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ASSISTED-DYING AND THE CONTEXT OF DEBATE: 'MEDICAL LAW' *VERSUS* 'END-OF-LIFE LAW'

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Abstract

This paper provides a reflective analysis of the nature of normative critiques of law generally, and within medical law specifically. It first seeks to establish the context within which critical analysis of law and legal measures takes place, and develops an argument that critiques should focus on political norms. Entailed in this claim is the contention that positions that seek to address controversial social problems can not resort simply to moral philosophy. It then provides a brief account of political liberalism that can contain and expose normative constraints on questions of moral and social contention. The focus then moves to a more direct reflection on medico-legal analysis. Considering both medical law as a discipline, and the study of end-of-life issues, the argument highlights the range of relevant issues that must be accounted for, and addresses the question of whether these are well conceived as ones of medical law. It is argued that a political framing offers a good general analytic context, but that when working in legal sub-disciplines analysts risk allowing 'locally' pertinent norms to dominate or unduly constrain wider debate. Thus it is questioned whether 'medical law' provides a coherent frame for social questions related to assisted-dying.

Keywords

Assisted-dying; Euthanasia; Assisted suicide; Physician-assisted suicide; Medical law; End of life law; Political theory; Socio-legal analysis

I. INTRODUCTION

English law functions within a system of political liberalism. The picture it paints is not of a single, perfectly coherent, consistently applied theory. But there is a strong attachment to a structure in which autonomy and liberty are prized, and many mutually exclusive and incommensurable personal values are protected and respected through an array of legal principles and mechanisms.[1] This is not reflective of a system in which 'anything goes'; many actions remain beyond the pale.[2] Nevertheless, the law sustains a broad pluralist outlook, remaining agnostic on many questions of what serves people's interests, often simply providing presumptions and default positions to apply in cases of uncertainty. In reflection of more general debates concerning liberalism,[3] many discussions in medical law find the most heated contention over legal prohibitions of, or regulatory curbs against, conduct that appears to be purely self-regarding or that is argued to be private. Many commentators are dubious of claims that the law should be employed as a means of enforcing a dominant morality.[4] Parallel with this, we find some scepticism of empirical claims about the need, where it is said to exist, for blanket policies to proscribe some conducts wholesale, in order to protect the vulnerable from an otherwise dangerously extensive liberty that would result in their abuse and harm.[5] In the context of end-of-life issues in English law, Dianne Pretty's is the most famous case in this regard. Mrs Pretty

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sought a proleptic immunity from prosecution for her husband should he assist her suicide.[6] Her final legal appeal—to the European Court of Human Rights—failed neither for her lacking mental capacity, nor for the immorality of assisted suicide; rather, it was due to a 'harm to others' argument.[7] Her and her husband's, and by extension everyone's, possession of the negative liberty she desired was deemed itself too harmful to those who would be abused in its name.

In this paper, I seek to address the theoretical and practical problems associated with these sorts of concerns. The law's limited protection of a 'negative freedom' for individuals to live (and die) as they choose are well noted, and the criticisms of this area of law form a staggering literature.[8] But the English system also secures 'positive freedoms' by conferring benefits through the Welfare State, and here the principled commitments to value pluralism assume a distinct form. It is still possible, at law, to recognise and protect competing values that different people hold and to allow these to form positive claims against the State,[9] but the numbers of choices that can be permitted are fewer. For one thing, they must be narrowed by resource constraints. When it comes to positive claims against the State for welfare support (in a broad sense), there are fewer supported conceptions of 'the good', and a more limited value-agnosticism, than can operate with regard to negative liberty. Put baldly, if the State is to coerce citizens to pay tax for the good of them *and* others, it needs a relatively robust conception of benefit and harm. It can not simply defer to individuals' own appraisals of what is good for them and their consequent claims of what they are thus due, and tax and allocate on that basis. Similarly, if social order is to be sustained, some compelling expression of values must be made, even if this may deny some people the freedom to live as they would choose.[10]

With regard to healthcare, there is an (at least putatively) objective limiting of patients' positive claims in the concept of clinical indication. Whilst a patient with decision-making capacity has complete sovereignty to refuse any intervention that would be for his own good, a decision to receive treatment is founded on the shared authority of him *and* his doctor.[11] As well as serving as a constraint against wasting limited resources, this suggests conceptions of harm and complicity in which the State will not engage, and by association doctors will not be forced (or even permitted) to participate: expertise is given an important and defensible function in positive assessments of health and well-being.[12] In this sense, and quite coherently, there is a functioning act/omission distinction in the effectuation of respect for different values at law. This paper explores these contextual questions and considers their bearing on debates on assisted-dying. It tests the boundaries of the clinical aspect of decision-making and presents concerns about ostensibly rightful decisions made by patients that appear to change the moral as well as the clinical context of further possible choices. It is not an argument concerning the lawfulness (or making lawful) of 'straightforward' intentional killing for benevolent purposes.[13] Nor is it an addition to debates on the use (or abuse) of the concept of clinical futility as a means to end lives where its invocation may mask prejudice or misunderstanding.[14] It is more generally about assessment of the interplay between positive and negative claims made at the end of life, the role of doctors and the State, and the likely existence of theoretically irreconcilable limits to some people's choices in the face of other people's greater freedoms. Furthermore, the paper may be viewed as a 'methodological' assessment of normative legal argument on end-of-life issues. It works through three stages. First, I consider the nature of normative critiques of the law, and argue that our concerns are rightly addressed in political rather than moral philosophy. Through this argument I develop a picture of the liberalism that the law should protect, and explain how it presents a view of the nature of jural relations within that system. I then consider the question of values and objectivity in regard to the liberalism. The light this analysis casts is then reflected back on debates about end-of-life issues, allowing conclusions to be drawn about the complexities within the existing legal scheme, and in legal scholarship. Important

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amongst these is the question of whether end-of-life issues are usefully explored within the paradigms of medical law. The nature of this field and the wariness of undue 'medicalisation', combined with the observation that many relevant cases (including Dianne Pretty's) are *not* strictly medical law cases, lead me to suggest that we should reappraise how we conceive our approaches to questions about assisted-dying and the law.

II. THE NORMATIVE CONTEXT: POLITICAL, NOT MORAL[15]

The prior question for legal analysts is: 'by what measure do we assess the law?' In regard to end-of-life issues, it seems that the most prevalent evaluations take place by reference to moral or ethical reasoning (often those two words are seen as synonymous). This is not to say that analysis can not be undertaken according to alternative measures. There is ample and welcome scope, for example, for 'black letter' study, economic critiques, sociological research, and a constant need for arguments to be reined in by careful reference to empirical reality. But where we are interested in the law doing what is *right*, aspire to a *better* society, or care about the protection of putatively *fundamental values*, such as dignity, autonomy, and humanity, our analysis will assume a moral perspective. In this section, I will argue that whilst accommodating moral concerns, the appropriate forum for normative critiques of law, at least if they are to have any practical utility, is not purely moral, but rather demands a political framing that is detached from any singular moral theory. I consider the taking of a purely moral perspective, and offer reasons to consider so doing to be unsatisfactory. I then look to a positive understanding of political liberalism that permits moral pluralism and is directed to protecting harmonious co-existence rather than the enforcement of a unitary and exclusive moral outlook.

