

# Reimagining Doctrinal Orientations of English Health Care Law Scholarship Since 1980

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**Abstract:** Defining a legal field has functional importance and a legitimising usefulness for the field. There is no doubt that health care law (HCL) has emerged as a field of law and a discrete academic discipline in England and Wales with indicators that gradually became identifiable post-1980. Increasingly, patients aggrieved by their clinical experiences have sought redress in the courts. Doctors have also resorted to the courts for declarations as to the legality of proposed procedures that are ethically sensitive. The burgeoning litigation in healthcare has not only generated an avalanche of case law for academic study, but has also exposed the inadequacy of the common law in resolving the specific bioethical and legal challenges raised by healthcare. Specific legislation was enacted for the first time to address issues raised by medical advances. Concomitant with the evolution of this field of law was the emergence of its academic discipline. It entered the curriculum of legal education as many universities began to teach HCL. This eventually triggered a proliferation of textbooks and journals. The proliferation of literature was accompanied by the creation of academic research centres. Active scholarship in this field has manifested itself in four different doctrinal orientations, namely medical ethics, human rights, and multidisciplinary and socio-legal approaches.

**Keywords:** Health Care Law, Medical Law, Medical Ethics, Healthcare and Human Rights, Feminism, Socio-legal

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## 1. Introduction

The existing literature is replete with varying labels or designations for this field. Typically, one may come across terms such as ‘medical law’, ‘health care law’, ‘health law’, or ‘law and medicine’. Some of these designations may also quite rightly have ‘ethics’ attached to them. My overriding concern in this thesis is to chart the legal aspects of healthcare or medical practice within the remit of my research question. Consequently, I exclude the ‘ethics’ component from my present analysis in this section, as regards designations for the field. It is indisputable that HCL goes hand in hand with ethics and so my decision to exclude ethics from the title of this thesis should not be taken to suggest I contend that ethics is irrelevant, but rather that law is my central concern. Nevertheless, the line between ethics and law in the context of healthcare is often difficult to draw. As Jackson has aptly noted, ‘it would be artificial to draw a sharp distinction between medical law and ethics.’ [1] Ethical discourse plays a role in legal analyses in this field of the law.

The evolution of HCL as a discrete body of law has also

stimulated the development of its academic discipline. The general view on the status of HCL as a field of law does not necessarily translate into unanimity among scholars in the field regarding its subject matter and methodology. As I have pointed out, the topics treated in the pioneering textbooks increased with each successive edition and the number of pages also grew significantly. It was therefore not surprising that in 2000, Kennedy and Grubb noted that the corpus of medical law was almost unrecognisable from its form at the time of their first edition in 1989 because it had metamorphosed from being exclusively concerned with medical negligence to encompassing family law and public law cases of real legal significance. [2] The significance of these observations is that HCL has now gained a large territory, making it sufficiently mature to give birth to sub-disciplines, such as mental health law and public health law. [3] However, it is clear that delineating the subject matter of HCL and its conceptual basis is not straightforward. In this regard, I recall Cane’s observation that the boundaries of a legal subject are not set by divine prescript but by the customs of lawyers. [4] He noted that the emergence of a separate legal subject is

largely a product of the systematising activities of academic lawyers. [5] In order to understand the boundaries of the subject, I will now consider the doctrinal orientation and research approaches that explicitly or implicitly inform the works of some of the leading scholars in the field.

I submit that four different approaches concerning HCL scholarship can be discerned from the literature. These are medical ethics, human rights, and multi-disciplinary and philosophical approaches. Each of them is underpinned by a different conceptualisation of medicine.

## 2. The Medical Ethics Approach

The medical ethics approach conceptualises modern medicine as a ‘social sphere’ with competing ethical claims. [6] Accordingly, it defines HCL as the law’s interaction with medical ethics. [7] Similarly, Davies has stated that the link between medical ethics and its practical expression in law is the essence of defining medical law. [8] In 1987, Grubb underscored the medical ethics approach when he suggested that in many of the areas of HCL, it is an understanding of ethical principles which may help to map out much of the uncharted waters in the field. [9] It should be noted, however, that this may not be so uncharted today. Medical ethics ‘looks at distinct case constellations from biomedical practice and seeks to make a normative statement about how one should behave in such cases.’ [10] Thus, Hoppe and Miola note that ‘while both law and morals [ethics], are frameworks of norms of differing binding quality and pedigree, ‘ethics’ can be the process which is used to reflect what course of action is appropriate in terms of moral obligations.’ [11]

