

‘Who’s for bioethics?’ Ian Kennedy, oversight and accountability in the 1980s

Bioethics ceased to be an ‘American trend’ during the 1980s, when growing numbers of British outsiders publicly demanded greater external involvement in the development of guidelines for medicine and biological science. Their arguments were certainly successful. By the beginning of the 1990s, when the *Guardian* described the growing ‘ethics industry’, supporters of this new approach were influential public figures. One of the earliest and most high profile of these supporters was the academic lawyer Ian Kennedy. Since the late 1960s, Kennedy has written on medical definitions of death and mental illness, euthanasia, the doctor–patient relationship and the rights of AIDS patients. In line with the ‘hands-off’ approach of lawyers, Kennedy’s early work stressed that decisions should rest solely with the medical profession; but this stance changed after he encountered bioethics during a spell in the United States. In 1980 Kennedy used the prestigious BBC Reith Lectures to endorse the approach that he explicitly labelled ‘bioethics’, critiquing self-regulation and calling for external involvement in the development of professional standards. Kennedy’s Reith Lectures, entitled *Unmasking Medicine*, are recognised as a pivotal moment in the history of British bioethics, with a senior doctor identifying them as ‘one of the key events in the retreat from paternalism’.¹

In addition to *Unmasking Medicine*, Kennedy endorsed bioethics in academic publications, newspaper columns and several other radio and television programmes during the 1980s. In this period, he also established a Centre of Medical Law and Ethics at King’s College, London, and served on several professional and regulatory bodies. During the 1990s he was a founding member of the Nuffield Council on Bioethics and chaired a public inquiry into human–animal ‘xenotransplants’. His contribution to British bioethics has

led one lawyer to claim that he ‘virtually invented the field in the United Kingdom’.² In 2002 the Labour government endorsed this view when it awarded him a knighthood for ‘services to bioethics’.³

On the one hand, there was little particularly new in Kennedy’s call for outside involvement. This was pointed out in 1981 by Dame Elizabeth Ackroyd, chair of the Patients Association, who claimed that ‘the proposals which Mr Kennedy puts forward are certainly ones which I support, and which indeed the Patients Association have advocated for a long time’.⁴ ‘I do not think’, Ackroyd continued, ‘that Mr Kennedy would claim that he was putting forward new ideas.’ Kennedy’s proposals did indeed echo those made by the Patients Association and Maurice Pappworth during the 1960s. They also drew on the civil rights campaigns Kennedy encountered in the United States, on Ivan Illich’s critique of professions and, perhaps most significantly, on the work of American bioethicists such as Paul Ramsey and Jay Katz.

But while there was little new in Kennedy’s calls for external involvement, they were certainly more influential than earlier British proposals. This owed a great deal to the changing political climate in the 1980s. Kennedy’s arguments dovetailed with a central belief of the Conservative government that was elected in 1979, which believed that professions should be exposed to outside scrutiny in order to render them accountable to their end-users. It is no coincidence that bioethics emerged as a recognised approach in Britain once the Conservatives promoted external oversight as a way of ensuring public accountability and consumer choice.

This analysis provides a framework for understanding the broad context in which British bioethics emerged and operated, connecting with major themes in contemporary history, such as declining trust in professions among neo-liberal politicians and the rise of measures designed to enforce public accountability, which Michael Power has characterised as the ‘audit society’. Power details how the 1980s saw the growth of mechanisms designed to monitor professional actions, whose main ingredient was reliance on experts independent from the profession in question. The early history of British bioethics offers substantive evidence in support of Power’s thesis. It also deepens our understanding of how the ‘audit society’ was shaped by the interaction between political ideologies and professional agendas. The new regimes of external oversight that emerged in the 1980s, such as bioethics, were not simply the top-down

product of Conservative demands for public accountability, but also depended on the presence of individuals and professional groups willing to define themselves as the new arbiters of best practice.⁵ We can thus see Kennedy's criticism of self-regulation and calls for outside scrutiny as a fundamental constituent of the audit society, which helped create the demand for bioethics.

Examining Kennedy's work also dispels presumptions that are often made about the nature and function of bioethics. Several historians, sociologists and anthropologists have criticised bioethics for failing to ask fundamental questions about the political economy of medicine, or of medical power and authority.⁶ But Kennedy regularly drew attention to the ideological aspects of medical decisions, criticised the focus on high-tech practices and claimed that professional authority infantilised patients. His calls for outside input were attempts to redress this perceived imbalance of power, involving others in 'the countless decisions taken by doctors which are not medical, but involve questions of morality or philosophy or economics or politics'.⁷

Yet while Kennedy asked critical questions about professional authority, his work was not, as some claim, simply an 'iconoclastic attack on medical paternalism'.⁸ Kennedy also echoed American bioethicists when he claimed that outside involvement would benefit doctors, by relieving them of difficult decisions and helping them overcome public and political mistrust. This is crucial to helping us understand why bioethics became an important approach in the 1980s. Rather than simply challenging the authority of the medical profession, then, Kennedy presented it with a new means of legitimacy in a changed political climate. This ensured that many senior figures endorsed his proposals and Kennedy was soon 'embraced by much of established medicine'.⁹ We can thus appreciate the growth of bioethics in the 1980s by seeing figures such as Kennedy as crucial *intermediaries* between politicians and doctors, who promised to fulfil the neo-liberal demand for oversight while also safeguarding medicine.

From paternalism to patient empowerment

Ian McColl Kennedy was born in the West Midlands on 14 September 1941, into what he described as a 'poor working-class' family.¹⁰ His parents, a teacher and an electrician, encouraged their

three sons to make the most of the opportunities provided by the postwar welfare state. In 2003 Kennedy recalled that: 'My father in particular was anxious to inculcate in us the notion that we were getting what opportunities we were enjoying by virtue of the taxes and the welfare state, on the back of those who had gone to war ... It was our duty to give something back, if we made it.'¹¹

Kennedy also grew up in a postwar era in which professions were well regarded.¹² This was especially true of medicine, following the creation of the NHS, the development of antibiotics and the production of 'magic bullets' against diseases such as polio. This high esteem was reflected by the fact that two of Ian Kennedy's brothers studied medicine at university, while he went on to read law at University College London (UCL) before attaining a Master of Laws degree from the University of California, Berkeley. During his time in the United States, Kennedy recalls, the growing civil rights movement strengthened his existing 'sense of social justice, of entitlement of anybody, no matter where they're from, to have an even break, to have a chance'.¹³

Kennedy returned to Britain in 1965, when he was appointed lecturer in law at UCL. While teaching jurisprudence, he became interested in the longstanding issue of when someone began and ceased to be legally defined as a person. Much of this interest stemmed from contemporary debates prompted by new medical technologies. Prominent lawyers such as Glanville Williams had previously investigated how medical techniques such as resuscitation impacted on legal definitions of life and death; but questions surrounding exactly when a person died had increased during the 1960s, thanks to the development of artificial respirators for brain-damaged and seriously ill individuals, and the realisation these so-called 'twilight patients' were a source of organs for newly developed transplant techniques.¹⁴ Since death was legally defined as 'absence of vital functions' such as circulation and breathing, and since a fundamental requirement in the crime of murder was that the killing must have been of a 'life in being', various groups questioned whether a patient dependent on a ventilator was alive or dead and, consequently, whether a doctor who turned a machine off could be charged with murder.¹⁵

These questions were highlighted by a 1963 coroner's inquest, *Re Potter*, which investigated the death of a man who had been seriously assaulted, stopped breathing and was then placed on an

artificial respirator. Having decided that he would not recover, doctors removed a kidney for transplantation, pronounced him dead and turned the machine off. A neurosurgeon later admitted that the patient had no hope of recovery and was only placed on the respirator because another patient needed a kidney transplant. The case raised the question of when death occurred and whether it had been caused by the original assailant, the doctor who removed the kidney, or the doctor who turned the machine off. The doctors involved told the inquest that they believed the patient died when he originally stopped breathing and the coroner agreed, clearing them of any wrongdoing and charging the assailant with manslaughter. But according to existing legal criteria, the patient had not died until the machine had been turned off and 'vital functions' had permanently ceased. Although the coroner's inquest diverged from this view, he ventured no firm opinion on when death now occurred. This uncertainty was compounded following the advent of heart transplants in 1967, when surgeons who removed hearts from ventilated patients in Japan and the United States were charged with murder, and British newspapers portrayed transplant doctors as 'vultures' hovering over ill and vulnerable patients.¹⁶

Kennedy engaged with this issue in 1969, writing an article that outlined 'the legal problems surrounding the moment of death' as they related to transplant surgery.¹⁷ He used a discussion of *Re Potter* to claim that 'the accepted legal definition of death seems no longer to fit the realities of modern medicine and proves unworkable in certain circumstances'.¹⁸ As he would throughout his career, Kennedy condemned the 'very English reluctance to do anything about the situation until it has caused difficulty' and called for guidelines to forestall legal cases.¹⁹ He warned that if the present uncertainty continued, 'techniques and practices which have come to be regarded as established must stop or forever be open to challenge as regards their legality'.²⁰

But Kennedy notably endorsed the 'hands-off' approach that lawyers adopted when it came to medicine, claiming that 'the re-definition of death should be left wholly to the medical profession'.²¹ Far from leading or guiding doctors, he argued, the law should only change 'once there is an established consensus in the medical world'.²² Kennedy believed this would give legal recognition 'to what is now accepted as a matter of practice ... that the turning off of a machine seems not a positive act of killing'.²³ 'In

other words', he suggested, 'since it is suggested that the law turns a blind eye to what doctors now do, the insecurity which dogs the doctor should be dispelled by the *gradual acceptance of agreed medical practice as lawful*.'²⁴ 'The law would be then,' he continued, 'that if the doctor could prove that what he has done was in good faith and was skilful there would be no further inquiry into the relative worth or propriety of his actions.'²⁵ Kennedy argued that this would help ensure 'security for the doctor', by fostering 'a realisation that the medical profession is a responsible body requiring a high standard of conduct of its members'.²⁶