A. The limits of moral argument

How are we best equipped to assess whether law and policy are defensible? Although it may seem attractive to develop a moral position and argue as if it can be transposed directly onto society through law, there are limitations to this approach. Many critiques of end-of-life issues assume a moral position, and work directly from there. They run approximately as follows. If we believe morally right proposition *x* (say that human life is sacred, or that autonomous adults' self-regarding choices ought not to be interfered with, each of which positions in turn entails various normative constraints), we accept that acting contrary to *x* is wrong. Some might argue that preventing instances of *x*'s breach (say the intentional killing of 'innocent' humans or the limiting of autonomous action) is so strong an imperative that the law should ensure it, and not interfere with it. Such claims necessarily disregard—indeed they deny the truth of—contradictory moral perspectives. We would thus be invited to conceive of morality as an unimpeachable unitary theory whose scope is clear, and take it that there is no compromise with it. For practical purposes, regulations would then be designed to enforce the morality. The authoritarian undertones to this may seem alarming, but any alternative, it would be argued, is much worse. On this view, there is no negotiation with what is right; advocacy of a position that defies the supposed morality is inherently and insurmountably problematic.

This manner of argument is objectionable for both principled and practical reasons. At the level of principle, we can draw from the normative anarchist's objection to *any* form of practical authority beyond a person's own self-guided assessment of what morality demands.[16] Although I argue against anarchism, believing that subjugation to *some* external law established through political authority is both good and defensible, I agree that little is left in the idea of respecting people as moral agents if they are not free to exercise their agency, and are instead forced to do right. Simply, I disagree that allowing people this freedom is *always* the most important thing.[17] Leaving people the latitude to choose to do right must leave them also the freedom to do wrong, and often this is for the best. It is

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instructive here to consider the perspective of Roger Brownsword, who has consistently and forcefully argued in favour of a robust theory of morality to underpin law, but who also argues for the importance of the political liberty to do wrong. The theory of rights that he defends unequivocally condemns rights-breaches; but he does not take that to imply that there is a role for the State always to ensure that right be done.[18] And in the wider literature on political liberalism, we find various means of explaining why limitations may be placed on agents' freedom; for example, to prevent unacceptable levels of harm to others, to protect others and promote their interests, or to overcome 'coordination problems'. Whilst some limits find justification, concepts such as agency become redundant if conduct is micro-managed and there is no or only very limited freedom for an agent to direct his life.

At the level of practice, there are two particularly pressing problems raised by a theory that would seek to ensure that the right or the good were always done. The first we might label 'nitty-gritty' practicality. It would be practically impossible to govern a large community of people so closely that no moral misdemeanour ever occurred. Even the most invasive, authoritarian State will have limits to its practical power. The second, more interesting practical objection is born of an epistemic concern. It is one thing to develop and express a theory of morality, hoping through an exercise in reasoning to convince people of the rightness or goodness it implies in assessment of any given conduct. It is another thing to *prove* that it is right. A rigid account of morality, however robust theoretically, will still face objections from dissenters who are not carried by the *a priori* truth of certain premises entailed within it. And this brings us to a both practical and principled *impasse* whenever we face two or more equally coherent theoretical positions, each of which precludes the other(s).

If a theorist believes that there is rightly a disjuncture between every matter that the law might speak to and every matter it should speak to—*ie* if there is some latitude given to permit some wrongful or bad conduct in some areas of activity—then a further 'meta-theory' is needed to mediate between cases where the morality prevails, and cases where freedom to do wrong is afforded. Regardless of moral truth, it is at the very least practically true that many competing moralities exist, and the role of the State generally (and thus the role of law) is best conceived not as a judge of which account of morality is superior, but as a means of achieving harmony between them, and mediating any conflict.[19] This mediation is best conceived as a question of politics.

B. The role of political analysis

Given the problems alluded to in the previous subsection, it is my contention that we must assess law, including that on end-of-life questions, in a political rather than purely moral light. Because there is a danger here of division by a common language, I need to be clear about my categorisations of moral and political. Some analysts consider political (and legal) philosophy to be a subset *of* moral philosophy, parasitic on moral norms, and bound ultimately by moral constraints. Accounts of politics such as this are forceful, and feature prominently, for example, in Robert Paul Wolff's outright denial of legitimate political authority, and Robert Nozick's description of the legitimacy of only a very limited State.[20] Their accounts are 'rights-based', the former drawing predominantly from Kantian moral theory, and the latter in part from Kant, but predominantly from Locke. Much classical philosophy also seems to combine the moral and the political realms, leading to works in contemporary bioethics drawing on ideas, for example, of 'civic virtue' and 'civic republicanism' that again seem to undermine a sharp division between the political and the moral.[21] Acknowledging these alternative approaches, and their distinct framing of issues, I still see sound analytic purpose in separating terminologically a moral and a political sphere, and treating the normative claims of each as qualitatively distinct.[22] Whilst some analysts would see the mechanisms that I label 'political' as themselves being 'moral' (*eg* because

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they consider morality to be an exercise in public reasoning), it is more illuminating to distinguish two sorts of issues. In this sense, I follow Thomas McPherson's categorisations, which focus not only on what morality and politics (as I understand them) *are*, but also what they *do* and *whom* they address:

> Morality, it would commonly be said, is concerned with 'personal relations'. (This is in no sense meant as a *definition* of 'morality'.) Politics is concerned with the State and with our relations to the State and its to us—in the liberal tradition with how to achieve peace and security and our interests, and with how to achieve 'more commodious living'.[23]

Crudely, we might say that morality is about the reasons, and the sources of reasons, that any individual agent might use to decide how to act in a way that is good or right, without regard or concession to ulterior motives. Compulsion comes only from the agent's wilful submission to morality itself; he acts morally because morality so demands, not, for example, for fear of punishment or retribution. Politics, by contrast, is about what *citizens* and *the State* can and should do given the nature of community they find, and the basis of this. This *does* include whether and how people may be compelled to act or refrain from acting, using means other than engagement of their moral reason. Furthermore, politics, or political liberalism at least, has a more limited 'jurisdiction' than morality: there are fewer aspects of conduct that the normativity can practically address. Importantly, it demands that the effect of a norm be considered as it applies within a community, rather than in isolated cases. On this understanding, 'the law' and regulation are the voice of the political, and represent its 'output'. Political arguments may be informed by moral reasons, but there is no pre-analytic reason to suppose that one necessarily shapes the other in a given case.