The medical ethics approach has inspired the work of many academics, including Kennedy and Grubb, [12] Morgan, [13] McLean, [14] Herring, [15] Davies, [16] Hoppe and Miola. [17] These scholars have a two-prong argument informing their methodologies or theories of HCL. First, they contend that there is a power imbalance between doctors and patients due to a multiplicity of factors, including information asymmetry and the basic vulnerability of patients. [18] Secondly, they maintain that the ethical dilemmas in healthcare, generated by medical advances, ought to be externally regulated through the instrumentality of law. [19] It needs to be emphasised that the medical ethics approach to HCL appears to take the relationship between ethics (or morality generally) and law as self-evident but that is not necessarily the case in legal theory. [20]

Medical ethics manifests in HCL in two ways: first, it operates as a regulatory framework through guidance by the General Medical Council and such non-statutory professional bodies as the British Medical Association and the Royal Colleges; second, there is ‘the overwhelming variety of opinion and debate contributed by philosophers, lawyers, sociologists and others, which seek not to regulate, but rather to discuss.’ [21] Hoppe and Miola have noted that the latter statement (‘unofficial sector of ethical discourse’) [22] is of limited utility as it does not seek to provide answers, given that it has no way of choosing between competing answers to

questions. [23] Thus, its utility in situations requiring normative statement is limited. [24] However, it may be used by judges to justify decisions that they have already come to – most notably if there is no settled law in the area or the judges wish to reshape the existing legal rules. In *Chester v Afshar*, [25] the House of Lords sought to change the law so as to prioritise patient autonomy (and thus make the decision ‘legal’ in nature). They cited a philosophical piece by Ronald Dworkin [26] to justify this.

There are many approaches to reasoning deployed in the unofficial sector concerning how to resolve complex ethical dilemmas. The popular approaches in the literature include deontology, consequentialism, principlism and feminism. A detailed exposition of these approaches is avoided here due to its adequate elaboration in the textbooks and monographs alluded to earlier in this section. For my present purpose, it suffices to briefly explain them. Consequentialism (also known as utilitarianism) [27] judges whether an action is ethically right or wrong by its outcomes or consequences. It is based upon the maximisation of the wellbeing (human welfare) or happiness of human beings. The difficulty with the consequentialist approach is how to determine what is good or predict [28] the consequences of all conceivable situations in healthcare.

A deontological theory, on the other hand, ‘holds that certain kinds of actions are good, not because of the consequences they produce, but because they are good and right in themselves.’ [29] A central tenet of deontological theory is that a person cannot justify the breach of a basic moral principle merely by referring to the consequences. The difficulty with the deontological approach is ‘how we decide what the principles are.’ This is exacerbated by the fact that we live in a diverse society and there is rarely any shared morality on all things. Indeed, as society increasingly becomes multi-faith and multi-cultural, it becomes harder to identify what constitutes a moral consensus before translating it into positive law. Another problem with this approach is that it follows a priori reasoning as it proceeds on ‘pre-existing abstract conceptual positions rather than illuminate[ing] the social practices that the law is regulating.’ [30]

Consequentialist and deontological theories may be exciting to ethicists but their relevance to finding rapid solutions to concrete ethical dilemmas in healthcare delivery are limited. In order to obviate this limitation of the medical ethics approach, Beauchamp and Childress propound a more practical approach known as principlism. [31] Principlism refers to the four principles of respect for autonomy, non-maleficence, beneficence and justice, which, according to Beauchamp and Childress represent a common morality for societies in general around the world. [32] Proponents of principlism contend that the best way to approach ethical problems is to test the problem against each of these principles so that possible options of solution will emerge. Brazier and Ost note that ‘whilst there may be congruity between liberal values and the four principles, Beauchamp and Childress’ approach is not accepted by all as illuminating the *correct* principles that inform bioethics and/or as the method by which

moral dilemmas in health care can be resolved.’ [33] There may not be a definite consensus on the ethical approach to adopt but ethical issues remain important consideration in judicial deliberations in controversial cases. Thus in *Bland*, Hoffman LJ stated:

[t]his is not an area in which any difference can be allowed to exist between what is legal and what is morally right. The decision of the court should be able to carry conviction with the ordinary person as being based not merely on legal precedent but also upon acceptable ethical values. [34]

