morally to accept. What is at stake in Marxism, he says, is a fundamental critique of the moral community embodied by legal doctrine.

The trouble is that while accepting Marxism as a moral alternative, he nowhere leaves room for a coherent 'liberal' (in the sense of 'social democratic') alternative. The key to this attitude is that for Simmonds the slide into positivism and an instrumental view of law necessarily means a degeneration into formlessness and incoherence. This, to some extent, mirrors Dworkin's views on policies as opposed to principles. But the distinction cannot be made as easily as that and there have been sophisticated attempts to produce a mix of principle and policy which does not degenerate into the formlessness and incoherence that Simmonds rightly decries. Bentham, with a rather straightforward application of the principle of utility was not particularly successful. But this does not mean the task is impossible though Simmonds apparently thinks that it does.

This points to another confusion. In the last chapter he outlines two options as to where to go from here. The option of revision of legal categories he sees as a non-starter: you cannot revise the moral community, that is legal doctrine, without destroying it. He himself opts for (limited) resistance. But some of the examples that he gives here seem to imply that it is market society itself that begins the degeneration of legal doctrine and yet previously he has argued that the market economy and legal doctrine are conceptually linked. If both these points are true then legal doctrine is not pure and contains within itself the seeds of its own destruction – a Marxist doctrine indeed. I am not convinced myself that revision is viable but there have been interesting works, both in legal reasoning and theory and in the broader political economy of law, which imply that it can. These merit careful consideration as strong counter-arguments to Simmonds' thesis.

This said, I think his is an excellent book, not least because it is so clearly and succinctly written – a model for the many rambling and opaque tomes in the field. It says many interesting things about legal theory and gets to profound questions about law and society. My quibbles with it could be seen as the price Simmonds pays, as he readily admits, for keeping the book short and punchy. It is a price well worth paying. Whether one can afford almost £20 for a book of 137 pages is another matter.

ZENON BANKOWSKI

Law, Ethics and Medicine by P. D. G. SKEGG.
Oxford: Clarendon Press, 1985, xii + 255 + (tables and index) 13pp (hardback £25.00).

There are few contemporary areas of interest in the law which have such an impact on the lives of individuals as that which considers the link between law and medicine. Medical ethics and medico-legal questions are
becoming major areas of concern for doctors, lawyers, philosophers and the public in general. In recent years, scholars have displayed an increased awareness of the complex issues surrounding the practice of medicine and its subsidiary industries, an interest extending to questioning even the contemporary concept of 'health' – a concept which has been equated with 'the degree of lived freedom'.

In an age of rapidly expanding technology, what is particularly interesting is that many of the issues which remain central and problematic are relatively old questions, even although the situations in which they arise may be technically different or more sophisticated. Ethical and legal problems continue to harrass the doctor, the patient, the lawyer and the philosopher, and – perhaps surprisingly – they remain much the same questions about life and death, consent and so on. In designing this book, Professor Skegg reflects this by concentrating on issues arising from traditional areas such as abortion, transplantation and death.

This approach, whilst apparently somewhat old-fashioned, nonetheless permits of an examination of some of the most deep-seated problems confronting patients and doctors. Analysis of the legal response to these situations gives a perspective both on what the law has done, and on what it may do in the future to limit and define the freedom of doctors and the rights of patients. However, it can also have the effect of precluding some of the major issues which have no obvious or immediate practical impact on individuals or relationship to traditional concerns. In other words, whilst every one of us is concerned (at least in the abstract) with issues such as the role of medicine in different communities, the part played by big business in the health of nations, the medicalisation of social and other issues, and so on, Professor Skegg's book concentrates on the traditional questions of whether or not an abortion is legal, when is someone alive (or dead), consent, transplants and so on.

