] The 'reasonable patient' is 'hypothetical' or 'mythical' construction. Interpreting what she might want

[31] See e.g. Brazier (1987) at 175.
[32] See Kennedy, p. 191; Teff (1985) at 434; Brazier (1987) at 176.
[33] See Brazier (1987) 171 on the impact of contingency fees (at that stage common in the USA but not in the UK) and note Kennedy p 190 on the impact of fee for service on medical practice. See also Teff at p 435.
[34] Kennedy p 191.
[35]Brazier (1987) 190.
[36]Brazier (1987) 189-90.

will be bedevilled by 'the different and idiosyncratic reactions of individuals to doctors, hospitals, illness and ultimately to the prospect of death do add unknown and unknowable factors to the equation. The trouble perhaps is that there is no standard patient only particular patients.' [37] Thus, there is no evidence on hand to resolve uncertainty as to what a 'reasonable patient' would want disclosed. At least under a 'particular patient' test, the doctor can assess an actual individual in front of them. [38] Thus, Brazier argues, a 'particular patient' test may be easier for a doctor to apply when trying to decide what to disclose than a 'reasonable patient' standard.

This difference of emphasis results from a different perspective on the nature and role of the law. Kennedy considers what rules will be most effective in court. This can be seen in his discussion of a different problem of uncertainty, raised by the speech of Lord Bridge in *Sidaway*, the question of when risks of grave adverse consequences were so substantial that no reasonably prudent doctor would fail to disclose them because it was so obviously necessary for an informed choice on the part of the patient to do so.[39] Kennedy shows the dangers of allowing this to lapse into apparently precise and but actually potentially unreliable statistical estimates, so that 'a case could then be won or lost on an argument about numbers in which the real issue of the plaintiff's legitimate complaint was lost.' Such tests would have a 'spurious certainty but could be invoked against the interests of patients.' [40] The focus was on what might happen in court.

Brazier is more concerned to understand how legal rules will operate in the clinic. The principle audience to be considered in evaluating the legal rules is the doctor rather than the judge. For her 'the debate about informed consent is only marginally about legal rules'[41] and it would be preferable to establish the norms of medical practice in a way that 'would make recourse to the law largely unnecessary.'[42] Focusing on the forensic context undermines role that Brazier identifies for the law, which

> 'should provide a clear and certain framework for the discharge of professional obligations. Too many grey areas afflict the judge-made rules…. And for the doctor the 'rules' governing his advice and counsel to patients are so bedevilled by fine distinctions and 'nice' points of law that he needs a law degree to understand his obligations of disclosure.' [43]

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

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[37] Brazier (1987) 189.
[38] Brazier (1987) 189-90.
[39] *Sidaway v Bethlem RHG* [1985] 1 All ER 643, 663.
[40] Kennedy (1988) p 199-200.
[41] Brazier (1987) 190.
[42] Brazier (1987) 193.
[43] Brazier (1987) 192-93.

The audience for health care law

Harvey Teff also demonstrates a concern with the impact of the law in the clinic. He shows how *Sidaway* is premised on a model of medical paternalism and argues in favour of an alternative model of therapeutic alliance.[44] He shares Brazier's concern with facilitating effective health care, offering the therapeutic benefits of patient involvement in decisions as one of the justifications for his model.[45] He too recognises the importance of understanding the practical impact of legal decisions, observing that awareness of the law amongst doctors may be limited so that 'legal criteria of informed consent have had only a marginal impact on the behaviour of medical practitioners, even in the United States.' He concludes that 'it seems unlikely that the introduction of informed consent into English law would have much effect on medical practice without effective strategies to alter attitudes among practitioners.'[46]

