***The Legitimacy of Medical Treatment: What Role for the Medical Exception?*** Sara Fovargue and Alexandra Mullock (eds.), London, Routledge, 2016, 256 pp., hardback, £90, 9781138819634

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Certain cases stick in the mind. One would have to be an exceptionally lazy (or half-witted) law student to fail to recall what happened in, say, *Donoghue v Stevenson*,[[1]](#footnote-1) *R v Dudley and Stevens*,[[2]](#footnote-2) or *Carlill v Carbolic Smoke Bomb Co*.[[3]](#footnote-3) The colourful facts *R v Brown*[[4]](#footnote-4) also belong in this category. The defendants had engaged in *consensual* sadomasochistic activities and been charged with wounding and assault occasioning actual bodily harm contrary to sections 20 and 47 of the Offences Against the Person Act 1861. Among other things, scrotums had been nailed to boards, fishhooks inserted into penises and hot wax inserted into a man’s urethra. It is not difficult to see why this case has more of a hold on one’s memory than, say, the finer points of the law of easements.

In *Brown* a majority of the House of Lords held that while consent may often be *necessary* in order to avoid committing an assault in these circumstances, it was not *sufficient*. This ruling had the devastating potential to circumscribe medical practice. After all, many common surgical procedures involve a level of bodily invasion that is capable of constituting actual bodily harm and would be considered a crime if performed by someone who was not medically qualified. As Sara Fovargue and Alexandra Mullock state in the Introduction to this edited collection, when a surgeon amputates a diseased leg or removes an inflamed appendix with a patient’s consent, they may worry about legal consequences if they make a serious error and bungle the operation (p. 1). But if the surgeon does their job well, they need not fear these possibilities. The amputation or the removal of an appendix would not be regarded as an assault.

After *Brown*, though, consent alone cannot provide a justification for such procedures. How, then can they be performed legally? Lord Mustill in his dissenting judgment said the answer must be that ‘proper medical treatment, for which actual or deemed consent is a prerequisite, is in a category of its own’.[[5]](#footnote-5) His judgment in *Airedale NHS Trust v Bland* confirmed this, ‘bodily invasions in the course of proper medical treatment stand completely outside the criminal law’.[[6]](#footnote-6) The medical exception is, therefore, an important feature of our law that prevents doctors from being criminalised merely for doing their job. Yet, with a few notable exceptions, this doctrine has been largely overlooked in the medical law literature. This superb collection of essays means that this is no longer the case and the editors are to be congratulated for assembling such high-quality contributions.

The chapter by Fovargue and Margaret Brazier, where they consider what constitutes proper medical treatment is particularly instructive.[[7]](#footnote-7) Although primarily concerned with providing a detailed examination of what is meant by each of the terms ‘proper’, ‘medical’ and ‘treatment’, it touches on much broader questions such as the public interest and the boundary between therapy and research. What these three words mean, Fovargue and Brazier argue, is important not only because they turn a ‘wrong’ into a ‘right’, but also because ‘a claim of proper medical treatment may go further and affect how society and the law regard not only what is ‘right’ in society but also what sorts of treatments *become* ‘rights’ that patients assert’ (p. 13). For example, non-therapeutic sterilisation was once viewed as unlawful, it then was considered proper medical treatment, and is now considered a right that men and women can demand.

A moving contribution by Celia Kitzinger and Jenny Kitzinger considers family perspectives on what constitutes proper medical treatment for people in chronic disorders of consciousness (such as those in persistent and minimally conscious states).[[8]](#footnote-8) Based on in-depth narrative interviews with 65 family members, their research indicates that people in such conditions often miss out on the legal right ‘to have their values, wishes and beliefs represented in decision-making about their medical treatments because family members are frequently not consulted, as they normally should be … about what those values wishes and beliefs were’ (p. 89). This chapter combines academic rigour with a perspective that is often overlooked in more doctrinal accounts of this branch of the law.

A particular highlight for this reviewer was the chapter by José Miola.[[9]](#footnote-9) Focusing on civil law equivalents to the medical exception, Miola distinguishes between ‘the 1980s and early 1990s (the ‘old’ cases), where medical discretion was allowed to run riot’ and ‘decisions made from the mid-1990s onwards (the ‘new’ cases), which are more patient oriented’ (p. 68). The former category includes apparently paternalistic cases such as *Blyth v Bloomsbury Health Authority*[[10]](#footnote-10) and *Re W (A Minor)*,[[11]](#footnote-11) and the latter cases such as *Ms B v An NHS Trust*, which focus on the promotion of individual autonomy.[[12]](#footnote-12) This change in emphasis, he maintains, has implications for the notion of proper medical treatment. The modern approach to medical practice has come to include questions that are ethical rather than technical in nature. However, these ‘are not necessarily matters which the medical profession are automatically and uniquely qualified to take or make’ and so if the medical exception is applied to these decisions they need to be made in way that is consistent with ‘acceptable ethical principles’ (p. 69). Miola argues that the new approach of the law is ‘to demedicalise issues, and to remove them from the legitimacy granted to decision-making by medical practitioners where they relate to ethical rather than technical decisions’ (p. 80). It is a compelling and convincing chapter.