There are two sorts of appeal to separating and embracing the political in this way that are worth highlighting. Both relate to the theoretical incoherence it permits, relative to what could be labelled 'pure morality'. First, we can explore under the heading of 'the political' a system of normativity that speaks to and protects a population of people (*ie* the sort of population that English law applies to). If we only engage, for example, with a community of abstracted Kantian persons, our analysis gives no hint of what to do with or for 'lesser' beings.[24] An understanding of rights only as they are derived by reference to such abstractions gives a skewed picture of what rights should exist for those that do not match it. The sorts of rights and attendant duties, for example, that a neonate should have can not meaningfully be drawn from principles that are learned by reference to, and which apply only to, a mentally agile, self-reliant, physically secure, atomised individual.[25] This wider scope is crucial, and is the reason that Dianne Pretty's case— whatever one's view on the decision—could not be considered in isolation from its position in a framework of rights, duties, and so forth that apply in a community of people of very different capacities (physical and mental). Many moral frameworks present their subjects as if they are conceptually uniform. The messier political framing for which I advocate here allows for the conceptual divergences amongst the biological class 'human' to be more satisfactorily (and honestly) addressed. Ngaire Naffine's paper "Who are law's persons?" is instructive in this regard.[26] Naffine distils three broad means of conceptualising legal persons: a straightforward legal category, *ie* whoever the law says is a person; a biological human being (generally one who is born and alive); and a rational, psychological agent. In reality, all three of these conceptions co-exist in human society and in English law, and this messiness needs to be accommodated. Even theorists who might seek to change the situation —*ie* who would narrow or extend the population of legal persons[27]—must start from here. Reform demands some account for *status quo* bias. The alternative is to sit on the sidelines declaring what is right or good, but to no good end.[28]

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The second reason to embrace the political as the right source of normativity is that it presents us with a forum for resolution of disputes between competing moralities, and demands an honesty in our claims about the normative basis of regulation. This is important, as there is an apparent paradox presented by the kind of political liberalism that English law houses: if we are agnostic to values (as English medical law norms suggest we should be), how can we know which values should support welfare measures, or secure valid restrictions to conduct? If, for example, we take a classic expression of liberalism and say that we will limit conduct only where it causes excessive harm to others, how can we without contention give substance to the very concept of harm? Strikingly, the answer is that we can not.[29] This is not to deny that certain moral theories can not themselves permit a level of pluralism, or that there can be no such thing as moral truth concerning the nature of harm. But necessarily appeal, for example, to reasonableness, rationality, or shared intuition will not reflect access to a truth that *is* apparent to everyone, or on which everyone really does agree.[30] Models of rational consensus or necessary reasonableness have a level of artificiality or over-claim in their support.[31] At the level I speak to here, this is an epistemological rather than an ontological objection, but it has compelling implications in practice. Theories that seek to overcome the problem—*eg* by appeal to 'fundamental human rights',[32] or to procedural mechanisms such as 'deliberative democracy'[33]—fare no better (or worse). However, the best result is not paralysis in the face of this epistemic uncertainty. Rather, an appeal must be made to a coordinated regime that assumes various truths, in part by contrasting it with alternative systems, or with having no system whatsoever.[34] Intellectual honesty demands an acceptance of the contentiousness in grounding political normativity. Its concepts require careful articulation, and qualified support. Where they may seem contingent, appeal must be made to means of assessing better or worse claims. Overall, it is not difficult to maintain broad assertions about our being better off in a political society than an apolitical one. Equally, there is considerable appeal in a system that sustains moral pluralism, allowing that amongst people we find contradictory and incommensurable moralities that to a great extent can co-exist harmoniously. Law and policy can be developed to accommodate this, but there will be limits. In the next section, I will address the question of the setting of these limits, both as a general question, and in regard to medical law.

III. LIBERAL PLURALISM AND LEGAL RIGHTS

Whilst the account of politics I have described is not idealistic, it does accommodate ideals: it is not an *anti-idealist* position.[35] Moreover, it allows the presentation of its practical norms to be made in the language of jural relations as described by Hohfeld.[36] In contrast with the framing of many accounts in medical law, I reject the notion that we are strictly engaged in a situation where we must 'balance' competing values or principles, such as 'sanctity *versus* autonomy' or 'compassion *versus* proper care'. To use the phrase of John Gray,[37] such things are "rationally incomparable": where a "radical choice" must be made between them, this is not done through 'balancing' them, or establishing which is 'weaker' on a single scale. Rather, it is done by discovering which rights, liberties, duties, and so forth are protected within the liberal framework, noting but not being distracted by the fact that these things are often (heuristically) clustered *under the headings*, for example, of autonomy, dignity, or sanctity. Apparently competing principles obscure claims that become commensurable rather than conflicting when they are stripped back to their component parts within the core of the political normativity that settles the bounds of obligatory conduct. As a result some perspectives are sustained whilst others are denied; some claims that some people would like to make are foreclosed. Crucially, ultimate appeal is to the liberalism itself; it is emphatically not to autonomy, sanctity, dignity, *etc.*. To know what conduct is politically permissible, we must ask what the political system recommends, not what seems attractive given reference to some lauded and isolated moral principle. We do not benefit from learning if a proposed policy offends autonomy or sanctity; we benefit from

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developing a robust conception of political liberalism and ascertaining whether it offends against *that*. With regard to our own conduct and choices, we may act according to a personal understanding of morality. Concerning others' conduct, the standard we can demand accords with political rather than moral imperatives Where there is latitude—encapsulated in a 'paired liberty'—distinct principles do not *compete*; rather they co-exist. Where it is permissible, one person may choose to live in accordance with one set of values, while another chooses a radically distinct sort of life. Where conduct must be prescribed, this may conflict with choices that people would otherwise make, and the reason it is defensible politically is that it is necessary to sustain the liberal system that protects as many values as possible. In the following two subsections, I will discuss how aspects of this liberalism relate to the *modus vivendi* politics of John Gray, and then I will frame the discussion in terms specific to medical law.

A. *Modus vivendi* and certainty

There is not space here to provide a substantial defence of the brand of liberalism I would see the law protect. It depends on a level of agnosticism that entails submission to practical reality concerning morality—*ie* it encourages a pluralist outlook given that we can not know that just one, or which, account of morality is superior—and it speaks to human communities, rather than communities defined more widely or narrowly. Much, though not all, of what I argue finds defence and articulation in John Gray's discussion of *modus vivendi*.[38] It is worth raising here just a couple of points of similarity and difference with Gray's liberalism, and some of the problems it presents.

First, although Gray shuns the idea of political liberalism's being the pursuit of a 'rational consensus' on a singular and exclusive best way of life, he does take it that certain things are universally good and bad.[39] Broadly, I accept what he means, although it is apparent that some questions are begged. For anything to be *universally* true, we need a prior concept of who is part of the universe, and this itself raises contention. If we presume that some of my interests may be harmed in qualitatively identical manner to all others' interests, we find that we exclude membership of the community to some beings that on some accounts should be included (*eg* embryos, the comatose, the dead). I thus qualify the claim to account for the reality of moral and political dissent on the very question of 'who is in'. A claim of universality is quite bland if we ignore the lack of consensus on this point. Following Bruce Jennings, I accept that human communities in part define themselves, and that this has normative implications.[40] This remains so even if protagonists within it simultaneously seek to change how people conceive community membership, and certainly does not entail that we must simply defer to people's views about who should be in.