Kennedy reiterated this position in a 1972 article for the *Medico-Legal Journal*, written while he was adjunct professor of law at the University of California, Los Angeles (UCLA). Again claiming that the 'old legal definition of death needs modification in light of advances in medical science', he outlined growing support for the view that death occurred when destruction of the brain stem caused irreversible coma and dependence on a ventilator, as an *ad hoc* committee from Harvard had proposed in a 1968 report.²⁷ Kennedy claimed that in order to avoid 'the impression of haste by overzealous surgeons' if the concept were adopted, two sets of doctors should employ a battery of standard tests to determine 'brain death' and the consent of relatives should always be sought for organ transplants.²⁸ He also argued that doctors should not support patients on ventilators once brain death had been confirmed and 'there was no hope of survival'.²⁹ As before, Kennedy concluded by stating that whatever criteria were adopted, the 'doctor's judgment must prevail' and the courts must 'follow the consensus of medical opinion'.³⁰

These two articles illustrate how British lawyers continued to defer to the medical profession in the 1960s and 1970s. Like Kennedy, others endorsed the *Bolam* ruling and claimed that doctors should be left to determine their own standards of care. In his closing remarks to a 1966 CIBA symposium on ethics and organ transplantation, the judge Lord Charles Kilbrandon stated that a lawyer would never answer the question of 'what is death ... because that is a technical, professional medical matter. It is entrusted to medical men to say when a man is dead, and nobody but a doctor can decide that.'³¹ At the same symposium, David Daube, professor of civil law at Oxford, similarly claimed that defining death was 'of a scientific character and *prima facie* not for

us'.³² Daube also echoed the *Hatcher* ruling when he warned that legal interference would 'frighten doctors into passivity' – preventing them from thinking about medical progress and the good of their patients.³³ He argued that when they considered specific practices, lawyers should always 'be generous and leave the verdict to the rectitude and good sense of the doctor'.³⁴

But Kennedy began to criticise this position after his return from the United States and appointment to King's College, London, in the late 1970s. In several publications, lectures and radio talks he now argued that patients should have greater say in their treatment and, crucially, that outsiders should play a role in setting standards for the medical profession. This was first evident in a 1976 article for the *Criminal Law Review*, in which he claimed that patients had a fundamental right to self-determination that overrode the paternalistic view that 'decisions concerning a person's fate are better made *for* him than *by* him'.³⁵ This, he argued, included terminally ill or elderly patients who wished to discontinue treatment that was keeping them alive. Kennedy stated that once a patient declared a wish to have treatment discontinued, the doctor was 'obliged to respect it'.³⁶ This principle, he continued, should be 'guaranteed and safe-guarded' by consent law so that 'if a patient withholds consent, if he refuses to be touched by a doctor, any further touching will be unlawful and give rise to civil and criminal liability'.³⁷

The same year, Kennedy published an article that departed from the usual line in the *Journal of Medical Ethics*, calling for outside involvement in the development of medical guidelines. This proposal arose in a discussion of issues raised by the case of Karen Quinlan, a young American woman who fell into a coma in April 1975 and was then attached to a ventilator 'without any prospect of regaining consciousness'.³⁸ Kennedy detailed how doctors and a county judge had refused a parental request for the ventilator to be turned off, as Quinlan showed evidence of residual brain activity and was therefore alive according to the 'brain-death' criteria.³⁹ He argued that the ongoing controversy and uncertainty surrounding the Quinlan case 'serves as a timely reminder of the need for a code of practice'.⁴⁰ Should a similar case arise in Britain, he continued, 'the unfortunate position exists whereby the doctor must make a decision which obviously could have grave legal ramifications without any legal guidance'. In contrast to his earlier work, which stated that decisions regarding ventilated patients should 'be left

wholly to the medical profession', Kennedy chastised lawyers for 'saying that these are medical matters' and shifting 'the responsibility for decision [*sic*] back to the hapless doctor'.⁴¹ He now believed that they were 'patently not merely medical matters' and asserted that 'doctors function within a framework of legal and social rules which go beyond the rules of their particular profession and must be observed'.⁴² This led Kennedy to conclude that any code of practice should be 'worked out by the medical profession after consultation with lawyers, theologians and other interested parties'.⁴³

After meeting a BBC radio producer, Kennedy had the chance to make these arguments in public. Between 1976 and 1978 he presented several radio programmes on the care of disabled babies, euthanasia and reform of the Mental Health Act.⁴⁴ In his 1977 documentary *The Check-Out*, Kennedy asserted that euthanasia was 'a matter on which not just doctors or lawyers, but all of us, must have our say and our way'. The only way to ensure this, he concluded, was to give 'all interested parties' a role in the development of regulatory codes.⁴⁵ Although the subject matter of Kennedy's documentaries varied, his underlying message remained the same. A *British Medical Journal* review of the 1978 programme *The Defect*, which debated screening for spina bifida during pregnancy, noted that Kennedy's core argument was that doctors' opinions 'should be challenged by other members of society'.⁴⁶

What influenced Kennedy's retreat from paternalism? His work from 1976 onwards certainly incorporated elements from Ivan Illich's and Thomas Szasz's radical critiques of medical authority. In a 1979 lecture at the Middlesex Hospital medical school, which highlighted the moral, political and economic aspects of medical decisions, and reiterated that they were 'not for doctors alone to make', Kennedy acknowledged his debt to Illich's claim that 'the whole of medicine is a moral enterprise, since it defines what is normal and, in behavioural terms, what is proper'.⁴⁷ Later in the lecture, he endorsed Illich's 'description of the doctor's attitude to his patient as one of infantilization'. Kennedy also shared Illich's scepticism towards the current state of medical ethics, believing that groups such as the SSME and the LMG were 'inward looking' and did little to challenge professional authority.⁴⁸ This was evident in his 1976 *Criminal Law Review* paper, where he quoted Szasz's 1961 claim that 'much of what passes for medical ethics is a set of rules

the net effect of which is the persistent infantilization and subjugation of the patient'.⁴⁹

But while he endorsed their critiques of paternalism, Kennedy distanced himself from the more radical aspects of Szasz's and Illich's work. He was clear that he did 'not necessarily endorse' Illich's sweeping denunciation of the professions and belief that 'nemesis for the masses is now the inescapable backlash of industrial progress'.⁵⁰ And in a radio talk on the Mental Health Act, Kennedy ridiculed as 'preposterous' Szasz's claim that 'there is no such thing as mental illness'.⁵¹ 'Most people', he countered, 'regard mental illness as a reality, not a myth', and there was little to be gained from believing that 'psychiatrists act as agents of a malevolent government intent on locking away or otherwise suppressing those who deviate from an accepted norm'.⁵²

Kennedy also acknowledged his debt to more moderate critics in this period, including the doctors Thomas McKeown and Muir Gray. McKeown and Gray both argued that the major causes of illness were poverty, poor public health and nutritional problems, and called for a less interventionist, technocratic approach to medicine.⁵³ In his 1979 lecture at the Middlesex Hospital, Kennedy drew on their work to claim that:

there seems little doubt that the single largest cause of illness, however defined, is poverty and what it brings in its wake ... Yet we continue to ride the same tired whirligig of disease identification, exchanging one problem for a new one. And we do so, notwithstanding the fact that, by comparison with the effects produced by sanitation and clean water, medicine's advances are really rather limited.⁵⁴

In this and other talks, Kennedy used McKeown and Gray to endorse a broad 'reorientation' of medicine, arguing that doctors should focus more on 'promotion of health' rather than simply the treatment of disease.⁵⁵ This reflected his own enthusiasm for social fairness and 'the politics of welfarism'.⁵⁶ And it ultimately bolstered his calls for outside involvement in setting standards and priorities: for 'if we are to change the way medicine is thought of and practised, it is we who must take that action. It is our responsibility'.⁵⁷

Yet the greatest influence on Kennedy's changing worldview appeared to be the 'brilliant insights' of the bioethicists he encountered while teaching in America during the early 1970s.⁵⁸ In his 1976 paper on self-determination, for instance, he cited Paul Ramsey's

'outrage' at the fact that it was 'possible to deprive many a patient of a fulfilment of the wish to have a death of one's own'.⁵⁹ At the beginning of *The Patient as Person*, Ramsey stated that a patient's interests would be better served by involving outsiders in medical ethics, and this became a constant theme in Kennedy's work from 1976. Kennedy also claimed to find 'much of value' in the work of Jay Katz and his young research associate Alexander Capron, who both also endorsed outside involvement with medical decision-making.⁶⁰

Kennedy was struck by this 'seminal work on bioethics' at a time when he believed 'we were doing nothing in this country'.⁶¹ On returning from the United States, he argued that Britain had 'no vehicle' for the public discussion of issues such as euthanasia, patient rights and medical decision-making. He dismissed the medical groups and the *Journal of Medical Ethics* as 'too narrow' and 'preaching only to the converted, namely the people who came to the lectures were the people you didn't need to have at the lectures, and the people who didn't come were the people you needed to reach'.⁶² This frustration was apparent in Kennedy's regular calls for external involvement from 1976 onwards. As he stated in *The Check-Out*: 'It's a deplorable fact that for far too long lawyers and others have ignored this important area [medical ethics] and left doctors alone to wrestle with its complexities'.⁶³