This is not to decry the value of such an approach, nor to imply that Professor Skegg's view is unhelpfully narrow. Indeed, although some parts of this book are virtually re-writes of articles already published by the author, he has an interesting, albeit very legal, view of these same matters. In reworking some of the old problems, he sheds light on many of the major issues concerning all of us, although it must be said that in parts the book reads in rather too legalistic a fashion to be easily readable for a wider audience.

The chapters dealing with consent to medical treatment are of particular interest in the light of the recent House of Lords decision in Sidaway. Here, the argument used by Skegg shows striking similarities to that used in his earlier articles, and reflects a similar perspective on the

1. Illich, I., Limits to Medicine – Medical Nemesis: The Expropriation of Health, (1977, Harmondsworth, Penguin Books).
2. See, for example, Klass, A., There's Gold in Them Thar Pills. (1975, Harmondsworth, Penguin Books).
3. See, for example, Oakley, A., 'Wisewoman and Medicine Man: Changes in the Management of Childbirth', Mitchell, J. and Oakley, A., (eds) The Rights and Wrongs of Women, (1976, Harmondsworth, Penguin Books), pp 17-58.
4. [1985] 1 All ER 643.
problems raised by this issue. Whilst he is at pains to point out that the
decision in respect of disclosure of information about therapy to a patient
is not necessarily a technical medical one, and that therefore decisions
about disclosure must be treated with caution, he nonetheless seems to
make a series of subtle assumptions about the extent of disclosure which
place considerable emphasis on the doctor’s perception about the
patient – assessments which, it could equally be argued, are not techni-
cally medical.

Moreover, in merely reporting what the courts have decided and what
the law is, Professor Skegg rather disappointingly makes no overt
criticism or challenge of these decisions or of the bases on which they
were decided, despite apparently adopting a particular moral stance. As
Skegg himself says:

‘There is nothing especially “medical” about the requirement that a
doctor must obtain a patient’s consent, and that he must sometimes
disclose information to a patient before the patient decides whether to
consent. These requirements are imposed not in the interests of the
patient’s health, but in the interests of individual liberty.”

However, in reporting uncritically the decisions taken by courts, he then
seems to minimise the ‘individual liberty’ argument. If freedom to make
choices is the central aspect of consent requirements, then why, we must
ask, is it only ‘sometimes’ that the doctor must tell the patient about the
risks and benefits of therapy? Even accepting that there are some clearly
defined situations in which the patient is overtly unable to consent – for
example, the mentally ill – Professor Skegg seems to suggest that there
are more widely drawn areas where disclosure is either not necessary or
can be limited.

However, it could well be argued that individual liberty is protected
only where full disclosure is routinely made, and that any interference
with this is an unwarranted assumption of authority over the rights of the
individual patient, who may after all prefer illness to therapy. However,
in considering treatment which is in the interest of the health of the
patient, Professor Skegg outlines five arguable situations in which the
nature and extent of disclosure can be limited. In terms of court de-
cisions, he is of course correct, but one could have wished for a more
critical appraisal of these decisions. Moreover, whilst his introduction of
the concept of individual liberty seems to set the framework for a critical
analysis of the extent to which courts have protected this by insisting on
meaningful disclosure, we find instead that his arguments seem to accept
some of the standard justifications for limiting disclosure which in fact
take considerable account of the use of the doctor’s actual or assumed
technical skills in the decision about what to tell a patient.

Thus, for example, if the patient is deemed (apparently by the doctor)
to be of limited ‘capacity to comprehend the issues involved and come to
a decision about them . . .’ then ‘the less may be the extent of the duty to

5. at p 85.
There are, it is submitted, a number of elementary flaws in merely accepting this, particularly if the consent requirements really are about the protection of the freedom of the individual. First, except in certain well-defined circumstances, the doctor may not be in a position to know about the capacity of the patient. The apparently inarticulate patient may nonetheless have the capacity to understand the implications of therapy. In any event, in the routine medical transaction, it is unclear how the doctor, who is not a psychologist or a psychiatrist, can reasonably be deemed to know what is the capacity of the patient.