Second, there is a need to establish some core of 'practical certainty', notwithstanding the concessions made to epistemic insecurity. Gray is right that moral certainty in politics is bound problematically to offend against some rationally valid moralities. But it is a necessity. For the principled and practical reasons outlined above, we need 'ground rules'. This does not involve a claim that they will be the best forever, or even the best in every place right now. Rather, they need to apply well in the contemporary jurisdiction under consideration. Their being subject to change does not weaken their importance, or their current force (practical or authoritative). Nor does it obviate or undermine attempts to change the system where there are good reasons to do so. In formulating bases for legal or regulatory interventions, I agree with Gray that the least problematic test available to political liberals is some manner of 'harm principle', and am more willing than he seems to be in *Two Faces of Liberalism* to embrace this. Furthermore, in developing this core of certainty, contrary to what Gray seems to allow, we do create a system of coherent and compatible legal rights, liberties, duties, *etc.*, that can function harmoniously.[41] This function can be seen as perfect in principle, and whilst not perfect in practice, it can be

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reasonably aspired to. In other words, we need not think that there are actual rights conflicts. Legal rights may *appear* to conflict, but this can be attributed to their qualifications' not all being stated expressly, and nothing more complex.

In substantiating this core of certainty, and using it to give expression to legally supported rights, the system affords what in practice amounts to some manner of a claim to objectivity. Although the limits it sets, and the positive freedoms it affords, will be contestable, it is right that attempts be made to reduce the impact of accusations that the limitations or demands are arbitrary. Various mechanisms may be used by policy-makers in this regard. In part these will be based on what is widely acceptable. But where positive benefits are being afforded, as well as the political judgment that they are worthwhile, there is an expert judgment needed that measures are efficacious.[42] Within this scheme, it is possible—and proper—to suspend the stronger levels of scepticism, and draw from evidence bases. Scientific fact can not tell us what treatment a person ought to receive, or what behaviour should be forbidden, but it can tell us what will, or will likely, happen if he receives a particular treatment or acts in a certain way. In a system that protects positive and negative freedoms, this is crucial and defensible. With these observations by way of a groundwork, let us now consider their application in regard to medico-legal analysis.

B. Medical law: plural values, positive claims, and clinical contexts

English medical law has developed to reflect significantly the sort of liberalism described in John Gray's book *Isaiah Berlin*.[43] It is not necessary here to give an historical account of the development of judicial, and now legislative, understandings of patients' interests, or the central importance of a personalised approach to assessing what will be good for any particular individual, whether or not he has decision-making capacity.[44] It is worth noting, however, that claims about legal principle concerning these matters can still be exaggerated in two directions: at times there are wrong-headed conflations of medical interests and best interests; and at times there are undue denials of the importance of medical interests in an assessment of what serves overall interests. At law, and I hope to have demonstrated at least presumptively that this is justifiable, the content of healthcare interests that the State must underwrite with positive obligations will be furnished by expert and personal considerations, as well as the obvious need to consider mechanisms to try to ensure a fair allocation of resources. If we speak of a 'right to healthcare', founded on the obligations presented in section 1 of the National Health Service Act 2006, we see that it is coherently conceived as a claim right, but one whose exercise requires the power not only of the beneficiary (the patient), but also of the provider. On some counts, this is viewed as 'paternalistic', though as the funding comes from compulsory taxation, the alternative—*ie* a wider scope of available treatments to match a 'whatever you want' system—would demand further government coercion, and be rather harder to sustain (not to mention the political implications of forcing doctors to act in ways that they reasonably consider to be harmful[45]). This shared sovereignty is reflected in proposed assisted-dying legislation, and one can see why that might be considered attractive.[46]

At the level of principle, however, matters are complicated because although it is often thought that 'clinical indication' is a necessary (though alone not sufficient) justification for a medical intervention, clinical benefit need not be the reason for a procedure to be lawful (think *eg* of cases of non-therapeutic sterilisation, assisted reproduction, abortion, organ donation, cosmetic surgery, *etc*.), or indeed the contingent factor in a decision of what is appropriate treatment. As a general statement of principle clinical benefit is not a necessary condition for intervention in every case. And given the freedom of patients—both those with and those without capacity—not to receive treatments that offend against their entrenched values, it is clear principle that clinical benefit is not a sufficient condition to mandate an intervention. There results a complex, and potentially inconsistent, position for patients who

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would seek to claim what they consider would be good for them. In the following section of this paper, I will explore this complexity as it relates to 'end-of-life' cases, and in so doing I hope to establish two broad conclusions: first, that it serves to undermine apparent simple answers to questions of how normatively grounded policy might work in practice; and second, that there is real difficulty with framing 'end-of-life' issues in exclusive 'medical law' paradigms. In relating this to the foregoing discussions of political liberalism, I will draw particular reference to Kenneth Veitch's *The Jurisdiction of Medical Law*.[47]

IV. 'END-OF-LIFE' CASES: VALUES, SOCIAL CONTEXT, AND LEGAL SUB-DISCIPLINES

The issues I have presented above indicate at least approximately the normative context within which the study of law, and thus medico-legal questions, most productively takes place. They provide good reason for accepting that analysis must be made through a political lens. No doubt in some areas of moral philosophy and bioethics there is value in more abstracted discussion. But in practical debates, including debates in applied ethics, instead of working in abstraction from human communities, we need to establish our understanding as one of a political system, and a consequent framework of legal rights, obligations, and freedoms. With this we can test the boundaries of what can and should be permitted, encouraged, and enforced, and what prohibited, at law. My purpose now is to move beyond the broad analytic context, to the social context whose understanding it is supposed to enhance. This will lead back into some final reflections about the nature of analyses that themselves assume a more 'localised' context. Study within a sub-discipline of law, such as medical law, can itself produce distorting dominant paradigms and received wisdoms (think for example of the primacy given to autonomy in medical law scholarship[48]). Although all analyses should trace back to the broad political system, emphases and subject-specific concepts assume an important role that may tarnish evaluations if they govern examination of related but distinct social questions. I will thus end by suggesting that in the context of assisted-dying, there is a real problem if medico-legal issues claim or assume precedence over alternative, valid concerns that do not naturally feature within discussions of medical law.

A. Artificial clinical context

In the textbook example of a healthcare interaction, a patient is correctly presumed to be competent to make a decision, his doctor offers some treatments that are clinically indicated, explaining carefully the benefits and risks of each and of doing nothing, and the patient makes an informed choice between the options. In practice, there may be many reasons why this is not quite how things go. Of interest in the context of end-of-life issues are the means and reasons employed for circumscribing the freedoms available. Decades of developing jurisprudence and scholarship have tested and questioned the continuing upshots of law and policy.[49] It is common to note the different matters that are lawful or not by reference to claims about passive or active conduct, and medical and benign *versus* non-medical and criminal reasoning. Yet the reality is a mesh of clinical and non-clinical considerations that themselves combine in the formation of a clinical opinion. We can usefully contrast two instances of what I would label 'artificial clinical need' to highlight what I mean.