Nonetheless, I was less than persuaded by Miola’s analysis of *Chester v Afshar*,[[13]](#footnote-13) where a 3:2 majority of the House of Lords held that a neurosurgeon who failed to warn a patient of the small risk of paralysis inherent in surgery, even if properly performed, was liable when that risk eventuated. This was so even when the risks involved in the surgery had not been increased by the failure to warn and the patient had failed to show that they would not have undergone an operation carrying the same risk. It is widely believed that the case is a departure from ordinary rules of causation and, as Miola points out, ‘the House of Lords found a way to compensate Ms Chester for what was, essentially, a loss of autonomy’ (p. 81). He states:

The court thus changed the law relating to causation to protect the principle of autonomy. Their Lordships appeared to begin by identifying the purpose of the law relating to informed consent as being the protection of patient autonomy, and then asked whether the law fulfilled that purpose. When they found that it did not, they declared the law to be deficient and so rectified the error. (p. 82)

This, Miola argues, is an example of the courts ‘refusing to medicalise what was identified as an ethical issue’ (p. 82). Performing Miss Chester’s back operation involves medical skill ‘but providing information to enable her to make a choice whether to consent to the operation does not’ (p. 82). Even though the treatment was a proper medical treatment ‘the law ensured that *it*, and not the medical profession, set out the boundaries of when that treatment started and ended’ (p. 82, emphasis in original). This approach rejects medicalisation and so the civil law equivalent of the medical exception no longer seems to apply.

But even if we accept that the case cannot be decided under ordinary causation principles, something that I have disputed elsewhere,[[14]](#footnote-14) it is far from evident that the purpose of the law in this area is to protect autonomy. A claimant cannot claim in the tort of negligence for interferences with autonomy *per se* when they have not suffered any physical damage. The better view is that the purpose of the law is to protect against injuries caused by carelessness. Furthermore, the tort of negligence is not a very effective vehicle for fulfilling the instrumentalist aim of enhancing protection for patient autonomy. The violence done to causation principles by *Chester* have the potential to undermine other established rules in this tort.[[15]](#footnote-15) Consequently, while the majority of Miola’s chapter is compelling, his positive assessment of this case is open to question.

Other standout chapters in this collection are Mary Neal’s analysis of abortion[[16]](#footnote-16) and Danielle Griffiths and Alexandra Mullock’s consideration of cosmetic surgery.[[17]](#footnote-17) Neal focuses on where lawful abortion falls on the spectrum of proper medical treatment and concludes that:

proposals for completely decriminalising abortion ought to bear in mind that, at least so far as surgical interventions are concerned, the complete exclusion of the criminal law is impossible (given that *all* surgery depends upon a medical exception to the criminal law), and interference with the current statutory framework may, in fact, leave the practice more, rather than less, vulnerable. (p. 141)

Griffiths and Mullock consider how the medical exception applies to non-therapeutic cosmetic surgery. Drawing on a number of social and ethical concerns associated with commercial cosmetic surgery, they dispute whether the medical exception is appropriate in this context. Although I was not necessarily convinced by all of the conclusions in these two chapters, they both provide exemplary scholarship, formidable reasoning and welcome new perspectives on the respective issues under consideration

Indeed, this collection is notable for the consistent high quality of the 13 chapters in it and the editors should be congratulated for compiling it. Space constraints, alas, prevent even a cursory description of all of the excellent contributions. But, given the food for thought contained here, it is doubtful that the medical exception will remain an under-researched topic for much longer.

1. [1932] AC 562. [↑](#footnote-ref-1)
2. (1884) 14 QBD 273 DC. [↑](#footnote-ref-2)
3. [1893] 1 QB 256. [↑](#footnote-ref-3)
4. [1994] 1 AC 212, HL. [↑](#footnote-ref-4)
5. [1994] 1 AC 212, 266 *per* Lord Mustill. [↑](#footnote-ref-5)
6. [1993] AC 789, 891 *per* Lord Mustill. [↑](#footnote-ref-6)
7. ‘Transforming wrong into right: What is “proper medical treatment”?’, Ch. 2. [↑](#footnote-ref-7)
8. ‘Family perspectives on “proper medical treatment” for people in prolonged vegetative and minimally conscious states’, Ch. 6. [↑](#footnote-ref-8)
9. ‘Moralising medicine: “Proper medical treatment” and the role of ethics and law in medical decision-making’, Ch. 5. [↑](#footnote-ref-9)
10. [1993] 4 Med LR 151. [↑](#footnote-ref-10)
11. [1992] 4 All ER 627. [↑](#footnote-ref-11)
12. [2002] EWHC 429. [↑](#footnote-ref-12)
13. [2005] 1 AC 134. [↑](#footnote-ref-13)
14. C. Purshouse, ‘Judicial Reasoning and the Concept of Damage: Rethinking Medical Negligence Cases’ (2015) 15 *Medical Law International* 155. [↑](#footnote-ref-14)
15. C. Purshouse, ‘Liability for Lost Autonomy in Negligence: Undermining the Coherence of Tort Law?’ (2015) 22 *Torts Law Journal* 226. [↑](#footnote-ref-15)
16. ‘Locating lawful abortion on the spectrum of “proper medical treatment”’, Ch. 8. [↑](#footnote-ref-16)
17. ‘The medical exception and cosmetic surgery: Culpable doctors and harmful enhancement?’, Ch. 7 [↑](#footnote-ref-17)