Teff does not go on to explore strategies to change attitudes, but Brazier's piece does. She advocated a standing commission on medical law and ethics, with its first task to investigate the problem of informed consent.[47] The idea of such a commission was common to many leading medical law academics at the time,[48]but the model envisaged by Brazier was illuminating. She suggested that what was needed was a solution achieved 'via co-operation not confrontation' through a body comprising medical and legal expertise and representing both doctors' and patients' interests. [49] She anticipated a statute or statutory code of practice which would clarify the criteria governing doctors' decisions. The legal standard would fall to be considered in the 'wider context of health care procedures generally' and reform might well focus on processes of consultation and use both Codes of Practice and NHS guidelines to supplement 'black letter' law. [50] Thus, 'the limitations of legal rules can be clearly defined. The legal norm can be set by a Commission in the context of the ethical and professional standards agreed upon.' She noted the need to investigate how the training of health professionals could help them to involve patients in decision making.

Brazier therefore establishes high expectations for the law as 'an incentive to effective and co-operative health care' with 'clear and comprehensible standards and agreed procedures for enforcement.'[51] However, she is realistic about the limitations of existing legal doctrines, considering the strengths and weaknesses of the trespass and negligence actions,[52] and ending her piece by raising the possibility that a 'specific form of legal redress' might need to be crafted to deal with the challenges of

[44] H. Teff, 'Consent to medical procedures: paternalism, self-determination or therapeutic alliance' (1985) 101 LQR 432-453.
[45] Teff 433, 436, 448.
[46] Teff 453.
[47] Brazier (1987) 191.
[48] See especially I. Kennedy, *The Unmasking of Medicine* (London: Granada, 1983), 129–30.
[49] Brazier (1987) 191.
[50] Brazier (1987) 192. The material summarised in the remainder of this paragraph is also on this page.
[51] Brazier (1987) 192-3.
[52] Brazier (1987) 179-182.

informed consent. This invites us to turn to the processes for formulating reforms of the law, which Brazier expects to 'reflect the expectations of the community',[53] and to be co-produced with the medical profession. Margot Brazier has made a distinguished and distinctive contribution to policy making, which further develops her method of working, and this is the subject of the final sections of this paper.

The Foundations of Law Reform

In 1997 Margot Brazier chaired a committee that was asked to review the need for the regulation of surrogacy arrangements, including issues relating to payments, and to advise on the need for changes to the Surrogacy Arrangements Act 1985 and/or section 30 of the Human Fertilisation and Embryology Act 1990.[54] In the same year another review was undertaken, of a different aspect of fertility law by another eminent law professor. In the aftermath of the *Blood* case on posthumous conception,[55] Sheila McLean was asked to consider various issues in the law of consent; whether there were circumstances in which explicit consent to removal of gametes might be waived, whether written consent to storage was always to be required or whether other aspects of the consent requirements under the Human Fertilisation and Embryology Act 1990 needed to be changed.[56] Both reviews proceeded on the basis of consultation, but interesting differences can be seen in the approaches taken. Once again, Margot Brazier's approach was to build analysis on an understanding of the social practices that might need to be regulated. In contrast, and like many other medical lawyers, Sheila McLean worked within the conceptual structure and perspective of the law.

The social reality of the legal 'problems'

The approach taken by the Brazier Committee placed the actual practice of surrogacy and the value questions that it raises at the centre of its considerations, not the drafting of the existing law. They

> 'set out, therefore, to obtain as much factual evidence as we could about the practice of surrogacy in the UK, and abroad; about its development since the Warnock Report; and about the impact of the 1985 and 1990 Acts.'[57]

This was no easy task given the lack of data being collected,[58] but the Committee pieced together a picture from the various sources of information available to them. Information on over 250 surrogacy arrangements was held by support organisations,

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[53] Brazier (1987) 192.

[54] *Surrogacy: Review for Health Ministers of Current Arrangements for payment and regulation* (1988*)* Cm 4068 ('Surrogacy Review'). The Terms of Reference are set out in para 1.2.

[55] *R v Human Fertilisation and Embryology Authority, ex p Blood* [1997] 2 All ER 687.