Seeing bioethics as the major influence on Kennedy's work also helps us determine why his calls for external involvement eventually became so influential. Like American figures such as Jay Katz, who promised not to 'indict science or stifle research', Kennedy stressed that involving outsiders would benefit medicine.⁶⁴ He spent most of his *Criminal Law Review* article, for example, assuring doctors that they would not be prosecuted for meeting a terminally ill patient's request to have their treatment discontinued. Indeed he argued, on the contrary, that meeting the growing demand for self-determination was less likely to prompt a legal challenge than the traditional approach of 'doctor knows best'.⁶⁵ And in his lecture at the Middlesex Hospital, he stressed that 'it is important at this point to make clear that I am not criticizing doctors or attacking them or purporting to sit in judgement over them'.⁶⁶ Instead, he sympathised that:

I think it is unfair that responsibility in many areas of human concern has been improperly shifted onto doctors by the rest of us, simply

because we are happy to have others bear this responsibility, and because the doctor, at least initially, seems prepared to take it on.⁶⁷

Kennedy promised that a more active role for outsiders would help doctors resolve the ‘many hard decisions which it is not really their job to make’.⁶⁸

But this conciliatory approach initially made little headway. While doctors may have encouraged interdisciplinary debates during the 1970s, they were less enthusiastic about devolving power to outsiders. In 1977 the BMA argued that outside involvement in medical decisions would damage doctor–patient relations, ‘endanger research, increase waiting-lists and threaten the health and morale of doctors’.⁶⁹ Their resistance was not lost on Kennedy, who admitted that ‘the moment I offer guidance or suggest what should be done, I am met with a chorus of cries, all variations on the theme that I do not really understand, that these are medical matters after all, that I should not trespass on the professional competence of others’.⁷⁰

But this attitude softened in the 1980s, when political changes fostered the ‘audit society’.⁷¹ Kennedy’s arguments now carried greater weight amid a political emphasis on oversight and public accountability, and senior doctors conceded that traditional forms of self-regulation might be untenable. He consequently became central to a growing form of public debate and regulation, which newspapers and the medical press joined him in labelling ‘*bioethics*’.

‘Who’s for bioethics?’ The Reith Lectures, the Conservatives and the 1980s⁷²

Following Kennedy’s radio lectures, which gained him a reputation as a skilled broadcaster, the BBC’s director-general invited him to give the prestigious Reith Lectures on Radio Four.⁷³ The Reith Lectures were established in 1948 to honour Sir John Reith, the BBC’s first director-general. They are delivered annually by public intellectuals, and speakers before Kennedy had included Bertrand Russell, the biologist John Z. Young and the anthropologist Edmund Leach.⁷⁴ When Kennedy was approached in spring 1979, the lecture themes were the only piece of programme content that the BBC board of directors had the power to select. After requesting

several options from Kennedy, they chose a broad analysis of the state of modern medicine.⁷⁵

The BBC officially announced Kennedy was its thirty-second Reith Lecturer in December 1979. The major focus of newspaper profiles in the build-up to his lectures was that he was talking on a subject which, the *Observer* stated, ‘the great panjandrums of the medical profession like to reserve for themselves’.⁷⁶ Journalists also detailed how a major premise of the lectures was that ‘the community should take back some of the control which it has ceded to the medics’, with ‘lawyers looking over doctor’s shoulders ... and a vigilant public endorsing their large decisions’.⁷⁷ The *Guardian* notably described this outside perspective as ‘*bio-ethics*’, which was a term that British newspapers had traditionally joined the *British Medical Journal* in attributing to ‘Americans, with their unfortunate gift for inventing new specialisms’.⁷⁸

Kennedy’s Reith Lectures, entitled *Unmasking Medicine*, consisted of six thirty-minute talks that were broadcast during November and December 1980. Each lecture discussed aspects of his work since 1976. Kennedy began the first lecture by stating that when it came to issues such as the definition of death, the treatment of the mentally ill and care of disabled babies, ‘medicine is in the hands of experts and sets its own path’.⁷⁹ He claimed that doctors had attained this power by portraying definitions of health and illness as ‘terms of scientific exactitude’.⁸⁰ Kennedy then drew on Illich and Foucault to contend that ‘the normal state against which to measure abnormality is a product of social and cultural values and expectations. It is not some static, objectively identifiable fact’.⁸¹ He continued that in medicine generally, and psychiatry especially, there was in fact a ‘relationship between calling someone ill and making a moral judgement about him’.⁸² ‘If illness is a judgement’, he argued, ‘the practice of medicine can be understood in terms of power. He who makes the judgements wields the power’.⁸³

Drawing on McKeown and Gray, Kennedy then discussed broader determinants of health and disease and claimed that ‘Very many of the people to whom we are readily prepared to ascribe the status “ill” find themselves ill because they are poor, grow up in bad housing, eat poor food, work, if at all, in depressing jobs, and generally exist on the margin of survival’.⁸⁴ This led Kennedy to the broad conclusion that permeated all his Reith Lectures:

As long as it is accepted that health is the exclusive preserve of doctors, something only they have competence in, then this state of affairs will continue. It is a matter of balance; the power is now with the professional. Only when it is realised that health is far too important to be left entirely to doctors, that it is a matter for all of us, will conditions be created for the necessary redirection of effort and resources. Only then will any real movement towards health be achieved.⁸⁵

In the second lecture, Kennedy revived his critiques of interventionist approaches to argue that medicine was ‘pursued in ways that do not best serve the needs of society’.⁸⁶ He claimed that this led to disproportionate investment in fields such as transplant surgery, which treated relatively few patients, while fields such as geriatric medicine and mental health were largely ignored. Kennedy concluded that this emphasis led the public to believe ‘in magic cures and the waving of magic wands’, while the reality was a ‘constant disappointment’ where ‘the promised or expected cures are not there’.⁸⁷

In lecture three, he outlined ‘a better path for the future’ and stated that ‘we must curb our predilection for medicine in the form of ever more complex technology’ and ‘direct more of our energy and resources towards the promotion of good health’.⁸⁸ The focus here was firmly on primary care and education, on preventing deaths through ‘cigarette smoking, alcohol consumption, appalling dietary habits, dangerous workplaces and roads’.⁸⁹ Kennedy concluded that ‘If GPs were more adequately prepared for the real health needs of their patients, which are as much to do with social problems as with particular diseases, then the beginnings of a better movement towards health could emerge’.⁹⁰

While his first three lectures drew mainly on Illich, McKeown and Gray, Kennedy’s fourth lecture owed a large debt to American bioethics. Here, he echoed Paul Ramsey’s claim that ‘medical ethics are not separate from but part of the general moral and ethical order by which we live’. Drawing on Jay Katz, he also called for ‘a wholesale re-examination of the sphere of alleged competence of the doctor’.⁹¹ Kennedy claimed that in choosing whether or not to treat severely disabled babies, doctors currently ‘decide on the basis of some rough-and-ready calculus of the future quality of life’.⁹² And this, he argued, led to uneven outcomes, ‘where in figurative terms, the baby in Barnsley lives, the baby in Bradford dies’.⁹³

Kennedy then pointed out that deciding issues such as quality

of life was in fact ‘profoundly difficult’, involving not only medical but also legal, economic, philosophical and social considerations.⁹⁴ He claimed to find it striking that ‘despite their significance they are not widely discussed. They are resolved in the consulting room and debated, if at all, in the medical journals.’⁹⁵ As before, he insisted that the solution lay in ensuring ‘that doctors conform to standards set down by all of us’.⁹⁶ This, he continued, would foster ‘regularity if not uniformity in the decisions arrived at but also some conformity between these decisions and those which the rest of us might take’.⁹⁷ Although he ventured no firm plan of how this might be achieved, Kennedy stated that a vital first step was ensuring that ‘doctors have some educational grounding in ethical analysis’. And in a now familiar swipe at paternalism, he stressed that this ‘must be taught not be some superannuated elder statesman nor by the latest medical star in the firmament, but by an outsider, someone who is not deafened by the rhetoric of medicine’.⁹⁸

After a fifth lecture in which he discussed the categorisation of mental illness and questioned the appropriate norm for mental health, Kennedy again endorsed outside involvement in the sixth and final lecture.⁹⁹ He argued that viewing patients as consumers rather than passive recipients of healthcare gave them greater ‘power to participate responsibly in decisions made about [their] life’.¹⁰⁰ Kennedy spent much of the lecture dismissing the suggestion that the best route to consumerism in Britain was an increase in private litigation. He argued that litigation was more justifiable in the United States because patients paid for their own healthcare through private insurance schemes and ‘if someone suffers harm unexpectedly, he needs money to pay for additional medical care or to meet other costs’.¹⁰¹ In Britain, by contrast, he claimed that there was ‘less need for this form of consumerist litigation’ thanks to ‘a social welfare system and free health care ... which can serve as the basic source of funds for patients who complain of harm’.¹⁰² Kennedy believed that litigation consequently had a ‘more limited’ role in Britain, with patients only being justified in suing doctors if they were detained without consent or treated without full disclosure of potential risks.