### 3. The Human Rights Approach

The human rights approach conceptualises medicine as a ‘field of intense imbalance or disequilibrium that opens up possibilities for the abuse of patients.’ [35] For example, the doctor has the information and skill needed by the patient, but which the patient lacks. The doctor by virtue of his privileged position is able to interfere with the body of the patient. This necessitates special protection for the weak and vulnerable. Accordingly, for the proponents of this approach, the subject-matter of HCL comprises the protection of patients through the mobilisation of a shielding mechanism: human rights. [36] Although Kennedy and Grubb do not develop their human rights perspective of HCL in detail, they have declared that HCL is, essentially, ‘a sub-set of human rights law.’ [37] In a similar vein, Brazier and Cave contend that the fundamental nature of the relationship between doctors and patients amply justifies the human rights approach. [38] Their view is persuasive since human rights emerged as a more formidable mechanism for safeguarding the individual against the sweeping powers of the state than the general protection afforded under private law. [39] As seen in *Bolam*, and notwithstanding the prominence of individual autonomy in bioethics and the increased recognition of self-determination in HCL, common law still tends to give power back to the medical profession to sit in judgment over the bioethical and legal issues raised in healthcare. The human rights approach, on the other hand, would enable the court to assume direct responsibility for determining the contested bioethical and legal controversies in healthcare. The human rights prism for delimiting the subject matter of HCL enables all aspects of medical practice to be recast as the loci of potential infringement of the human rights of the patient. [40]

A different reflection on the *Human Rights Act, 1998* (HRA), which incorporated the provisions of the *European Convention on Human Rights and Fundamental Freedoms* [41] into UK law, was undertaken in 2007 by Wicks. She explores what happens when, rather than drawing on ethical principles, the familiar range of HCL issues is unpacked and repackaged from a human rights perspective. [42] In this regard, she argues in favour of the prioritisation of individual autonomy and rights as an underlying value in English HCL. [43] In some instances, Wicks demonstrates that the conceptual unity of HCL could be explained through the prism of human rights. Wicks has successfully demonstrated that ‘the end-of-life decision-making, reproduction, rights in the body, consent to

treatment and medical confidentiality are indeed topics best understood within a human rights framework.’ [44] Noteworthy in this regard is the fundamental distinction between human rights based analysis and analytical perspective of traditional medical ethics or bioethics. Human rights law has the advantage of relying on hard law to determine the norms that it considers more important than others but traditional bioethics rely simply on “structured analytical framework”. [45] For example, the Four Principles: autonomy, beneficence, non-maleficence and justice, originally devised by Beauchamp and Childress, [46] are considered by some as the standard theoretical framework from which to analyse ethical situations in medicine. A notable caveat here is the acknowledgement by Brazier and Ost that ‘principlism is not by any means the theoretical approach adopted by all bioethicists, although it is a dominant approach in the United States and the UK.’ [47].

The critical distinction between the work of Garwood-Gowers et al and Wicks is that the former sought to gauge the probable effect of the HRA on aspects of HCL, whereas the latter undertook a more fundamental enterprise of trying to translate HCL as being constituted into a complete human rights analysis. In my view, in a jurisdiction like England and Wales, where common law was employed in the service of HCL disputes long before the passing of the HRA, human rights thinking has gradually entered into HCL discourse either in the courts or academic circles. Thus, it is true to say that human rights have played a role in developing and shaping aspects of the law in the field. For example, human rights were important in the *Evans* [48] case on consent to the use of stored embryos and reliance on Article 8 in the *Purdy* [49] case, leading to the DPP’s policy on assisted suicide.

The human rights approach is, however, prone to some limitations. Traditionally, patients’ grievances were redressed through the mechanism of private law. In this regard, tort law in the form of battery and negligence is of primary significance. In contrast, an action can only be brought under the HRA against the state. However, it has been argued that the HRA ‘allows the courts a unique opportunity to improve the consistency and coherence of the common law without being unduly fettered by precedent’. [50] The courts are also public bodies, so they must act compatibly with the HRA. Some of the early rulings of the courts indicate that they would rather interpret the provisions of the HRA as being compatible with common law than allow the HRA to completely replace the former. [51]

For the human rights prism to be useful in illuminating HCL, it is submitted that rights need to be reconceptualised from the positive sense of a right to make a claim, to a negative right, so that patients can assert a right not be harmed. A negative right is a right not to be subjected to an action of another person. Thus, negative rights permit or oblige inaction on the part of a duty bearer under the Hofeldian theory of right. [52] On the other hand, a positive right imposes an active duty on the duty bearer; it permits or obliges an action. If HCL is to be ‘patient friendly’, seeking to empower patients, then patients must,

amongst other things, have a negative right in relation to safe clinical interaction. In this way, a patient can directly enforce his or her negative right not be harmed, through the HRA, rather than using the route of torts of battery and negligence.