[56] *Consent and the law: review of the current provisions in the Human Fertilisation and Embryology Act 1990 for the UK Health Ministers* (1997) *Human Reproduction Update* Vol. 3, No. 6 pp. 593–621.

[57] Surrogacy Review para 1.18.

[58] For the challenges and how they were addressed, see paras 1.19-1.32. Chapter 3 sets out the findings.

especially COTS (Childlessness Overcome Through Surrogacy). A survey of Guardians ad Litem (who would be involved in associated court proceedings, representing the children's interests) elicited information on cases that had reached the legal system. The Human Fertilisation and Embryology Authority provided data on surrogacy arrangements that used the regulated IVF technologies and further information was available from a British Fertility Society survey. From this detective work, the Committee felt able to estimate that there were between 100 and 180 surrogate arrangements annually, leading to between 40 and 50 surrogacy births in England.[59] It also considered surrogacy was being used for convenience rather than for medical reasons, a significant concern at the time of the Warnock report that was found to be 'totally ethically unacceptable',[60] and concluded that there was no evidence of this happening.[61] Consequently, little space was devoted to this issue as it did not arise in real life.

The Review Committee also sought to understand the experiences of those actually involved in surrogacy arrangements.[62] It analysed the consultation responses so as to understand views from those who had actually been involved in arrangements as well as commentators without this personal experience. Of the 369 responses, 38 came from surrogate mothers and 79 from commissioning parents.[63] The Report also distinguished the views of members of COTS from others so that differences could be seen.[64] Oral hearings and a seminar were held to supplement the consultation responses.[65] This attempt to shape the policy making process by the experiences of those involved in it is rather different from the approach taken in many consultation processes. It is far more common to take the shape of the process from the conceptual tools already available to the policy makers. The differences can be illustrated by comparing the approach adopted by the other review from 1997 into law and fertility.

Discourses of public ethics

The questions asked in McLean's consultation process were defined in the terms of the pre-existing legal structure. [66] Thus, respondents were asked what the consequences of permitting non-consensual removal of gametes would be for the

[59] Para 6.22. The notes to this paragraph contain the mathematical workings and assumptions that lay behind this estimate but do not acknowledge high degree of the uncertainty attached. However, the only weight placed on these numbers is to distinguish them from the much higher usage of regulated fertility treatments so that a regulatory approach such as the HFEA would be disproportionate.
[60] Warnock para 8.17.
[61] Surrogacy Review para 4.7.
[62] Para 2.
[63] Para 1.36.
[64] Para 1.38-1.41 and Annexes E1 and E2.
[65] Paras 1.42-1.47, see further below for discussion of this approach as a 'conversational' approach.
[66] They can be found in *Consent and the law: review of the current provisions in the Human Fertilisation and Embryology Act 1990 for the UK Health Ministers* (1997) *Human Reproduction Update* Vol. 3, No. 6 pp. 593–621 at pp. 619-20.

general law of consent (Q2), implying that the internal consistency of the law was as interesting to the project as whether or not such removal should be permitted (Q1). Rather than asking when and why such removal might be acceptable, the consultation canvasses whether or not it can be fitted into the legal categories of 'best interests of the patient' (Q3), 'necessity' (Q4) or 'substituted judgment' (Q5). The key point here is that the approach adopted assumes the validity of the conceptual framework that the law had developed.[67]

This can be seen even more clearly in relation to the export of posthumously harvested gametes for treatment elsewhere in the European Union (the issue litigated by Diane Blood). Here, the consultation document asked two questions, both of which are about legal interpretation rather than the policy that the law might wish to enshrine. Question 10 asked whether 'the HFEA's discretion to permit export [can] be interpreted in such a way as to permit the export of gametes which have been unlawfully obtained?' Question 11 asked whether 'there [is] a need for clarification of the provisions of s.24(4) concerning export?' Respondents who advocated a fundamental change of policy might reasonably suggest that 'clarification' is too weak a word and that reform was required. They might also consider that whether or not the existing discretion can be 'interpreted' in the way suggested is rather less significant than whether export should be allowed and whether the decision to permit it should be a matter of the regulator's discretion at all (rather than the applicant's right). The adoption of the existing legal framework within the consultation document thus obscures deeper policy questions.