Kennedy nevertheless believed that this small number of cases might, if successful, ‘ensure that standards of practice were established which met the approval of outsiders’.¹⁰³ But he also noted that British courts ‘tend toward conservatism’ and would be

‘reluctant to break new ground’ by departing from the *Bolam* ruling and judging medical conduct themselves.¹⁰⁴ He proposed that consumerism in Britain should therefore ‘take another tack’. This involved the establishment of a supervisory ‘board or committee’ charged with ‘establishing standards which doctors must meet in their practice, measuring the doctor’s performance in the light of these standards, and creating means of redress for the patient and sanctions against the doctor if these standards are breached’.¹⁰⁵

Kennedy was keen to distance his proposed body from ‘paternalistic’ organisations such as the GMC. ‘Standards will have to be set and measured by others’, he argued, and ‘the principle of outside scrutiny, a key feature of consumerism, seems inevitable.’¹⁰⁶ He closed the Reith Lectures by proposing that the impetus for this ‘separate method of supervision’ would ‘have to come from the consumer, and the consumer will have to be prominently represented on any Board or Committee which is set up’.¹⁰⁷

Transcripts of the Reith Lectures appeared weekly in the BBC’s *Listener* magazine, and all six were published as a book by Allen and Unwin in May 1981. As Kennedy wrote in a preface, the book provided ‘the opportunity to put a bit more flesh on the bones of my arguments’ and contained an additional chapter on the definition of death. It also included a detailed bibliography ‘to show how wide is the range of materials which someone entering into this area of study needs to cover’.¹⁰⁸ This included books by Illich, McKeown and Szasz, by bioethicists such as Ramsey and Katz, and by practically minded philosophers such as Mary Warnock and Peter Singer. Kennedy then defined precisely what this ‘area of study’ entailed and firmly aligned his Reith Lectures with the approach he encountered in the United States. ‘Fundamentally’, he stated, ‘it is the study of the practice of medicine today.’ But this, critically, was ‘not a field in which it is necessary to be trained in medicine. *Indeed, it could be said that only someone who is free from any claims which medical professional loyalty may make on his objectivity who can successfully examine the institution of medicine.*’¹⁰⁹ Kennedy outlined how this approach involved ‘ethics and law, together with sprinklings of philosophy, sociology and politics ... as they relate to medicine’. While he admitted that there was no ‘single label for it’ in Britain, he noted that ‘In the United States the area goes by the name of “Bioethics”’.¹¹⁰

In the book chapter based on his sixth Reith lecture, Kennedy

argued that support for outside involvement was growing and that paternalistic attitudes were ‘clearly out of line with the political tenor of the day’. ‘Consumerism is with us’, he stated, and ‘the doctor has the choices only of accepting it willingly and co-operating, or of accepting it unwillingly.’¹¹¹ But Kennedy had to rely mainly on American examples to support this claim, including the ‘series of ethics committees’ that included a majority of non-doctors. ‘We have much to learn’, he concluded, ‘from how this aspect of consumerism has developed in the United States.’¹¹² When it came to Britain, Kennedy cited the presence of lay members on GMAG as ‘a good example of the sort of arrangement I envisage’.¹¹³ But GMAG was not really comparable to the American committees that Kennedy praised. Scientists remained in the majority and were viewed as its ‘backbone’ by civil servants, while lay members lacked influence.

But this situation was to change during the 1980s, thanks to the election of a government that shared Kennedy’s enthusiasm for outside involvement and ‘empowered consumers’. Kennedy’s call for the public to ‘take back control of medicine’ dovetailed with a central ideology of Margaret Thatcher’s Conservative Party, which won the 1979 general election. While they lauded private enterprise, the Prime Minister and politicians on the right of the Conservatives, such as Keith Joseph and Nicholas Ridley, regarded state-supported and self-regulating professions as complacent, wasteful and unresponsive to the market forces they saw as vital to regenerating the economy.¹¹⁴ Seeking a coherent strategy for revitalising Britain, they drew on neo-liberal theorists such as Milton Friedman and William Niskanen, who believed that welfare states had allowed professions to become overly bureaucratic and self-serving, and argued that the solution lay in remodelling them on market lines.¹¹⁵

The influence of this neo-liberal worldview was apparent in a 1980 speech by Nigel Lawson, who encouraged privatisation of the public sector during his time as Treasury Secretary, Secretary of State for Energy and Chancellor of the Exchequer. Lawson declared that the new government would ‘break from the predominantly social democratic assumptions that have underlain policy in postwar Britain’ by exposing many professions and public services to ‘the disciplines of the market’.¹¹⁶ As the 1980s progressed it became clear that this involved promoting outside scrutiny and involvement as a means of devolving power from professionals to

end-users – to parents, patients, students etc. – and enabling them to make decisions that furthered their own interests.

Reflecting the Conservative commitment to ‘rolling back the frontiers of the state’, scrutiny was not to be performed directly by politicians but was entrusted to an array of consultants and agencies who acted on behalf of consumers, which Alex Mold defines as ‘consumerism by proxy’.¹¹⁷ Mold claims that when it came to medicine, ‘consumerism by proxy’ was evident in the Conservative belief that managers and fund-holding GPs were the best guardians of patients’ interests.¹¹⁸ But it also, crucially, dovetailed with Kennedy’s belief that patient empowerment was best achieved through outside scrutiny of medical practices and decisions.

Throughout the 1980s, in professions such as teaching, medicine, academia, social services and local government, reliance on professional expertise subsequently gave way to new mechanisms of external audit that were designed to enforce value-for-money, public accountability and consumer choice.¹¹⁹ Change was gradual and proceeded well into the 1990s, but Lawson’s speech demonstrates that the Conservatives voiced their intentions early on. This was not lost on the medical profession, which linked Kennedy’s Reith Lectures to this neo-liberal worldview. Writing in the *Lancet*, for example, John D. Swales, head of medicine at the University of Leicester, pointed out that ‘Kennedy’s views enjoy the enormous advantage of following the current political tide’. Swales claimed that doctors should ‘therefore look a little more closely at what he is saying rather than succumbing to dismissive comments on his style’.¹²⁰ Sir Douglas Black, the president of the Royal College of Physicians, similarly believed that ‘Kennedy’s views have to be taken seriously, both for their own sake and because they are representative of the forces that seek to effect a radical change in the focus of medicine’.¹²¹

While the psychiatrist Stephen Little criticised Kennedy for a lack of concrete proposals, he also conceded that: ‘To follow the rhetoric of the present government, the public must become more fully informed of the pressures on its medical practitioners and administrators, of the shortcomings as well as the advances.’¹²² And Michael Thomas, chair of the BMA, endorsed Kennedy’s call for a diverse committee that acted as proxy for patients and the public, as part of ‘a situation where all doctors are willing to accept that the public has a right to take part in the decisions on major moral and

ethical issues'. Such changes were needed, Thomas stated, because 'the era which required paternalism is past'.¹²³

This complicates the 'origin myth' that bioethics was opposed by a recalcitrant medical profession. While some doctors dismissed Kennedy's lectures as 'doctor bashing', many senior figures saw the benefits, or inevitability, of external involvement with medicine.¹²⁴ These views were compounded between 1981 and 1984, when growing numbers of politicians and public figures echoed Kennedy's calls for external oversight and patient empowerment. In 1981 Margaret Thatcher appointed Norman Fowler as Secretary of State for Health and Social Services. Fowler explicitly viewed patients and the public as 'consumers', and believed that non-doctors should play a major role in designing policies that rendered medicine more transparent, competitive and publicly accountable.¹²⁵

As the next chapter shows, this was evident when senior figures at the Department of Health and Social Security (DHSS) prioritised the appointment of an 'outside chair' to a public inquiry into IVF and embryo research in 1982. It was also clear in the 1983 decision to select the businessman Sir Roy Griffiths as chair of an inquiry into NHS management. Reflecting the government's enthusiasm for market-oriented reform, the other inquiry members were executives from British Telecom, United Biscuits and Television South West. Their report echoed Fowler's desire for consumer influence when it claimed that: 'Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question'.¹²⁶ In a further blow to paternalism, Griffiths's inquiry suggested that the NHS would be better run by general managers recruited from outside the medical profession.¹²⁷

Further support for external involvement also came from public figures such as Mary Warnock, following her selection as chair of the government's IVF inquiry, and the Australian-born lawyer Geoffrey Robertson, who used a 1982 *Observer* column to claim that 'interdisciplinary co-operation and insistence on public participation' were vital to solving 'the present, not to mention the future, dilemmas of bio-ethics'.¹²⁸ Robertson argued it was no longer adequate for lawyers to 'wash their hands and leave decisions in the sterilized gloves of the medical profession'.¹²⁹ 'Workable and acceptable' rules for medicine, he stated, 'should not be developed

behind a closed door marked “Medical Ethics – laymen and lawyers keep out”.¹³⁰

Many speakers at a 1984 GMC conference on ‘Teaching Medical Ethics’ also endorsed outside involvement with medicine. The sociologist Margaret Stacey, for example, criticised ‘the “closed system” in which the medical profession works wherein the greater part of social as well as professional time is spent with other members of the profession’.¹³¹ Stacey argued that making decisions on a patient’s behalf, without consulting other professionals or the patient themselves, derived from an outdated ‘model of the [doctor–patient] relationship where the doctor is seen as active and the patient passive, as opposed to one of mutual activity, a partnership in healing or managing disease’.¹³² She proposed that doctors should rectify this by opening their records to patients and, where applicable, the public. Stacey claimed that ‘this would be not only in the interest of the public but also of the profession’. ‘All doctors are aware how difficult such judgements are’, she continued, ‘and to make records more open would help the public share these problems too.’¹³³

At the same conference, John Habgood, the Archbishop of York, argued that ‘insights and values from another field of awareness should be fed into the practical business of decision-making’.¹³⁴ Habgood similarly presented outside involvement as beneficial to doctors, claiming that it would help them share the ‘crushing burden’ imposed by ‘decisions to make which bear directly on the lives of individuals with whom you are personally involved’.¹³⁵

Surveying this changing landscape for the *Hastings Center Report* in 1984, the doctor and philosopher Raanan Gillon argued that the 1980s marked the end of ‘medicine’s halcyon days when doctors – for the most part only senior doctors – discussed the dilemmas of medical ethics in privacy and leisure’. ‘Today’, he noted, ‘everyone in Britain seems to be muscling in.’ Gillon claimed that these changes were ‘ably abetted by the lawyer whom doctors love-hate, Professor Ian Kennedy’.¹³⁶ While Gillon conceded that he was no longer the sole advocate of oversight, he nevertheless noted that Kennedy continued to ‘vigorously stir the pot’.