#### 4. The Pragmatist Approach

The third doctrinal approach is the pragmatist or multi-disciplinary approach. It focuses on practical issues and avoid abstraction or general theorisation. [53] Thus, it is an evidence-based approach to the application of the discipline of law to healthcare practice for the benefit of all stakeholders. The pragmatist approach develops its 'analysis around the practices of health care rather than principles of law or ethical theory abstracted from this context.' [54] Brazier, Teff [55] and Montgomery are notable examples of scholars whose writings in this field of law manifest this approach. This approach consists in 'building analysis around the practices of healthcare, rather than principles of law or ethical theory abstracted from this context.' [56]

Contributing to the 20th Anniversary Special Issue of the *Medical Law Review* in honour of Brazier, Montgomery [57] explored her approach to the role and nature of HCL in an important academic paper she wrote on informed consent. [58] He identified four key characteristics of the multi-disciplinary approach as epitomised in Brazier's academic and public work: (1) the role of law is seen as facilitating effective healthcare as well as protecting patients' rights; (2) it is empirical as it shows an interest in the realities of clinical practice; (3) it engages in healthy cynicism about the consequences of legal intervention in medical practice, and (4) it is conscious of the need to develop tailored responses required to 'break the shackles of the traditional forms of action (negligence and battery) and also look more broadly to soft law to 'supplement the stark legal rules'. [59] In seeking to propound a solution to a problem in the field of HCL, the multi-disciplinary approach 'begins from what life is like from the patient's perspective, and is open to the contributions from a wide range of disciplines to make sense of the law's role in their experiences.' This approach always keeps in focus the notion that If the purpose of the law is, in part, to facilitate effective health care, then it is important to understand what might happen as a consequence of the legal rules being discussed. In this way, the social and institutional context of the doctor-patient relationship becomes important in analysing issues in HCL. The principal audience to be considered in evaluating the legal rules is the doctor rather than the judge, or the realities of the clinic rather than the norms of litigation in the court room. [63] For example, Brazier, in suggesting the setting up of a commission to start afresh and a study to fine tune the principles of informed consent and medical practice, advocated the establishment of norms in healthcare practice in such a way that 'would make recourse to the law largely unnecessary.'

The pragmatic approach is intrinsically appealing for two reasons. To begin with, by emphasising empiricism in developing an understanding of the relationship between law

and medicine, the approach has the capacity to produce a body of rules in HCL which substantially mirror the realities in the healthcare field. The resultant law will not appear to have been imposed from above on some kind of ad hoc basis as in judge-made law or rushed legislation. Moreover, the approach ensures that the body of rules in HCL is accessible to the intended audience, who are predominantly doctors and patients. As Montgomery notes in his tribute:

For Brazier, the law needs to be comprehensible to doctors. It is the way in which they interpret it which will make the biggest difference to patients. [65]

Indeed, in view of the importance of making HCL comprehensible to doctors, Teff, for example argues that 'it seems unlikely that the introduction of informed consent into English law would have much effect on medical practice without effective strategies to alter attitudes among practitioners.' [66]

The challenge which the pragmatist approach presents to legal scholarship is that it creates the impression that a well-grounded knowledge of the nuances of healthcare is required before legal scholars can critique the interface between law and medicine. Although this is not necessarily bad, it dislodges traditional HCL scholars from the comfort zone of black-letter or doctrinal scholarship towards socio-legal approaches, which often require multi-disciplinary efforts. Indeed, this approach envisages a broadening of the researcher's jurisprudential horizon beyond strict, positive or hard rules to embrace the regulatory efficacy of other types of regulation. In this regard, it is apposite to recall Montgomery's admonition that 'a full range of legal tools needs to be brought to bear; processes and soft law as well as strict rules.' [67]