A further illustration of the problems of constraining consultation responses by the existing legal provisions can be seen in the response from Diane Blood, published in the journal *Human Reproduction*.[68] After giving an account of the reasons for her views on the policy question of posthumous donation of gametes, she discusses two aspects of the law. One was the proper interpretation of the judgments in the case that she brought and of its implications as seen by counsel (her own and those for the Human Fertilisation and Embryology Authority). This raises some interesting issues about the limitations of analysis done on the basis of the texts of judgments (and statutes) without full understanding of the way they are used and applied in practice – a theme also present in Brazier's analysis of informed consent law. Diane Blood had privileged access to material that academics can rarely see (a privilege that brings both advantages and disadvantages in terms of objective argumentation) and her perspective is illuminating but not germane to the points being explored in this piece.

The second aspect of the law covered in Diane Blood's response was expressed by her to be concerned with the legal concept of 'best interests' but was in fact

[67] NB the North American 'substituted judgment' test is proposed for consideration even though – as McLean notes – the UK courts had been 'reluctant to employ' it, see paras 5.16-5.22.
[68] (1998) Vol 13(9) 2654-2656.

addressed to points raised by McLean about the legal doctrine of 'necessity'.[69] The subtlety of the distinction between these two principles may be of interest to lawyers, but it is unnecessary to explore it to address the policy question of whether posthumous non-consensual harvesting of gametes should be permitted. If policy does require it to be allowed, then it may be that clarification of the definitions of 'necessity' or 'best interests' is a sensible way to proceed. However, it seems at least as likely that a bespoke legal solution would be needed, setting out the circumstances and conditions in which harvesting should be permitted. Putting the legal doctrines before the policy is a little like 'putting the cart before the horse'.

The consultation questions posed by the Brazier Committee were different in kind.[70] Rather than focussing on the precise terms of the law, views were sought on the underlying policy questions. Should there be a blanket ban on payments (Q1)? If not, what categories of payment should be permitted (Qs 2-4)? Should there be a body to regulate surrogacy arrangements or agencies (Q6)? Should it be mandatory to for agencies to be authorised (Q8) and should people making surrogacy arrangements be obliged to use an agency (Q9)? There is no need to have an understanding of either the details or the terminology of the law to answer these questions. The consultation process seeks to engage with the language, concepts and ideas used by non-professionals. It sought to understand opinion on the issues in its own terms rather than requiring respondents to make sense of the language used by lawyers.

The Brazier committee thus built its consideration of the case for reform outside of the conceptual structures of the law. There is an attempt to understand the practice of surrogacy from the perspective of those involved, not merely as an idea to be examined in a disinterested manner as a matter of principle(s). This approach sees the foundations of good policy analysis as based on a rich understanding of the practices to be regulated and the value questions that they raise. Specific legal responses need to be built on these social practices and values rather than from professional disciplines, whether of bioethics or law. The discourse of 'public ethics' should be rooted in social practice rather than an imposition upon it by professional outsiders.

Value-based analysis

In order to achieve this, the Brazier report approached their task in a rather different way to McLean. They explained it as requiring them to

[69] Blood introduces and pursues the discussion in terms of 'best interests' but examines and challenges the specific wording used by McLean in Question 4, which is in fact concerned with the scope of the defence of 'necessity'.

[70] The questions are set out in Annex D to the report. The consultation document can be found at M. Brazier, S. Golombok, A. Campbell, 'Surrogacy: review for the UK Health Ministers of current arrangements for payments and regulation: Consultation document and questionnaire' (1997) *Human Reproduction Update* Vol. 3, No. 6 pp. 623–628.