It is useful to begin with the 'classic case' of a patient who refuses a blood transfusion for religious reasons. It is canonical that this is his right. In such a case, the patient's own value system may itself be seen as a legitimate bar to a course of action that would otherwise be clinically indicated, and alternative products to blood may be recommended, when in otherwise qualitatively identical cases they would not be. In such cases, it would seem uncharitable (at best) to think that the patient is 'just being awkward' or is manipulating the

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system. It is his right to make the initial refusal, and thus the doctors must take the consequent position and work from there. So far, so reasonable. But let us contrast this with a scenario based on the case of Kelly Taylor (which ultimately was never litigated). It was reported in February 2007 that Mrs Taylor, a terminally ill woman with Eisenmenger's Syndrome and Klippel-Feil Syndrome, was launching a legal case to force her doctors to sedate her with drugs and then withdraw food and hydration to allow her to die without suffering. She had a settled wish to die, but had failed in previous attempts to kill herself by overdose, and had stopped an earlier attempt to die by starvation because it had proved too painful.[50] From the reporting, it seems that the legal challenge was to be based on Article 3 of the European Convention on Human Rights (ECHR),[51] which at least arguably can found a case for greater latitude than has otherwise existed in the context of end-of-life cases.[52] What is of interest here is that Mrs Taylor was not asking for the freedom to commit suicide in private (with or without assistance). Nor was she asking for anything that of itself was beyond the remit of lawful treatment; terminal sedation and withdrawal of artificial nutrition and hydration *can*, in the right circumstances, be accepted as lawful and clinically indicated options, which may serve a patient's best interests. She wanted decisions that individually were arguably lawful to combine to allow her an earlier death. It is doubtless for this reason that her carers considered it to be a case of euthanasia.[53] However, 'euthanasia' is not a term of (English) legal art, and thus cries of 'this would be euthanasia and therefore…' have no legal bite.

As far as the law is concerned would the conduct be lawful? Could, and should, a patient be free to follow this course of action? As Richard Huxtable notes, the order of events could have been reversed; *ie* she could have chosen first to refuse food, and then been sedated when the suffering that this caused became unbearable.[54] In such a circumstance, her initial, lawful refusal could be said to change the context; making sedation clinically indicated when otherwise it would not be. A scholarly analysis suggests a compelling argument could be made for the lawfulness. I would agree with Huxtable that the legal reasoning would be "banal, given its familiarity and simplicity."[55] I agree too that we should encourage recognition of a distinction between real life and analysis based on an abstracted "mechanical application of 'the law'."[56] But what becomes clear is that the whole of Mrs Taylor's decision-making *could* be seen as an attempt at getting something she was not (legally) due. The reason to raise this is not to settle finally the question, but to highlight how both she and her carers may be cast as *manipulating* the legal position to lead to their view of a favourable outcome. The many falsehoods shrouded in the act/omission distinction are of great familiarity to anyone engaged in end-of-life debates.[57] But the issue here is slightly distinct; it is not just about whether a convenient legal fiction can be employed to legitimise something that might seem morally dubious. There seem to be power games, and they expose further the fragility of the line between clinical and moral judgment. As we have seen, 'clinical indication' is not the whole, and sometimes not even a part, of a medical decision. Where the shared sovereignty is defined by distinct roles—the patient as an expert in his values, the doctor as an expert in medicine, and each in the relevantly associated questions concerning the patient's interests—there is scope for slides in either direction, which each side might fight hard to resist.[58] In short, the normative context for assessment of end-of-life questions should be political philosophy; the practical context demands that we account, amongst other things, for *realpolitik*. And this leads to the question of whether we would do well to try to avoid an artificial clinical context altogether; should 'end-of-life' issues be conceived as necessarily involving doctors and patients?

B. Is 'end-of-life law' 'medical law'?

As Suzanne Ost discerns,[59] there are trends that suggest a strong (and welcome) 'de-medicalisation' of end-of-life issues, many of which have nevertheless become the bread

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and butter of 'medical lawyers'. This raises an important question, which ties in neatly with reservations about the 'coherence anxiety' of medical law as a discipline.[60] In essence, has a separate and equally robust discipline of 'end-of-life law' emerged? It seems at least arguable that it has. Medical law, if it is a coherent discipline, is this because medicine forms a sufficiently strong common thread to hold together an otherwise disparate mass of legal inquiry. Nor is this form of 'coherence' unique to medical law.[61] Given the enormous literature on law and assisted-dying, and the strength of arguments that suggest it ought not to be medicalised,[62] it may, however, be that 'end-of-life' has itself become the central theme in a largely unstated, unavoidably macabre, but thriving legal discipline of its own.[63] If this is right, I am doubtful whether there is good reason to place it under the shadow of medical law. However, I suspect that many would find the dissociation difficult. If we polled colleagues, asking them to nominate the two most important end-of-life cases in English medical law, my suspicion is that a majority would cite *Bland*[64] and *Pretty*.[65] Noticeably, Dianne Pretty's is not strictly a medical law case at all! No medics were involved, and the legal questions related directly to the English law applicable to Mr Pretty and the Director of Public Prosecutions, and only indirectly to, albeit with clear and profound affect for, Mrs Pretty. It is true that she was suffering from a condition that left her requiring specialised care. But this should not blind us to the non-medical nature of the legal question under issue: indeed, it is worth emphasising the European Court of Human Rights' observation in *Pretty* that "there is no complaint that the applicant is not receiving adequate care from the State medical authorities."[66] I can not here argue against policies (proposed or existent) that have medical conditions that 'qualify' people for lawful assisted-dying, and I acknowledge the politically pragmatic reasons for their doing so. I likewise recognise that there is a proper place for study of assisted-dying on medical law courses. But I maintain that there is sufficient reason in what has preceded to demand some wariness, and prompt further investigation into end-of-life policy outside of medical law paradigms.

These observations become more pronounced when set against Veitch's analysis of the 'jurisdiction' claimed by medico-legal scholars.[67] Overall, Veitch's study produces and encourages a self-conscious assessment of how common law medical cases should be understood and analysed. Part of his methodology involves detailed and critical engagements with a small number of prominent cases. In chapter 5, he exemplifies various issues in relation to human rights and medical law, focusing specifically on three cases: *Pretty*; *A* v. *M and B* v. *H*;[68] and *Burke*.[69] Interestingly, of *Pretty* Veitch says the following (in footnoted text):

> Strictly speaking, this [*ie Pretty*] would not be classified as a 'medical law' case. Nonetheless, given its relevance to the issue of physician assisted suicide and the discussion which it has elicited within the academic medical law community, the case merits inclusion here.[70]

It would seem facetious to deny *Pretty*'s relevance to "the issue of physician assisted suicide". But I do wonder if the paradigm this implies (within or without Veitch's specific framing) undermines, or even to a great extent forecloses, a critical study of the idea of husband-assisted suicide, which was the actual issue under litigation. Notably, there would be something quite ironic in the *reinforcement of* medicalisation by a discipline that is widely conceived to represent a *challenge to* medicalisation.