#### 5. Socio-Legal Approaches

Socio-legal approaches consist in the use of, for example, post-modernist theories, rhetorical analysis, literary criticism and the feminist perspective to critique the legal regulation of medical practice and the organisation of healthcare delivery. In his discussion of HCL, Harrington, for example, often adopts some of the 'postmodernist postulates of consumerism and anti-utopian idealism from Harvey and Bauman' as his theoretical premise.] Similarly, Veitch often draws upon social critiques of medicine, such as those of Bauman, Foucault and Illich as the prism for his exploration of HCL themes. [69] The feminist aspect of socio-legal approaches is more pervasive in the literature and consequently warrants a nuanced elaboration here.

In order to be able to explore feminism in relation to healthcare, it is apposite to explain briefly what feminist approaches to law entail. The contention of the various feminist approaches to law, reduced to their barest core is that 'throughout history and even today, public discourse has been almost exclusively conducted by men from the perspective of men.' [55] Thus, the nature of women, their interests, lived experiences and perspectives in law and other spheres have been constructed by men from men's own perspective and interpretation of the world. To counter this state of affairs,

feminists analyse and criticise law as a patriarchal institution which subjugates women to men. [71]

It may be an overstatement to assert that the feminist critique of law significantly accelerated the *emergence* of HCL in this jurisdiction. The feminist movement extended their crusading zeal into the sphere of HCL and later medical ethics in the evolution of HCL in England and Wales (more prominently post-1990s). However, in the North Americas, the deployment of a feminist critique of medicine had been going for some time until this period. Sheldon and Thomson lament the apparent neglect of feminism in mainstream HCL, noting that:

a review of the existing medical law textbooks gives the impression that feminist perspectives have had no serious impact on this part of the legal academy. A brief perusal of how these books deal with abortion might serve to illustrate this point. Only in McHale and Fox's own book is any serious attempt made to draw upon the substantial feminist literature in this area. Mason and McCall Smith's *Medical Ethics and Law* is more typical of the norm. Their chapter on abortion is broken down into the following sections: the evolution of the law, the Abortion Act 1967, the rights of the fetus and other people's rights, abortion and the incompetent, reduction of multiple pregnancies and selective reduction. The only mention of the significance of abortion services to women is in the introduction to the chapter, where the authors note in passing that attitude to abortion depend on one's views on the fetal right to life versus the woman's right to control her own body. [49]

There are various strands of feminism as an ideological construct. [49] Consequently, the approaches of feminist critiques of HCL and ethics are not necessarily uniform. Nevertheless, it can reasonably be surmised from the literature that certain basic tenets run through the aims which the seemingly disparate feminist approaches seek to achieve in the context of HCL and ethics. In the first place, they contend that the dominant analytical frameworks of 'utilitarianism/consequentialism' and 'deontology/Kantianism' are traditionally masculine ethical models which never challenge the patriarchal context in which medicine is practised. [49] Feminist healthcare ethics criticise 'the institution of medicine for contributing to the oppression and continuing disempowerment of women.' [49] In England and Wales, the mantra of feminism in HCL discourse was manifested to a degree when HCL was still in its nascent form as a discipline and continues to shape scholarship and policy discourse in the field. For example, reflecting on the competing rights of women and fetuses, McLean remarks that:

Showing respect for the embryo/fetuses at the expense of women's rights is a monumental misunderstanding of the concept of respect and a perverse interpretation of the value of human rights. It is to the law's shame that it has in the past colluded in this to the detriment of women. [76]

It may be useful in illuminating our appreciation of the entry of feminism into HCL discourse to explore some of the sites in which feminist critique has been most persuasive.

One typical site of contestation between feminist approaches and the traditional non-feminist paradigms of HCL has been the criminalisation of abortion. The Abortion Act, 1967 and its subsequent amendments in the Human Fertilisation and Embryology Act, 1990 have attracted rigorous and scholarly illuminating critique from feminist perspectives. [55] The critical issues concern the moral status of the foetus and the right rights of the pregnant woman. Feminist commentators tend to argue that a woman's right to choose whether she intends to carry the foetus to full term is what is most important because 'it reflects the self-determination of the woman.' [56] Commenting on the debate which preceded the introduction of the Abortion Act, Sheldon decried the perceived task of the law as 'responsibilisation' which reduces to this: 'if the woman seeks to evade the consequences of her carelessness, the law should stand as a barrier.' [47] Similarly, Jackson has added that the legalisation of abortion in 1967 was not intended to enhance women's reproductive autonomy, but rather to 'enable doctors [to] act lawfully in assisting women who were driven to distraction by the prospect of yet another mouth to feed.' [49] The significance of the implications of abortion law for the disempowerment of women has made the topic of abortion assume prominence, not only in purely feminist scholarship, but even in the HCL curriculum in many law schools in England and Wales.