> ‘analyse the underlying social, ethical and legal issues inherent in surrogacy arrangements as we perceive them in 1998… address the psychological implications of surrogacy arrangements, consider how procreative liberty and welfare may be balanced, and examine the role of law in such a personal and intimate area of human life.’[71]

The starting point was values and attitudes, with the proper role of law being one of the questions to be explored. It was not to be assumed that the law had a role at all, nor that its role could be developed within the existing legal categories. The Committee hoped that

> ‘Responses to the consultation paper will help to inform the review team of current public and professional attitudes towards surrogacy arrangements. In this sensitive and highly personal area of human conduct it is essential that any review of the law and practice is conducted on the widest possible base of information.’[72]

The work of the Committee was constrained by the exclusion of certain policy options – in particular, that of a commercial market with specifically enforceable contracts to give up the child. However, this was the result of their explicit rejection by the Government when the review was commissioned.[73] The legitimacy of these limitations therefore lies in the democratic authority of the Minister. In contrast, McLean’s approach seemed to confer an assumed legitimacy on the conceptual structure of the very legal framework that she was commissioned to evaluate.

The interest in attitudes and values also meant that the Brazier review was less concerned with the conclusions previously reached by policy makers and lawyers than in the reasons behind them. Thus, the account of Warnock inquiry explores both the majority and minority views and concentrates on their rationales not how many members of the committee adopted them.[74] Similarly, the summary of the Glover report explains what problems it thought could and should be avoided as well as noting that it concluded that a restrictive approach should be taken.[75] The summary of issues to be addressed in 1998 identified the need to safeguard the welfare of the children; to protect the interests of the surrogate, her family and the commissioning couple (noting that the right of the state to intervene in the choices of adults was itself controversial); to consider whether payment contravened ethical values or increased the risks involved in surrogacy.[76] The Report could be criticised

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[71] Para 4.

[72] M. Brazier, S. Golombok, A. Campbell, ‘Surrogacy: review for the UK Health Ministers of current arrangements for payments and regulation: Consultation document and questionnaire’ (1997) *Human Reproduction Update* Vol. 3, No. 6 pp. 623–628.

[73] Surrogacy Review paras 1.4-1.5.

[74] Surrogacy Review Chapter 2 and paras 4.3-4.4.

[75] Para 3.40, considering J Glover, *Fertility and the Family* The Glover Report on Reproduction Technologies to the European Commission (Fourth Estates, London, 1989).

[76] Para 4.6.

for failing to analyse the nature of these values in sufficient depth,[77] but the point here is that public policy was seen as an expression of values rather than legal doctrine. This places the framework for critique outside of the law, rather than within it (as implied in McLean's consultation document). It also looks to identify these values from the attitudes of those engaged in practices rather than in the discipline of bioethics (the approach in Kennedy's piece on *Sidaway*).

Law and policy – a therapeutic turn?

The final area with which this paper is concerned is way in which Brazier's work has developed an understanding of the importance of processes, both within regulatory systems and of law reform. Much medical law scholarship has concentrated on the substantive questions of whether medical practices or scientific advances should be proscribed or limited, to the detriment of consideration of the way in which regulation might operate. This paper noted earlier Brazier's interest in 'soft law' in the form of codes of practice as a possible solution to informed consent law. The Surrogacy Review develops this area of analysis further and can be seen as an approach that considers the impact of legal processes as an area of study in its own right. Used well, processes might contribute to the therapeutic operation of health services. Constructed badly, they might undermine it. This theme can be extended into the policy making process too. The Brazier Committee articulated an understanding of their consultation exercise that was more a conversation than survey of views. This raises interesting questions about the contribution that can be made by the well-handled oversight of policy matters and can be explored further in the work of the Retained Organs Commission, which Margot Brazier chaired, between 2001 and 2004.