Indeed, the regularity with which Kennedy continued to publicly ‘stir the pot’ led medical journals to dub him ‘the ubiquitous Ian Kennedy’.¹³⁷ In a 1981 radio documentary, he proposed the establishment of outside ‘inspectors’ that would ‘ensure proper

accountability across many professions'.¹³⁸ Writing for the *Journal of Medical Ethics* the same year, Kennedy justified this proposal on the grounds that: 'If a profession by definition exists to serve the public interest, then clearly it must ultimately be the public who judge what that interest is and whether it is being served.'¹³⁹ Kennedy's profile increased further in 1983, when he hosted the BBC television series *Doctors' Dilemmas*, in which actors presented a doctor with an ethical dilemma and their decision was scrutinised by a diverse studio panel. In a favourable review for the *British Medical Journal*, Raanan Gillon claimed the programme's message, like all Kennedy's work, was that 'doctors and medical students need far more interdisciplinary discussion and debate about medical ethics'.¹⁴⁰

Kennedy used his high profile to reassert that outside involvement would benefit doctors. In his final Reith Lecture, he promised that if his proposals were implemented, 'it wouldn't only be the patient who would gain. The doctor too would benefit, as would the practice of medicine.'¹⁴¹ He expanded on these benefits in a *Journal of Medical Ethics* article that rejected his portrayal as a 'doctor-basher'. Here, Kennedy criticised the tendency to label all non-doctors as 'laymen', which he believed rhetorically stripped them of any expertise. He argued that philosophers and lawyers were trained to analyse ethical or legal issues, and that when confronted with particular ethical dilemmas 'it may be the doctor who is the layman'.¹⁴² Kennedy claimed that external input would thus offer 'great help to doctors if only they would understand that it offers a guide to what they need to do where none existed before'.¹⁴³

In the preface to his book of the Reith Lectures, Kennedy also claimed that giving patients greater say in their treatment would 'reduce the burden of responsibility placed on doctors'. 'I am quite sure', he argued, 'that we do doctors a great disservice by shuffling off onto them a range of problems which they should not be expected to deal with.'¹⁴⁴ In an updated version of the book, published in 1983, Kennedy stressed that this would encourage 'a relationship of partners in the enterprise of health'.¹⁴⁵ The stress on 'partners' helped Kennedy frame bioethics as a collaborative endeavour, in which lawyers, philosophers, politicians and patients were 'not interfering, but trying to help'.¹⁴⁶ He concluded that giving patients greater responsibility and allowing outsiders to set standards would not impede medical practice, but would 'produce

guidelines for future conduct, tools for analysis, which will forearm the doctor'.¹⁴⁷

In the updated edition of *Unmasking Medicine* and a 1984 article for the *Criminal Law Review*, Kennedy also reassured doctors that he was not advocating outside involvement on a case-by-case basis in 'a ghastly on-site Committee'. He instead proposed that 'it is the guidelines for conduct, and the analytical tools, which will be worked out by the non-doctor, along with the doctor'.¹⁴⁸ As in his final Reith lecture, Kennedy recommended that these guidelines should be designed and issued by a 'permanent standing advisory committee' comparable to the President's Commission in the United States. In addition to drawing up codes of practice, he proposed that the committee's interdisciplinary staff would also keep 'developments in medicine under constant review, with a view to identifying and responding to ethical issues'.¹⁴⁹ And Kennedy again stressed that this committee would benefit doctors by aligning medicine with public expectations and thereby preventing 'a sense of bitterness and frustration, out of which grows further litigation'.¹⁵⁰

By the mid 1980s growing numbers of doctors appeared to agree. Speaking at the GMC conference on 'Teaching Medical Ethics', the surgeon Ronald Welbourne argued that student doctors should be taught by individuals 'drawn from all relevant disciplines', including 'clinical practice, moral philosophy, theology, law, sociology and other branches of learning'.¹⁵¹ Welbourne claimed that each of these disciplines 'is essential and none is adequate alone'.¹⁵² He also shared Kennedy's belief that outside involvement in developing guidelines would benefit 'patients and doctors' by boosting public confidence and preventing excessive 'legislation and litigation'.¹⁵³

We might expect Welbourne to have supported interdisciplinary approaches, as he served on the editorial board of the *Journal of Medical Ethics* and chaired the Institute of Medical Ethics (IME), which was the new name for the SSME. But support also came from other quarters. Although the *Lancet* was more guarded than Welbourne, identifying external involvement as 'an uneasy but necessary compromise', it nevertheless acknowledged that it had become vital to protecting the interests of 'the individual patient, those of the doctor, and those of scientific progress'.¹⁵⁴ In a review of *Doctor's Dilemmas*, it noted that if 'difficulties and decisions were aired more widely, decision-making might be more even and suspicions might be allayed'.¹⁵⁵ And in another article, entitled

‘Who’s for Bioethics Committees?’, the *Lancet* reiterated that bioethics would safeguard ‘not only patients but also doctors and the institutions in which they work’. Outside involvement, it concluded, would help doctors develop guidelines, prevent litigation and ration ‘the available and now inadequate resources of the National Health Service’.¹⁵⁶

This professional acceptance underpinned the increasing recruitment of philosophers, lawyers and other non-doctors to regulatory commissions and medical bodies during the 1980s. Thanks no doubt to his ‘ubiquitous’ profile, Ian Kennedy was especially popular. Between 1984 and 1988 he was appointed to the GMC, a parliamentary Commission on the Safety of Medicines, the government’s Expert Advisory Group on AIDS and a parliamentary review of guidelines for research on fetuses and foetal tissues.¹⁵⁷ These appointments illustrate the political and medical utility of bioethics. Recruiting individuals such as Kennedy to professional bodies helped doctors appear publicly accountable, which safeguarded them from political criticism. Their presence on public inquiries and regulatory committees, meanwhile, helped politicians challenge vested professional interests and fulfilled the neo-liberal enthusiasm for oversight.

But this does not equate to the positivist accounts of ‘moral progress’ found in participant histories.¹⁵⁸ Despite growing support for bioethics, the government only convened ‘broad-based’ inquiries to look into contentious new procedures such as IVF and gene therapy during the 1980s. Non-doctors such as Kennedy remained firmly in the minority on bodies such as the GMC and had little influence in their meetings.¹⁵⁹ As before, they also had little say in the governance of clinical treatment. This offered a notable contrast to the United States, where hospital ethics committees that included bioethicists and ‘community representatives’ had the power to consider treatment and advise on individual cases.¹⁶⁰ Despite his very public lobbying, the permanent ‘inspectorate’ that Kennedy often endorsed remained conspicuous by its absence.¹⁶¹ This led him to complain that Britain lagged behind countries with national ethics councils, and that ‘apart from the odd *ad hoc* committee, we seem happy to stumble along; so doctors, patients, nurses, and their advisers often seek in vain for guidance’.¹⁶²

But Kennedy appeared most frustrated by the fact that the courts still relied on the ‘hands-off’ philosophy embodied in the *Bolam*

ruling. This was apparent in the 1984 case *Sidaway v. Board of Governors of the Royal Bethlem Hospital*, which arose when a woman sued her doctor and his hospital for not disclosing the full risks of a pain-relieving operation that left her partially paralysed.¹⁶³ Rejecting her claim for damages, the Court of Appeal and the House of Lords both ruled that the doctor was not negligent since most responsible neurosurgeons elected not to warn patients that the operation carried a small risk of paralysis.¹⁶⁴ This verdict distinguished Britain from the United States and Canada, where courts increasingly argued that disclosure of information should be judged against what a reasonable patient would want to know. And it also led Kennedy to bemoan the fact that instead of recognising a patient's right to control their own treatment, the British courts continued to endorse 'the "right" of doctors to decide for patients'.¹⁶⁵

Indeed, they endorsed the *Bolam* ruling well into the 1990s, ruling against patients who sued their doctors for failing to disclose the failure rate of sterilisation procedures and the possible risks of contraceptive drugs, on the grounds that the doctors in question had conformed with professional norms.¹⁶⁶ If we are to read bioethics as a decisive shift in the location of biopower, then, it appears that figures such as Ian Kennedy only made inroads into regulatory committees and public debates. In the clinic and the courtroom, as before, doctors remained the arbiters of best practice.

Conclusion

This chapter has detailed why bioethics ceased to be an 'American trend' during the 1980s. Calls for outside involvement with science and medicine became increasingly influential in Britain during this period thanks to the interaction between personal, political and professional agendas. Figures such as Ian Kennedy drew on the work of American bioethicists, among others, to endorse an approach that the medical lawyer Jonathan Montgomery calls 'ethical consumerism', proposing the introduction of mechanisms that redressed paternalism and gave 'outsiders' greater say in the development of professional standards.¹⁶⁷

Kennedy claimed that this approach resulted from 'a changed attitude among the products of the welfare state towards the medical profession, whereby the doctor is expected to see his patients as partners in the enterprise of healthcare'.¹⁶⁸ Like many

‘products of the welfare state’, Kennedy was influenced by the leftist politics of the 1960s and 1970s. In addition to American bioethicists, his calls for outside involvement drew on Ivan Illich’s critique of paternalism and reiterated the civil rights belief that ‘we should respect each person’s autonomy, his power to reach his own decisions and act on them’.¹⁶⁹

This political background and his enthusiasm for the welfare state ensured that Kennedy was no fan of the Conservative government. Indeed, he often criticised its belief that many aspects of public life could be ‘regulated (if that is the right word) entirely by market forces’.¹⁷⁰ But while his demands for outside involvement and patient autonomy were influenced by a markedly different ‘sense of social justice’ to that of Margaret Thatcher’s cabinet, they nevertheless became influential thanks to the way they mapped on to the government’s neo-liberal desire for publicly accountable and ‘customer-focused’ professions.¹⁷¹ This overlap is crucial to understanding why Kennedy’s calls for outside involvement were more influential than those of earlier figures such as Maurice Pappworth. While doctors resisted these earlier proposals, they had little choice but to accept them once the Conservatives came to power and it became clear that ‘the era which required paternalism is past’.¹⁷²