None of this is to deny the practical claim that Veitch makes: he is right that members of the medical law community have focused a great deal on *Pretty*, making it an eminently sensible selection for his purposes. Furthermore, as he suggests, the academic medical law community does engage with all manner of questions concerning suicide and assisted-dying (some of us with, and some without, 'medical blinkers' on). Given this, and in regard to the wider themes of this essay, I would make a final point that is well underscored by further

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reference to Veitch's analysis. I have argued that the context of our normative analysis should be political, and traceable back to a single source of political normativity. To conduct a critique of the *Pretty* case, we should look to what is socially and politically defensible, informed by moral questions but not beholden to a singular and exclusive morality that has no practical purchase in regard to law and society: in legal metaphor, we should not answer questions with positions that do not have 'standing' in the communities we are addressing, or the practical debates we are evaluating and informing. Where we define our analysis by reference to important social questions—*eg* should further forms of assisted-dying be legalised?—we may usefully consider ourselves to be engaging in an unorthodox but specialist area of law, such as 'end-of-life law' or 'medical law'. The important norms that inform these areas are found through wider political inquiry. So, to put it bluntly, 'medical law cases' do not have their own isolated jurisdiction; rather, they represent an area of jurisprudence on which some analysts happen (through choice) to be particularly well informed. However, when studied in isolation, specific paradigms that are peculiar to medical law will assume some level of dominance (again think *eg* of autonomy). Such paradigms may skew analysis unduly, and are more easily avoided by an analytic approach that does not cling unnecessarily to a limiting discipline. It is not clear that 'end-of-life law' should be contained within 'medical law', even where both are traceable back to the same overall legal system.

What I have outlined here has significant implications for many of the debates that take place in specialist journals such as the *Medical Law Review*. It suggests an important methodological point. A focus on end-of-life issues is special (though by no means unique) because we find a social problem, rather than a traditionally defined legal approach, and try to address it through a legal analysis. If expertise is to develop around a problem rather than a disciplined approach—assisted dying is what we have considered here, but it could as well be embryology, organ donation, care for the vulnerable, and so on—then it implies the engagement of a different manner of scholar than one may find working in some 'traditional' areas. It is clearly no coincidence that many medical lawyers undertake co-authored works, and are not bemused by pleas for interdisciplinarity. I am not arguing that medical lawyers are talking medical law out of existence, or indeed that *all* medical lawyers are engaged in multi-disciplinary research. I am, however, claiming that a sustained focus on questions such as assisted-dying creates fresh analytic dynamics that are not medico-legal. The involvement of the medical profession in relation to some end-of-life issues does not make the whole a medical (or medical law) issue. As long as we continue to consider it as such, we may not see quite to what extent death can be considered apart from medicine.

V. CONCLUSIONS

I have sought to demonstrate why normative analyses of end-of-life issues should be undertaken within a political framework. This claim holds regardless of whether the reader is attracted to the particular form of political liberalism that I would defend. In a system that houses plural and competing moralities, it is right that the answers of what the law should do be found according to political reasoning, rather than by reference to some esoteric and exclusive moral theory. The expression of relevant issues in political terms highlights the complexity of the paradigms that have developed at law, including in medical law. Immediately it demonstrates how difficult a 'quick fix' would be, even if the principles seemed clear. But it also suggests that in debates concerning assisted-dying analysts are no longer really working within medical law. The subject of concern is not medicine, medics, or medical practice, or at least not exclusively so. The special focus that holds the body of scholarship together is death and dying, and *its* study could well be described as the development of an area of legal inquiry in its own right.

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References

1. Regarding medical law, this principle is evidenced particularly in relation to mental capacity—see especially *Re T (Adult: Refusal of Treatment)*[1993] Fam 95; *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819: *Re MB (Medical treatment)* [1997] 2 FLR 426; *St George's Healthcare NHS Trust* v. *S* [1998] 3 WLR 936; *Ms B* v. *An NHS Hospital Trust* [2002] 2 All ER 449; *Re Z (Local Authority: Duty)* [2005] 1 WLR 959; and the Mental Capacity Act 2005—and that relating to provision of information to patients—see especially *Chester* v. *Afshar* [2005] 1 AC134.
2. On apparently self-regarding and consensual harms see especially *R* v. *Brown* [1994] 1 AC 212; *R* v. *Cox* [1993] Med. L. Rev. 1:2, 232; *Pretty* v. *The DPP* [2001] EWHC Admin 788; *Pretty* v. *DPP* [2002] 1 AC 800; *Pretty* v. *UK* (2002) 35 EHRR 1.
3. Perhaps the most notable texts are Mill, JS. On Liberty. Alexander, Edward, editor. Broadview; 1999. ; Hart, HLA. Law, Liberty, and Morality. Stanford University Press; Stanford: 1963. ; Berlin, I. Four Essays on Liberty. Oxford University Press; Oxford: 1969. ; and Joel Feinberg's four volumes on The Moral Limits of the Criminal Law. Oxford University Press; Oxford: 1987. 1987, 1988, 1989, and 1990.
4. Thus, *eg*, John Keown, who has written many moral critiques of the law in favour of the sanctity of life principle, also addresses the question on the terms of those who would refrain from legislating on empirical grounds concerning harms that will be caused: Keown, J. Euthanasia, Ethics and Public Policy–An Argument Against Legalisation. Cambridge University Press; Cambridge: 2002.
5. Smith S. Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia. MedLR. 2005; 13:1, 17–44.
6. *Pretty* above, note 2.
7. *Pretty* v. *UK* above note 2. See the discussion of Article 8 (paras 57-78) and Article 14 (paras 84-90).
8. The word 'staggering' is not hyperbole. Amongst the many texts that feature prominently in debates on assisted-dying (both as a freedom from interference, and as a positive right) are the following: Harris, J. The Value of Life. Routledge and Kegan Paul; London: 1985. ; Dworkin, R. Life's Dominion. Harper Collins; London: 1993. ; Singer, P. Rethinking Life and Death. Oxford University Press; Oxford: 1994. ; Keown, J., editor. Euthanasia Examined–Ethical, Clinical and Legal Perspectives. Cambridge University Press; Cambridge: 1997. ; Otlowski, M. Voluntary Euthanasia and the Common Law. Oxford University Press; Oxford: 1997. ; Dworkin, G., et al. Euthanasia and Physician-Assisted Suicide–For and Against. Cambridge University Press; Cambridge: 1998. ; Biggs, H. Euthanasia–Death with Dignity and the Law. Hart; Oxford: 2001. ; Snyder, L.; Caplan, AL., editors. Assisted Suicide–Finding Common Ground. Indiana University Press; Bloomingham and Indianapolis: 2002. ; McMahan, J. The Ethics of Killing–Problems at the Margins of Life. Oxford University Press; New York: 2002. ; Keown, Euthanasia, Ethics and Public Policy, above note 4; Ost, S. An Analytical Study of the Legal, Ethical and Moral Aspects of the Living Phenomenon of Euthanasia. Edwin Mullen Press; New York: 2003. ; Tännsjö, T., editor. Terminal Sedation: Euthanasia in Disguise?. Kluwer Academic Publishers; Dordrecht: 2004. ; Huxtable, R. Euthanasia, Ethics and the Law: From Conflict to Compromise. Routledge Cavendish; Abingdon: 2007. ; McLean, S. Assisted Dying: Reflections on the Need for Law Reform. Routledge Cavendish; Abingdon: 2007.
9. See *eg Ahsan* v. *University Hospitals Leicester NHS Trust* [2007] PIQR P19.
10. For critiques based on similar concerns to those raised here, see Huxtable R. Whatever you want? Beyond the patient in medical law. Health Care Analysis. 2008; 16:3, 288–301.; McIvor, C. Bursting the Autonomy Bubble: A Defence of the Court of Appeal Decision in *R (On the Application of Oliver Leslie Burke)* v. *GMC*. In: Smith, S.; Deazley, R., editors. The Legal, Medical and Cultural Regulation of the Body: Transformation and Transgression. Ashgate; Farnham: 2009.