The importance of processes

One interesting strand of the Surrogacy's review's proposals is the interest in incentives, enforcement and processes. It went beyond the issue of *whether* payment should be permitted or prohibited – a binary question – to consider how concerns about exploitation might be addressed. Thus, an analogy with adoption is found attractive in part because it would be more inquisitorial than adversarial; allowing the suitability of commissioning parents to be fully considered, ensuring representation for the child and giving the judge the necessary powers to give full weight to their welfare. [78] It is the requirement to undertake this process, rather than the more streamlined 'parental order' application, that would be the principle consequence of breaching the ban on payments. The formal sanction would be

[77] There are also issues about the quality of evidence adduced, particularly in relation to psychological risks, where there is almost no reference to research evidence despite clear claims being made in the report (see, for example paras 4.9-4.10).

[78] Para 7.13.

ineligibility to apply for a parental order, but the result would be an individualised assessment of the interests of the child to see whether the risks that were to be avoided were in fact likely to occur. Judicial oversight, with the power to dispense in adoption proceedings from the prohibition on payments, would ensure that the actual circumstances (not issues of principle) would determine the outcome. A similar intention lay behind the recommendations to ensure that surrogacy cases were heard in the High Court by experienced judges, with powers to get to the truth through DNA tests and checks against criminal records.[79] A full assessment of the operation of legal rules required examination of and careful design of the processes by which they are put into effect. Thus, medical lawyers need to consider more than 'black letter' legal rules.

A rich understanding of the meaning of 'law'

Brazier's suggestion for improving the law of informed consent included the drawing up of a code of practice. This technique of supplementing Parliamentary and judge made law with 'soft law' is developed further in the thinking of the Surrogacy Review. It envisaged that such a code, initially as part of a voluntary registration scheme,[80] could become an influential guide to practice if it was adopted by health professional bodies and incorporated into their professional guidance.[81] The intention was that the reach of such 'soft law' would be thus extended, as the regulatory bodies of the health professions could enforce it by designating professional assistance of unregistered agencies as professional misconduct. The Review suggested that the ethical guidance from non-statutory bodies, such as the Royal Colleges and the professional associations of counsellors and social workers, could also be harnessed.

The Review Committee set out areas to be covered in the Code of Practice, but mostly addressed structure rather than substantive issues.[82] This approach brings a number of advantages. It avoids regulatory excess as the number of surrogacy arrangements was too small to justify a statutory regulator.[83] It brings a process benefit by encouraging the various professional groups to consider surrogacy and develop a common ethical position to be reflected in their guidance, ensuring that they do not ignore the practice. Finally, it mitigates against the risk that law is too blunt an instrument to respond flexibly to developments as they emerge. Each of these factors provides a reason to believe that a regulatory system relying on this richer range of incentives is more likely to bear fruit. This displays a similarly subtle understanding of how law actually impacts on practice to that shown in Brazier's analysis of informed consent.

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[79] Para 7.24.
[80] Para 6.24.
[81] Para 7.5, 7.25-7.28.
[82] Section 8 of the Report.
[83] See n 59 above and the associated text.

Public engagement and the art of conversation

This insight, that policy making processes can in themselves make it more likely that sound policy emerges, was explicit in the Review Committee

> 'We saw one purpose of the consultation exercise as providing information to the professional and lay audience to which it was directed to help enable them to reach informed conclusions on the issues raised by the review and the consultation exercise itself.'[84]

This is a model of consultation as conversation; both educating and listening. It was taken further by the addition of oral evidence sessions to supplement the written submissions and discussions with Mary Warnock, the HFEA and Bracewell J (an experienced High Court judge with a particular interest in the area.[85] Finally, a seminar was held under Chatham House rules to enable further dialogue to take place.[86] This understanding of the role of those asked to develop policy on matters of ethics is an illuminating one. As was seen in relation to the consultation questions themselves, it does not seek to privilege academic and professional analysis over the understanding of those involved in the practice.