This latter point highlights that the demand for oversight did not emanate solely from Kennedy or politicians. While there were disgruntled voices at the outset, doctors were certainly willing partners in the emergence of bioethics. This stemmed partly from their sensitivity to the ‘political tide’ and a desire to align medicine with the growing demand for oversight. But it also stemmed from the way in which Kennedy drew on American bioethicists and framed outside involvement as beneficial to medicine. This undermines the ‘origin myth’ that portrays bioethics as a radical critique of a conservative and reluctant medical profession. Indeed, Kennedy acknowledged this in 2007, telling the *Guardian* that politicians and doctors would have both ignored him had he been nothing more than ‘a pain in the neck’.¹⁷³

This helps us identify what bioethics is and why it became influential. As Charles Rosenberg states, bioethics is best viewed as a ‘mediating element’ between politicians, the public and health professionals.¹⁷⁴ But the form it takes varies between different locations, thanks to the specific contexts in which it emerges and the individuals who position themselves as bioethicists. In contrast to

the United States, where theologians and then philosophers dominated, Ian Kennedy's work ensured that lawyers were integral to the emergence of British bioethics.¹⁷⁵ His Reith Lectures, in particular, engendered a public debate on the law relating to medical practices and the position the courts should adopt *vis-à-vis* doctors. This gave a greater profile to lawyers who already looked at medicine, such as Margaret Brazier and Sheila MacLean, and encouraged others to do likewise. The focus of much writing in this burgeoning area of 'medical law' had more in common with work in American bioethics than traditional legal fields such as tort, family and contract law, and focused on the moral aspects of medical practices and the ethical values that underpinned patient rights.¹⁷⁶

Specific national factors also ensured that Kennedy's vision of bioethics was more limited in Britain than in the United States. Judges were reluctant to overturn the longstanding *Bolam* ruling and decide the appropriate standards for medicine, while his calls for a national ethics committee were ignored. Those lawyers interested in medical law instead exerted their greatest influence as members of *ad hoc* inquiries into new biomedical technologies, which included greater numbers of 'non-experts' from the 1980s onwards. Yet despite the central role that lawyers played in the emergence of British bioethics, and to the surprise of many, the government chose a philosopher to chair its high-profile inquiry into IVF and embryo experiments in 1982.¹⁷⁷ The next chapter demonstrates how Mary Warnock's appointment fostered a debate on the place of philosophy in bioethics and, more contentiously, on how interdisciplinary committees formulated acceptable rules for science and medicine.

Notes

- 1 Professor Sir Christopher Booth, cited in Reynolds and Tansey (eds), *Medical Ethics Education in Britain*, p. 51.
- 2 Laurence Gostin, 'Honoring Ian McColl Kennedy', *Journal of Contemporary Health Law and Policy*, Vol. 14 (1997) pp. vi–xi (p. vi).
- 3 Anon, 'Professor Loses Job But Gains Knighthood', *Times Higher Education Supplement*, 4 January 2002, p. 11.
- 4 Dame Elizabeth Ackroyd, 'Mr Kennedy and Consumerism', *Journal of Medical Ethics*, Vol. 7 (1981) pp. 180–1 (p. 180).
- 5 Power's original work was criticised for a 'top-down' approach and lack of specific case studies, but this has been rectified by recent

- studies on the history of oversight in social services, teaching and local government, while Power has also expanded and refined his thesis. See Michael Power, 'Evaluating the Audit Explosion', *Law and Policy*, Vol. 25 (2005) pp. 185–202. For professional case studies, see Duncan Campbell-Smith, *Follow the Money: The Audit Commission, Public Money and the Management of Public Services* (London: Allen Lane, 2008); Roy Lowe, *The Death of Progressive Education: How Teachers Lost Control of the Classroom* (London: Routledge, 2007); Eileen Munro, 'The Impact of Audit on Social Work Practice', LSE Research Online (2004). Available online at http://eprints.lse.ac.uk/523/1/Audit-SocialWork_05.pdf (accessed 13 February 2014).
- 6 For example, Rose, *The Politics of Life Itself*; Jasanoff, *Designs on Nature*; Evans, *Playing God*; Cooter, 'The Ethical Body'.
 - 7 Ian Kennedy, 'What is a Medical Decision?', in Ian Kennedy, *Treat Me Right: Essays in Medical Law and Ethics* (Oxford: Clarendon Press, 1988) pp. 19–31 (p. 24). This chapter is the text of the Astor Memorial lecture, which Kennedy gave at the Middlesex Hospital medical school on 3 July 1979.
 - 8 Boyd, 'The Discourses of Bioethics in the United Kingdom', p. 489.
 - 9 Gostin, 'Honoring Ian McColl Kennedy', p. x.
 - 10 Claire Donnelly, 'Inquiring Mind. The HSJ Interview: Sir Ian Kennedy', *Health Services Journal*, Vol. 113 (2003), pp. 22–3 (p. 22).
 - 11 Ibid, p. 22.
 - 12 Judt, *Ill Fares the Land*; Perkin, *The Rise of Professional Society*.
 - 13 Sir Ian Kennedy, interview with the author (Portland House, London, July 2010).
 - 14 See Glanville Williams, *The Sanctity of Life and the Criminal Law* (London: Faber and Faber, 1958). On ventilated patients as 'twilight' individuals, see Gordon Wolstenholme (ed), *Law and Ethics of Transplantation* (London: CIBA Foundation, 1968).
 - 15 Edward Shottter (ed), *Matters of Life and Death* (London: Darton, Longman & Todd, 1970); Wolstenholme (ed), *Law and Ethics of Transplantation*; Church Assembly Board for Social Responsibility, *Decisions About Life and Death* (1965).
 - 16 See Nathoo, *Hearts Exposed*; Margaret Lock, *Twice Dead: Organ Transplants and the Reinvention of Death* (Berkeley and London: University of California Press, 2001).
 - 17 Ian Kennedy, 'Alive or Dead? The Lawyer's View', *Current Legal Problems*, Vol. 22 (1969) pp. 102–28 (p. 103). While his article concentrated primarily on organ transplants, Kennedy also highlighted other implications of cases such as *Re Potter*. What, he wondered, were the legal rights and liabilities where X makes a gift *inter vivos* and then six years and eleven months later becomes irreversibly

- unconscious after suffering extensive brain injury, but is 'kept alive' on a ventilator for another month to avoid estate duty? Kennedy recounted that 'more than one hospital physician' assured him that 'this practice is not unknown'. Ibid, pp. 110–11
- 18 Ibid, pp. 108, 106.
 - 19 Ibid, p. 106.
 - 20 Ibid, p. 109.
 - 21 Ibid, pp. 111, 115.
 - 22 Ibid, pp. 115, 113.
 - 23 Ibid, pp. 116, 124–5.
 - 24 Ibid, p. 125. Emphasis in original.
 - 25 Ibid, p. 126.
 - 26 Ibid, pp. 116, 126.
 - 27 Ian Kennedy, 'The Legal Definition of Death', *Medico-Legal Journal*, Vol. 99 (1972) pp. 36–41 (p. 38). For more background on the Harvard committee's report and the history of the 'brain-death' concept, see Lock, *Twice Dead*, pp. 89–91, 111–12; Rothman, *Strangers at the Bedside*, pp. 160–5. See also Ad Hoc Committee of Harvard Medical School, 'A Definition of Irreversible Coma', in Peter Singer and Helga Kuhse (eds), *Bioethics: An Anthology* (London: Blackwell Publishers, 1999) pp. 287–92.
 - 28 Kennedy 'Legal Definition of Death', p. 41.
 - 29 Ibid.
 - 30 Ibid, pp. 39, 40.
 - 31 Lord Kilbrandon, 'Chairman's Closing Remarks', in Wolstenholme (ed) *Law and Ethics of Transplantation*, pp. 212–16 (p. 213).
 - 32 David Daube, 'Transplantation: Acceptability of Procedures and the Required Legal Sanctions', in Wolstenholme (ed), *Law and Ethics of Transplantation*, pp. 188–201 (p. 190).
 - 33 Ibid, p. 189.
 - 34 Ibid, p. 196.
 - 35 Ian Kennedy, 'The Legal Effect of Requests by the Terminally Ill and Aged not to Receive Further Treatment from Doctors', *Criminal Law Review* (1976) pp. 217–32 (p. 219). Emphasis in original.
 - 36 Ibid, p. 229.
 - 37 Ibid, pp. 231, 217.
 - 38 Ian Kennedy, 'The Karen Quinlan Case: Problems and Proposals', *Journal of Medical Ethics*, Vol. 2 (1976) pp. 3–7 (p. 3).
 - 39 Ibid, p. 3. Following a successful appeal, doctors removed Karen Quinlan from the ventilator in March 1976; but she continued to breathe unaided until her death from pneumonia in 1985. For more on the Quinlan case, see Stevens, *Bioethics in America*, pp. 109–49; Rothman, *Strangers at the Bedside*, pp. 222–46.