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11. *R (On the Application of Oliver Leslie Burke)* v. *The General Medical Council* [2005] EWCA Civ 1003.
12. See Sen, A. Health Achievement and Equity: External and Internal Perspectives. In: Anand, S.; Peter, F.; Sen, A., editors. Public Health, Ethics, and Equity. Oxford University Press; Oxford: 2004. It should also be noted that in limited cases in English law, conscientious objection is permitted: it is likely that any assisted-dying law would contain a conscience clause: see *eg* the Assisted Dying for the Terminally Ill Bill 2005, clause 7.
13. See *eg* the Assisted Dying for the Terminally Ill Bill 2005.
14. See *eg* Keown J. Restoring moral and intellectual shape to the law after *Bland*. LQR. 1997; 113:482–503.; Ardagh M. Futility has no utility in resuscitation medicine. JME. 2000; 26:396–399.; Read J, Clements L. Demonstrably Awful: the Right to Life and the Selective Non-Treatment of Disabled Babies and Young Children. JLS. 2004; 31:4, 482–509.; Wreen M. Medical futility and physician discretion. JME. 2004; 30:275–278.
15. The arguments presented in sections II and III of this paper, and their relationship to alternative critical positions, are made in much greater detail in my forthcoming book "What Makes Health Public?".
16. Wolff, RP. Defense of Anarchism. University of California Press; 1998. Christopher Wellman distinguishes "normative anarchists" from "descriptive anarchists" by reference to their reasons for being anti-statist: a normative anarchist's objections are principled, and hold that there is no political legitimacy; a descriptive anarchist is anti-statist because he believes on consequentialist grounds that the matters are better when there is no State: Wellman C. Liberalism, Samaritanism, and Political Legitimacy. Philosophy and Public Affairs. 1996; 25:3, 211–237. See also Christopher McMahon's similar discussion of "libertarian anarchists" and "consequentialist anarchists": McMahon C. Autonomy and Authority. Philosophy and Public Affairs. 1987; 16:4, 303–328.
17. A John Simmons, who doubts the legitimacy of the State, notes the potential for alternative "favorable evaluations" by which to assess political society: Simmons AJ. Consent Theory for Libertarians. Social Philosophy and Policy. 2005; 22:1, 330–356. In the argument here in favour of political normativity, I appeal to an alternative "favorable evaluation" than one afforded by a singular moral theory.
18. See *eg* Brownsword's recent discussion in Brownsword, R. So what does the world need now? Reflections on regulating technologies. In: Brownsword, R.; Yeung, K., editors. Regulating Technologies: Legal Futures, Regulatory Frames and Technological Fixes. Barnes and Noble; 2008. p. 40-41.
19. See Gray, J. Two Faces of Liberalism. Polity Press; Cambridge: 2000. This work and the claim made in the text here are discussed in further detail below.
20. Wolff, In Defense of Anarchism, above n. 16; Nozick, R. Anarchy, State, and Utopia. Blackwell; Oxford: 1974.
21. See *eg* Jennings B. From the Urban to the Civic: The Moral Possibilities of the City. Journal of Urban Health. 2001; 78:1, 88–103.; Jennings, B. Public Health and Civic Republicanism. In: Dawson, A.; Verweij, M., editors. Ethics, Prevention, and Public Health. Oxford University Press; Oxford: 2007.
22. See also Powers M. Bioethics as Politics: The Limits of Moral Expertise. Kennedy Institute of Ethics Journal. 2005; 15:3, 305–322. [PubMed: 15881599]
23. McPherson, T. Political Obligation. Routledge and Kegan Paul; London: 1967. p. 76
24. See Griffin, J. On Human Rights. Oxford University Press; Oxford: 2008. p. 35
25. Although this is tautologically true, it bears explicit statement as so much moral analysis of law seems to ignore the problem of universalising from subjects that conceptually do not exhaust the sorts of beings that are under consideration. It is worth noting that many different sorts of analysis share this critical perspective: *eg* MacKenzie, C.; Stoljar, N., editors. Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self. Oxford University Press; Oxford: 2000. ; Gaylin, W.; Jennings, B. The Perversion of Autonomy: Coercion and Constraints in a Liberal Society. second edition. Georgetown University Press; Washington: 2003. ; Griffin, On Human Rights, *ibid*..