Conclusion

This piece has shown how in both her academic and public service work, Margot Brazier developed a distinctive approach that rooted legal and policy analysis in practice rather than theory and which sought to maintain a close link between those engaged in health care and the legal system within which they were working. The last section suggested that this could be captured within the metaphor of a continuing conversation between lawyers, health professionals and 'lay' people involved in the issues. Margot developed that approach further forward in her work as chair of the Retained Organs Commission (ROC), established in April 2001 as a response to concerns raised by the discoveries of the Bristol Royal Infirmary and Alder Hey inquiries that significant collections of organs existed in UK hospitals and medical schools about which the general public was unaware.[87] By the time it was closed to the public in 2004 she had shaped a cathartic response to public concerns

[84] Brazier Review para 1.34
[85] See paras 1.42-1.44 and Annex F.
[86] Para 1.46-7, Annex G.
[87] *Royal Liverpool Children's Inquiry Report* (London: The Stationery Office, 2001), HC12; *Bristol Royal Infirmary Inquiry, Interim Report: Removal and Retention of Human Material* (Central Office of Information, 2000).

and had honoured the commitment 'to work in partnership with families and health professionals both to address the problems of the past and to work to create a better future'.[88]

In contrast to the 'professional' membership of most inquiry teams of this era, the Commissioners were selected from over 400 applicants following public advertisement to ensure that they included those directly affected by the traumatic experiences that gave rise to public concern. Margot Brazier saw the Commission as 'working to heal the hurt of the past' and 'to attempt to formulate good practice in partnership with families, support groups, health professionals (especially pathologists) and trusts.' She saw this as 'an awesome task' and told members of the public that the Commission 'can only try to do the job with your help'.[89] This was a modest account of a model piece of work during which, under Margot's leadership, the Commission oversaw the collection of robust information on the collections of post-mortem materials held within the NHS (never previously catalogued) and the establishment systems for communicating with and informing families affected, as well as laying the foundations for law reform.

All this demonstrates the characteristics of Margot's work that have been highlighted in this piece. The concern to establish the truth about what was really happening. The focus on getting it right for the people involved, rather than building a framework from abstract principles. The recognition that full range of legal tools needs to be brought to bear; processes and soft law as well as strict rules. This exemplifies her concern with 'know-how' as well as 'know-that' and provides an important counter-balance to work that is too narrowly focussed on lawyers' law and bioethicists' principles. I had not fully appreciated until preparing this piece quite how influential Margot had been on my own work. It has led me to realise that she had already identified a whole range of the themes that have driven my own understanding of the subject. These include the significance of the social context of health care law,[90] the need to incorporate institutional norms into legal analysis[91] (as the judiciary has in fact implicitly assumed),[92] the importance of harnessing those norms into reform proposals if the law is to promote good care and not merely restrain poor practice,[93] and the importance to engaging in public ethics not merely academic discussions.[94]

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[88] Foreword, *Retained Organs Commission: Annual Report 2002-2003* (London: Retained Organs Commission 2003.

[89] Taken from M Brazier 'The NHS Retained Organs Commission: Who We Are; What We do' distributed to members of the public at the Commission meeting in Southampton 5 December 2003.

[90] J. Montgomery, 'Medicine, Accountability and Professionalism' (1989) 16 *Journal of Law and Society* 319-339 and J. Montgomery, 'The virtues and vices of professionalism' in D Bhugra and A Malik (eds) *Professionalism in Mental Healthcare*, (Cambridge, Cambridge University Press, 2011) 17-31 .

[91] J. Montgomery, 'Time for a paradigm shift? Medical law in transition' (2000) 53 *Current Legal Problems* 363-408.

[92] J. Montgomery, 'Law and the Demoralisation of Medicine' (2006) 26 *Legal Studies* 1-26.

[93] P Alderson, J Montgomery, *Health Care Choices: Making decisions with children* (London, Institute for Public Policy Research, 1996).

[94] J Montgomery, 'The Nature of Public Health Ethics' (2011) *Cambridge Quarterly of Healthcare Ethics* forthcoming.

The work of some scholars casts a shadow over those who follow them. Others, like Margot, light the way.