- 40 Kennedy, 'The Karen Quinlan Case', p. 7.
- 41 Ibid, p. 3.
- 42 Ibid.
- 43 Ibid, p. 4.
- 44 Kennedy, interview with the author (2010).
- 45 Ian Kennedy, 'The Check Out: A Humane Death', in Kennedy, *Treat Me Right*, pp. 300–14. This chapter was based on a BBC radio talk originally broadcast in August 1977.
- 46 Anon, 'Medicine and the Media', *British Medical Journal*, Vol. 2, issue 6148 (11 November 1978) p. 1361.
- 47 Ian Kennedy, 'What is a Medical Decision?'
- 48 Ian Kennedy, quoted in Reynolds and Tansey (eds), *Medical Ethics Education in Britain*, p. 46.
- 49 Kennedy, 'The Legal Effects of Requests by the Terminally Ill', p. 219, n 4. See also Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (London: Paladin, 1972).
- 50 Kennedy, 'What is a Medical Decision?', p. 23. See also Illich, *Medical Nemesis*, p. 154.
- 51 Ian Kennedy, 'The Mental Health Act: A Model Response that Failed', *World Medicine*, Vol. 37 (1978) pp. 37–8, 75–6, 81–2 (pp. 37, 75). This article was based on a BBC radio talk broadcast in February 1978.
- 52 Ibid, pp. 37, 75.
- 53 Kennedy, interview with the author (2010); Kennedy, 'What is a Medical Decision?', p. 22. See also J. A. Muir Gray, *Man Against Disease: Preventive Medicine* (Oxford: Oxford University Press, 1979); Thomas McKeown, *The Role of Medicine: Dream, Mirage or Nemesis?* (Oxford: Blackwell, 1979). For an overview of McKeown's work and influence, see Bill Bynum, 'The McKeown Thesis', *Lancet*, Vol. 371 (2008) pp. 644–5.
- 54 Kennedy, 'What is a Medical Decision?', p. 22.
- 55 Ian Kennedy, 'Tinkering with or Retooling the NHS is Not What is Needed', *Listener*, 20 November 1980, pp. 677–9. See also Kennedy in Reynolds and Tansey (eds), *Medical Ethics Education in Britain*, p. 48.
- 56 Kennedy, interview with the author (2010).
- 57 Kennedy 'Tinkering with or Retooling the NHS', p. 679.
- 58 Kennedy, 'What is a Medical Decision?', p. 27.
- 59 Kennedy, 'The Legal Effect of Requests by the Terminally Ill', p. 220. See also Ramsey, *The Patient as Person*, p. 116.
- 60 Kennedy, interview with the author (2010).
- 61 Ibid.
- 62 Ibid.

- 63 Kennedy, 'The Check-Out', p. 313.
- 64 Katz, *Experimentation with Human Beings*, p. 5.
- 65 Kennedy, 'The Effect of Requests by the Terminally Ill', p. 226.
- 66 Kennedy, 'What is a Medical Decision?', p. 23.
- 67 Ibid, pp. 23–4.
- 68 Ibid, p. 24.
- 69 Anon, 'Complaints by Patients', *Lancet*, Vol. 310 (1977) p. 1238.
- 70 Kennedy, 'What is a Medical Decision?', p. 24.
- 71 Power, *The Audit Society*. See also Marilyn Strathern (ed), *Audit Cultures: Anthropological Studies in Accountability, Ethics and the Academy* (London: Routledge, 2000).
- 72 Anon, 'Who's for Bioethics Committees?', *Lancet*, Vol. 327 (1986) p. 1016.
- 73 In 1978 the BBC entered *The Check-Out* as its documentary entry for the prestigious Italia Prize.
- 74 Nathoo, *Hearts Exposed*, p. 214, n.16. The BBC has archived recordings and transcripts of all the Reith Lectures, which are available online at <http://www.bbc.co.uk/radio4/features/the-reith-lectures/archive/> (accessed 13 February 2014).
- 75 Reynolds and Tansey (eds), *Medical Ethics Education in Britain*, p. 47.
- 76 Nigel Hawkes, 'Tough-Talking Lawyer who Wants to Cure the Ills of Medicine', *Observer*, 2 November 1980, p. 5.
- 77 John Cunningham, 'Ritual of the Medicine Man', *Guardian*, 3 November 1980, p. 11.
- 78 Paul Keel, 'The BBC's Quest, in the Name of Reith', *Guardian*, 15 December 1979, p. 17. On press portrayals of 'bioethics' as an American approach, see Nigel Hawkes, 'The Making of Baby Brown', *Observer*, 30 July 1978, p. 9.
- 79 Ian Kennedy, 'We Must Become the Masters of Medicine, Not Its Servants', *Listener*, 6 November 1980, pp. 600–4 (p. 600).
- 80 Ibid, p. 600.
- 81 Ibid. There are traces here of Foucault's mentor, Georges Canguilhem, although Kennedy did not acknowledge him as he did Illich and Foucault. See Georges Canguilhem, *The Normal and the Pathological* (New York: Zone Books, 1991).
- 82 Ibid. Kennedy here discussed the controversy surrounding the American Psychiatric Association's definition of homosexuality as a mental illness, which was overturned during the 1970s following protests by campaign groups.
- 83 Ibid, p. 601.
- 84 Ibid, p. 602.
- 85 Ibid, p. 603.

- 86 Ian Kennedy, 'Now, More than Ever, Wealthier Means Healthier', *Listener*, 13 November 1980, pp. 641–4 (p. 641).
- 87 Ibid, p. 643.
- 88 Ian Kennedy, 'Tinkering with or Retooling the NHS', p. 677.
- 89 Kennedy, 'Now, More than Ever, Wealthier Means Healthier', p. 677.
- 90 Ibid.
- 91 Ian Kennedy, 'Medical Ethics are not Separate from but Part of Other Ethics', *Listener*, 27 November 1980, pp. 713–15 (p. 713).
- 92 Ibid, p. 713.
- 93 Ibid, p. 713.
- 94 Ibid, pp. 714, 715.
- 95 Ibid, p. 715.
- 96 Ibid, p. 713.
- 97 Ibid, p. 715.
- 98 Ibid.
- 99 Ian Kennedy, 'Great Caution Must be Exercised in Visiting the Status of Mentally Ill on Anyone', *Listener*, 4 December 1980, pp. 745–8. This lecture essentially repeated claims made in the first three Reith Lectures, with Kennedy claiming that diagnosing mental illness was a 'moral, social and political' enterprise, and calling for a shift away from pharmaceutical intervention to tackling the economic and social causes of mental illness.
- 100 Ian Kennedy, 'Consumerism in the Doctor–Patient Relationship', *Listener*, 11 December 1980, pp. 777–80 (p. 777).
- 101 Ibid, p. 778.
- 102 Ibid.
- 103 Ibid, pp. 778–9.
- 104 Ibid, p. 780.
- 105 Ibid, pp. 780, 777.
- 106 Ibid, p. 777.
- 107 Ibid, p. 780.
- 108 Ian Kennedy, *Unmasking Medicine* (London: Allen and Unwin, 1981) p. vii.
- 109 Ibid, p. vii. Emphasis added.
- 110 While he may have approved of the approach, Kennedy admitted that he never found the term bioethics 'terribly appealing'. See Ibid, p. vii.
- 111 Ibid, p. 128.
- 112 Ibid, pp. 122–3.
- 113 Ibid, p. 122.
- 114 On Conservative distrust of public services and state-supported professions, see Eric J. Evans, *Thatcher and Thatcherism* (London: Routledge, 2004) pp. 65–78; Dennis Kavanagh, *Thatcherism and British Politics: The End of Consensus?* (Oxford: Oxford University

- Press, 1989) pp. 85–7; Perkin, *The Rise of Professional Society*, pp. 472–80. On distrust of medicine in particular, see Stephen Harrison and Waqar I. U. Ahmad, ‘Medical Autonomy and the State 1975 to 2025’, *Sociology*, Vol. 34, no. 1 (2000) pp. 129–46.
- 115 William Niskanen, *Bureaucracy: Servant or Master?* (London: Institute for Economic Affairs, 1973). Conservative enthusiasm for this neo-liberal view was evident in Nicholas Ridley’s glowing foreword to Niskanen’s book. I am grateful to Raymond Plant for pointing me towards Niskanen’s work.
- 116 Nigel Lawson, *The New Conservatism* (London: Centre for Policy Studies, 1980) pp. 6–7. Several writers stress that the various tactics and policies enacted by Thatcher’s Conservative government were not a pre-formed ideology or political philosophy. What commonly became known as ‘Thatcherism’ was instead a mixture of different ideas, applied in order to think about and act upon specific problems in a rather *ad hoc* way. As Rose details, however, the neo-liberal rationalism of the Chicago School nevertheless came to provide a way of linking up these various tactics so that ‘they appeared to partake in a coherent logic’. See Nikolas Rose, *Powers of Freedom: Reframing Political Thought* (Cambridge: Cambridge University Press, 1999) p. 27. See also Evans, *Thatcher and Thatcherism*.
- 117 Lawson, *The New Conservatism*, p. 5. On the neo-liberal belief that external audit ensured competitiveness, transparency and public accountability, see Power, *The Audit Society*; Rose, *Powers of Freedom*; Rose, ‘Government, Authority and Expertise in Advanced Liberalism’, pp. 283–99. On ‘consumerism by proxy’, see Mold, ‘Patient Groups and the Construction of the Patient-Consumer’, pp. 512–15.
- 118 Mold, ‘Patient Groups and the Construction of the Patient-Consumer’. See also Alex Mold, ‘Making the Patient-Consumer in Margaret Thatcher’s Britain’, *Historical Journal*, Vol. 54, no. 9 (2011) pp. 509–28.
- 119 I have written elsewhere on how the Conservative distrust of the professions led British universities to make fields such as biology more competitive and managerial during the 1980s. See Duncan Wilson and Gaël Lancelot, ‘Making Way for Molecular Biology: Institutionalizing and Managing Reform of Biological Science in a UK University during the 1980s and 1990s’, *Studies in the History and Philosophy of the Biological and Biomedical Sciences*, Vol. 39 (2008) pp. 93–108.
- 120 J. D. Swales, ‘Thoughts on the Reith Lectures’, *Lancet*, Vol. 316 (1980) pp. 1348–50 (p. 1348).
- 121 Black, ‘Both Sides of a Public Face’, p. 2044.
- 122 Stephen Little, ‘Consumerism in the Doctor–Patient Relationship’, *Journal of Medical Ethics*, Vol. 7 (1981) pp. 187–90 (p. 190).