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26. Naffine N. Who are Law's Persons? From Cheshire Cats to Responsible Subjects. MLR. 2003; 66:3, 346–367.
27. See *eg* Harris J. Taking the 'Human' out of Human Rights. CQHE. forthcoming 2011 (available online).
28. See the methodological considerations in Wolff J. Harm and hypocrisy–Have we got it wrong on drugs? Public Policy Research. 2007; 14:2, 126–135.
29. Gray, Two Faces of Liberalism, above note 18.
30. See Gray, *ibid.*. See also Geuss, R. Philosophy and Real Politics. Princeton University Press; Princeton and Oxford: 2008. , especially the discussion of Rawlsian theory at p. 85.
31. See *ibid.*, including the comparable discussions of a dominant Kantianism in contemporary political theory in the introductions of each book.
32. See Freeman M. The Philosophical Foundations of Human Rights. HRQ. 1994; 16:491–514.
33. See Hasman A, Holm S. Accountability for Reasonableness: Opening the Black Box of Process. Health Care Analysis. 2005; 13:4, 261–273.
34. Most famously by comparative reference to a 'state of nature'.
35. I share many of his concerns, and draw much from his argument, but differ from Geuss in this regard: see Geuss, Philosophy and Real Politics, above n. 30.
36. Hohfeld, WN. Fundamental Legal Conceptions as Applied in Judicial Reasoning. Campbell, D.; Thomas, P., editors. Ashgate Dartmouth; Aldershot: 2001.
37. See Gray, J. Isaiah Berlin. Princeton University Press; Princeton: 1996. , especially chapter 2.
38. Gray, Two Faces of Liberty, above note 19.
39. See *ibid.*, especially pp. 8-9, 66-68, and chapter 4.
40. Jennings, "Public Health and Civic Republicanism," aboved n. 20. Jennings draws from the influential work: Anderson, Benedict. Imagined Communities–Reflections on the Origin and Spread of Nationalism. Revised edition. Verso; London: 1991.
41. Contrast the discussion in Gray, Two Faces of Liberalism, above n. 19, especially pp. 14-17 and pp. 84-85. I agree with Gray that moral rights are not *foundational*, but do not see that this implies a contention that within an established political system no framework of *legal* rights can be established, or why he need claim that *these* rights will necessarily clash.
42. See the reasoning in Buchanan A. Human Rights and the Legitimacy of the International Order. Legal Theory. 2008; 14:1, 39–70., especially pp. 61-64.
43. Gray, Isaiah Berlin, above n. 37; Coggon J. Best Interests, Public Interest, and the Power of the Medical Profession. Health Care Analysis. 2008; 16(3):219–232. [PubMed: 18642085]
44. See Brazier, M.; Cave, E. Medicine Patients and the Law. 4th edition. Penguin; London: 2007. chapters 5 and 6. ; Mason, JK.; Laurie, GT. Mason & McCall Smith's Law and Medical Ethics. seventh edition. Oxford University Press; Oxford: 2006. chapter 10. ; Jackson, E. Medical Law–Text, Cases and Materials. second edition. Oxford University Press; Oxford: 2010. chapters 4 and 5. See also Coggon, J. Doing what's best: organ donation and intensive care. In: Danbury, C.; Newdick, C.; Waldmann, C.; Lawson, A., editors. Law and Ethics in Intensive Care. Oxford University Press; Oxford: 2010.
45. Indeed note the parallels with this claim of the power of the medical profession as regards assisted-dying policy specifically. As Francis Pakes clearly demonstrates, a unified and oppositional medical profession is a potent political force that can make policy stand or fall: Pakes F. Under Siege: The Global Fate of Euthanasia and Assisted-Suicide Legislation. European Journal of Crime, Criminal Law and Criminal Justice. 2005; 13:2, 119–135.; Pakes F. The legalisation of euthanasia and assisted suicide: A tale of two scenarios. International Journal of the Sociology of Law. 2005; 33:71–84.
46. Consider the substantial role for physicians in the Assisted Dying for the Terminally Ill Bill 2005.
47. Veitch, K. The Jurisdiction of Medical Law. Ashgate; Aldershot: 2007.
48. A point picked up by Veitch in his analysis, and which leads him to focus specifically on the principle of autonomy: see *ibid.*, especially chapters 3 and 4.
49. See *eg* notes 1, 2, and 8 above.

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50. See Anon. Legal battle over 'right to die'. BBC Online. Feb 12. 07http://news.bbc.co.uk/1/hi/health/6353339.stm; Anon. Euthanasia woman withdraws case. BBC Online. Apr 18. 07http://news.bbc.co.uk/1/hi/england/bristol/6568217.stmSee also Kelly Taylor's 'personal story' on the Dignity in Dying website: http://www.dignityindying.org.uk/personal-stories/uk/south-west/bristol/kelly-taylor-story-17.html (all pages accessed 19 September 2010).
51. In the first report cited in *ibid.*, there is reference to her claim being based on the ECHR's prohibition of "inhuman or degrading treatment". See also Anon. [accessed 19 September 2010] Terminally ill woman seeks right to die. Guardian online. Feb 12. 07 http://www.guardian.co.uk/uk/2007/feb/12/health.humanrights
52. See Coggon J. Could the Right to Die with Dignity Represent a New Right to Die in English Law? MedLR. 2006; 14:2, 219–237. See also Munby J's overruled first instance decision in *Burke* v. *General Medical Council* [2004] EWHC 1879 (Admin) and Munby, Justice. A Duty to Treat?–A Legal Analysis. In: Smith, S.; Deazley, R., editors. The Legal, Medical and Cultural Regulation of the Body: Transformation and Transgression. Ashgate; Farnham: 2009. It is not clear how Munby's reasoning can not apply to assisted-dying measures that would shorten life, as well as those aimed at serving other patient preferences.
53. Dyer C. Dying woman seeks backing to hasten death. BMJ. 2007; 334:329. [PubMed: 17303849]
54. Huxtable, 'Whatever you want?' above note 10, pp. 291-292.
55. *Ibid.*, p. 292.
56. *Ibid.*.
57. For a discussion of this question see Coggon J. On Acts, Omissions, and Responsibility. JME. 2008; 34:8, 576–579.
58. For a more thorough analysis of claims about medical decision-making and the possible reasons for allowing or denying a person's choice, as evidenced by study of common law decisions, see Coggon J. Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism? Health Care Analysis. 2007; 15:3, 235–255.
59. Ost S. The De-medicalisation of Assisted Dying: Is a Less Medicalised Model the Way Forward? MedLR. forthcoming 2010; 18:4.
60. See Ruger T. Health Law's Coherence Anxiety. GLJ. 2008; 96:2, 625–648. (although Ruger's focus is 'health law', the arguments apply also to medical law); Veith, The Jurisdiction of Medical Law, above note 47, chapter 1.
61. See Ruger, *ibid.*, pp. 627-628.
62. Further to Ost, 'The De-medicalisation of Assisted Dying,' above n. 53, see *eg* Faber-Langendoen K, Karlawish JHT. Should Assisted Suicide Be Only Physician Assisted? Annals of Internal Medicine. 2000; 132:6, 482–487.; Ogden RD. Non-Physician Assisted Suicide: the Technological Imperative of the Deathing Counterculture. Death Studies. 2001; 25:5, 387–401.
63. How widespread the *perception* of this might be is arguably more limited: for whatever its representative value, a search for the exact phrase "end of life law" on Google Scholar on 19th October, 2010 produced a modest 65 results (including one paper by me).
64. *NHS Trust* v. *Bland* [1993] AC 789.
65. Above n. 2.
66. *Pretty* v. *UK*, above n. 2, paragraph 53.
67. Note that Veitch uses the concept of 'jurisdiction' as a methodological tool to describe and critically analyse both the practices of courts in medical law cases and the works of academic medical lawyers. My concern here is principally with the latter, though informed by the whole of his analysis.
68. *NHS Trust A* v. *M; NHS Trust B* v. *H* [2001] 1 All ER 587.
69. *R (Burke)* v. *General Medical Council* [2004] 2 FLR 1121; *R (Burke)* v. *General Medical Council* [2005] 3 FCR 169.
70. Veitch, The Jurisdiction of Medical Law, above note 47, p. 114, note 6.