Another issue, which has attracted feminist critique, albeit subtle, relates to compulsory caesarean operations. [49] The agonising conundrum which once again arises here is whether the bodily integrity of a pregnant woman can be sidestepped in favour of protecting the foetus by a compulsory caesarean operation. Hewson has observed that the trend towards caesarean cases suggest that the courts were unfairly pushing women to save themselves, whereas men in comparable healthcare situations are not similarly treated. She notes that:

[T]he assumption in the most recent cases seems to be that pregnant women are not really autonomous individuals entitled to equal protection, but merely a subdivision of what courts once called infants and lunatics, incapable of making decisions for themselves, for whom doctors and courts should be surrogate decision-makers. [49]

Clearly, the patriarchy accusation made by feminists against HCL is substantiated by Hewson's foregoing remarks. Apart from abortion and forced caesarean sections, other aspects of human reproduction have also attracted the attention of the feminist movement.

Furthermore, feminist discourse has identified the privileged status of medicine over nursing and midwifery as another fertile site of patriarchy in which women are subordinated. [8] The premise of this argument is that historically, and in fact until recently, the medical profession is virtually monopolised by men. Consequently, when it comes to the working out the standard of care in negligence cases, the Bolam test facilitates the perpetuations of domination and oppression of women.

These diverse doctrinal orientations reinforce the maturation of HCL as a distinct academic discipline since

scholarship provides crucial evidence of the emergence of a field of law. There does not appear to be an immediately discernible coherence in these doctrinal approaches that could imbue HCL with a conceptual unity. But Morgan has rightly noted that HCL transcends the traditional legal requirement for a clear and settled framework because he considers HCL as ‘not just a subject but a responsibility.’[84] The responsibility which Morgan alludes to entails four elements, namely a process of naming, blaming, claiming and declaiming. Each of these elements has important philosophical dimensions which Morgan explains:

Naming - is this person ill, unwell, chronic, acute etc.; blaming - exploring the role of caring for oneself and one’s responsibilities for health care, particularly whether we are responsible for our own health, but also the State’s responsibility for provision of health care; claiming - what are our entitlements to health care, of access to services?; and declaiming - about saying who we are and who we want to become, giving a moral and symbolic emphasis to law. [10]

Clearly, these elements distribute responsibilities for various stakeholders in healthcare. Nevertheless, HCL scholars and practitioners bear the initial responsibility for developing a body of law that will fairly apportion these responsibilities. To accomplish this does not really depend upon the niceties of disciplinary categorisation in the strict sense, but being attuned to the dynamic dimension of this field of law and responding appropriately. Thus, I agree with Veitch that:

[i]f medical law has any definable feature at all, it might be thought to reside in the nature of the problems it seeks to address (problems arising from developments in medicine and biomedical science that engage questions of human values), rather than in the construction of clearly delineated legal boundaries. [86]

## 6. Conclusion

Defining a legal field has functional importance and a legitimising usefulness for the field. There is no doubt that HCL has emerged as a field of law and a discrete academic discipline in England and Wales with indicators that gradually became identifiable post-1980.

Also, concomitant with the evolution of this field of law was the emergence of its academic discipline. It entered the curriculum of legal education as many universities began to teach HCL. This eventually triggered a proliferation of textbooks and journals. The proliferation of literature was accompanied by the creation of academic research centres. Active scholarship in this field has manifested itself in four different doctrinal orientations, namely medical ethics, human rights, and multidisciplinary and socio-legal approaches. Despite the diversity in these theoretical approaches, the conceptual unity of the field lies in the commonality of the problems of healthcare practice that are addressed by HCL. The trajectory of HCL can be illuminated by an appreciation of its historical development.

That said, the ultimate validity of HCL as a discrete field depends largely on its acceptability by scholars, the legal community and, more importantly, its utility. It must empower patients and provide guidance in resolving novel challenges attendant upon ever-increasing medical advances.

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