- 123 Michael Thomas, 'Should the Public Decide?', *Journal of Medical Ethics*, Vol. 7 (1981) pp. 182–3 (p. 182).
- 124 Boyd, 'The Discourses of Medical Ethics in the United Kingdom', p. 489.
- 125 Norman Fowler, *Ministers Decide: A Memoir of the Thatcher Years* (London: Chapmans, 1991) p. 197.
- 126 Roy Griffiths (chair), *NHS Management Inquiry* (London: Department of Health and Social Security, 1983) p. 2.
- 127 For more background, see Klein, *The New Politics of the NHS*, pp. 117–23.
- 128 Geoffrey Robertson, 'The Law and Test Tube Babies', *Observer*, 7 February 1982, p. 8.
- 129 Ibid.
- 130 Ibid.
- 131 Margaret Stacey, 'The View of a Social Scientist', in 'Report of a Conference on the Teaching of Medical Ethics, held on Thursday 16 February 1984' (General Medical Council) pp. 10–15. File held at National Archives FD7/3268. A revised version of this talk was reprinted as Margaret Stacey, 'Medical Ethics and Medical Practice: A Social Science View', *Journal of Medical Ethics*, Vol. 11 (1985) pp. 14–18.
- 132 Stacey, 'The View of a Social Scientist', p. 12.
- 133 Ibid, p. 12.
- 134 The Most Revd and Rt Hon. J. S. Habgood, Archbishop of York, 'The View of a Theologian', in 'Report of a Conference on the Teaching of Medical Ethics, held on Thursday 16 February 1984' (General Medical Council) pp. 8–10 (p. 8). National Archives FD7/3268. This talk was reprinted as J. S. Habgood, 'Medical Ethics – A Christian View', *Journal of Medical Ethics*, Vol. 11 (1985) pp. 12–13.
- 135 Habgood, 'The View of a Theologian', p. 10.
- 136 Raanan Gillon, 'Britain: The Public Gets Involved', *Hastings Center Report*, Vol. 14 (December 1984) pp. 16–17 (p. 16).
- 137 Anon, 'Research Ethics Committees', *Lancet*, Vol. 321 (1983) p. 1026.
- 138 Ian Kennedy, 'Response to the Critics', *Journal of Medical Ethics*, Vol. 7 (1981) pp. 202–11 (p. 206).
- 139 Ibid, p. 206.
- 140 Raanan Gillon, 'Medicine and the Media', *British Medical Journal*, Vol. 286 (1983) p. 715.
- 141 Kennedy, 'Consumerism in the Doctor–Patient Relationship', p. 777.
- 142 Kennedy, 'Response to the Critics', p. 207.
- 143 Ibid, p. 204.
- 144 Kennedy, *Unmasking Medicine*, p. ix.
- 145 Ian Kennedy, *The Unmasking of Medicine* (London: Paladin Press,

- rev. and updated edn, 1983) p. 124. Nikolas Rose has described how seeing individuals as empowered ‘partners’ in a relationship with professionals and service providers entails a distinctly neo-liberal conception of the human actor as ‘an entrepreneur of his or her self’, who is ‘active in making choices in order to further their own interests’. In this view, it is the individual rather than the state who is answerable for their own health, security, productivity, etc. See Rose, *Powers of Freedom*, p. 142. Emphasis in original. See also Foucault, *The Birth of Biopolitics*, pp. 225–6.
- 146 Kennedy, *The Unmasking of Medicine*, p. 115.
- 147 Ibid, p. 118.
- 148 Ibid p. 119.
- 149 Ibid, p. 129.
- 150 Ian Kennedy, ‘The Patient on the Clapham Omnibus’, *Modern Law Review*, Vol. 47, no. 4 (1984) pp. 454–71 (p. 468).
- 151 R. B. Welbourne, ‘The View of an Editor of *The Journal of Medical Ethics*’, in ‘Report of a Conference on the Teaching of Medical Ethics, held on Thursday 16 February 1984’ (General Medical Council) pp. 18–20 (p. 20). National Archives FD7/3268. This talk was reprinted as R. B. Welbourne, ‘A Model for Teaching Medical Ethics’, *Journal of Medical Ethics*, Vol. 11 (1985) pp. 29–31.
- 152 Welbourne, ‘A Model for Teaching Medical Ethics’, p. 29.
- 153 Ibid.
- 154 Anon, ‘Research Ethics Committees’, p. 1026.
- 155 Ibid.
- 156 Anon, ‘Who’s for Bioethics Committees?’, p. 1016.
- 157 Kennedy, interview with the author (2010). A full list of Kennedy’s appointments can be found in his *Who’s Who* entry. See *Who’s Who and Who Was Who* (Oxford University Press, 2010), <http://www.ukwhoswho.com> (accessed 13 February 2014).
- 158 Cooter, ‘The Ethical Body’, p. 435.
- 159 Kennedy, interview with the author (2010).
- 160 Rothman, *Strangers at the Bedside*, pp. 255–6.
- 161 Kennedy, ‘Consumerism in the Doctor–Patient Relationship’, p. 780.
- 162 Ian Kennedy, ‘The Patient on the Clapham Omnibus: Updated and with a new Postscript’, in Kennedy, *Treat Me Right*, pp. 175–213 (p. 176).
- 163 *Sidaway v. Board of Governors of the Royal Bethlem Hospital and the Maudsley Hospital* [1984] QB 493, [1984] 1 All ER 1018. For more background to the case, see Brazier, *Medicine, Patients and the Law*, pp. 103–5.
- 164 Brazier, *Medicine, Patients and the Law*, p. 104.
- 165 Kennedy, ‘The Patient on the Clapham Omnibus: Updated’, p. 210.

- 166 The first case was *Gold v. Haringey Health Authority* [1987] 2 All ER 888, where a woman sued her doctors when she became pregnant after a failed sterilisation operation. The second was *Blyth v. Bloomsbury Health Authority* [1993] 4 Med LR 151 CA, where a woman suffered long-term bleeding after the injection of a contraceptive drug. On the continued reliance on the *Bolam* ruling during the 1990s and beyond, see Brazier, *Medicine, Patients and the Law*; Jonathan Montgomery, 'Time for a Paradigm Shift? Medical Law in Transition', *Current Legal Problems*, Vol. 53 (2000) pp. 363–408. This attitude was questioned in 2001 by the senior judge Lord Woolf, who argued that the courts had long been excessively deferential to the medical profession and that this was beginning to change. For a discussion of Woolf's speech and an assessment of possible changes, see Jonathan Montgomery, 'Law and the Demoralisation of Medicine', *Legal Studies*, Vol. 26, no. 2 (2006) pp. 185–210.
- 167 See Montgomery, 'Time for a Paradigm Shift?'; Jonathan Montgomery, 'Medical Law in the Shadow of Hippocrates', *Medical Law Review*, Vol. 52 (1989) pp. 566–76.
- 168 Kennedy, 'Patient on the Clapham Omnibus', p. 454.
- 169 Ibid, p. 456. On how civil rights politics encouraged the postwar generation to concentrate on individual autonomy and critique professions, see Judt, *Ill Fares the Land*, pp. 86–9.
- 170 Ian Kennedy, 'Preface', in Kennedy, *Treat me Right*, pp. vii–viii (p. viii).
- 171 Kennedy, interview with the author (2010). Several writers have outlined how the civil rights belief in individual autonomy mapped on to the neo-liberal enthusiasm for 'empowered consumers'. See, for example, Mitchell Dean, *Governmentality: Power and Rule in Modern Society* (London: Sage, 2nd edn, 2010) pp. 180–2; Rose, *Powers of Freedom*, pp. 141–2.
- 172 Thomas, 'Should the Public Decide?', p. 182.
- 173 John Carvel, 'Duty Bound', *Guardian*, 17 October 2007, p. 18.
- 174 C. Rosenberg, 'Meanings, Policies and Medicine: On the Bioethical Enterprise and History', *Daedalus*, Vol. 128, no. 4 (1999) pp. 27–47 (p. 38).
- 175 Jonathan Montgomery, 'Lawyers and the Future of UK Bioethics', *Verdict – The Magazine of the Oxford Law Society* (2012). Available online at <http://eprints.soton.ac.uk/341657/> (accessed 13 February 2014); Sheila MacLean, interview with the author (University of Glasgow, July 2009).
- 176 Montgomery, 'Law and the Demoralisation of Medicine', p. 207. As Roger Brownsword notes, 'there is no older or more deeply contested jurisprudential question than how we should understand the relation-

ship between law and morality', and medical lawyers often confronted the longstanding issue of what links, if any, should exist between the law and morals. Many principal figures in the field, such as Ian Kennedy, Kenneth Mason and Alexander McCall Smith, shared Lord Chief Justice Coleridge's 1893 view that 'It would not be correct to say that every moral obligation involves a legal duty; but every legal duty is founded on a moral obligation'. See, for example, J. K. Mason and G. T. Laurie, *Law and Medical Ethics* (Oxford: Oxford University Press, 8th edn, 2011) pp. 1–26; Ian Kennedy and Andrew Grubb, *Medical Law: Text and Materials* (London: Butterworths, 1989). For further discussion of this approach, see Roger Brownsword, 'Bioethics: Bridging from Morality to Law?', in Michael Freeman (ed), *Law and Bioethics* (Oxford: Oxford University Press, 2008) pp. 12–30; Jonathan Montgomery, 'The Legitimacy of Medical Law', in Sheila MacLean (ed), *First Do No Harm: Law, Ethics and Healthcare* (Aldershot: Ashgate, 2006) pp. 1–17.

177 MacLean, interview with the author (2009).