Moreover, it is highly questionable whether the understanding required is intellectual, rather than practical and personal – even emotional. In other words, the patient may not understand the technicalities of therapy, but surely can understand the impact on him or herself of the risk of sickness or abdominal pain following a particular therapy. To suggest that – except again in extreme circumstances – the patient cannot understand this, and that the duty to disclose is therefore less, seems to minimise rather than enhance individual freedom. Indeed, one could equally argue that the less apparently intelligent the patient, the greater is the need for disclosure and discussion about risks in order that choices can be made.

Professor Skegg also gives further examples of the kinds of limitations of capacity which might justify restricting the level of disclosure. For example, he suggests, the current medical condition of the patient may bear on this problem. If he is talking about the profoundly mentally handicapped or the seriously mentally disturbed, then one can appreciate that the patient may genuinely be unable to assimilate information, but this does not necessarily limit the need for disclosure – rather the doctor should make adequate disclosure to those with the capacity or authority to make decisions on behalf of the patient. If however, Professor Skegg is talking about the patient’s physical rather than mental condition, then it would seem that he is adopting a stance which prefers the possibility of curing to the individual freedom not to be cured or not to accept the risk/benefit equation calculated by the doctor.

He further suggests that the ‘limited intelligence or education’ of the patient might serve as a reason or justification for limiting the amount of information to be disclosed. Again, however, we must ask to what extent the issues involved in choosing or rejecting therapy are intellectual? Would these circumstances not rather suggest that a full discussion should be had with the patient in order to ensure that he or she does in fact understand the likely risks and benefits?

Professor Skegg also suggests, without clear definition, that ‘the complexity of the issues involved’ might be used as a reason to justify limitations on disclosure. What complexities? Are these technical complexities or personal ones? If they are technical complexities, then one wonders how the withholding of information on these grounds can be squared with his earlier assertion that these are personal rather than

6. at p 88.
7. at p 88.
medical decisions. If he is referring to personal complexities then surely only the patient can know this and he or she is not in a position to know about them unless the relevant information is made known to him or her. In other words, these justifications for non-disclosure or limited disclosure reflect fundamental assumptions that the doctor is (a) in a position to know the capacity of the patient and (b) that therapy, as a good thing, takes some kind of priority over the individual liberty of those of limited intellectual capacity.

The emphasis on therapy as a good thing is reflected in another of Professor Skegg's examples of situations in which disclosure may be limited. Where the procedure is 'essential for the patient's health', the obligation to disclose 'will generally be much less than it is where the procedure in question is not essential.' In reporting this as representing the law, one need not quibble with Professor Skegg. It is clear that this is indeed the attitude adopted by the courts, but one might have hoped for some discussion of the implications of accepting this view. In support of this position, we are referred to the case of *Bolam v Friern Hospital Management Committee*, a case which has had considerable influence on the development of the law in this area and which drew heavily on Lord Denning's judgement in *Hatcher v Black*. However, these decisions have been criticised as reflecting an unacceptable level of paternalism - as an unqualified acceptance of the therapeutic imperative - and as such they seem to raise difficulties which cannot simply be ignored. In any event, who is to decide on the importance of the therapy? If the assessment of importance is to be based on cases such as these, then again it would seem that 'important' is a medical rather than a personal choice, thus minimising the individual's freedom of choice which Professor Skegg apparently views as so important.

These are but some of the limitations postulated by Professor Skegg in the light of legal decisions. However, their uncritical acceptance seems to reflect an ambivalence about the nature of the consent requirements. Indeed, no account is taken of the work of Buchanan, who effectively criticises these types of argument and renders them seriously suspect. Professor Skegg, however, seems to fall into the trap, however subconsciously, of accepting that questions about disclosure of information are appropriately and significantly influenced by medical expertise rather than as having their roots firmly placed in the individual freedom of the patient.

Moreover, he seems to confuse the extent of the duty (legal) to disclose information with the duty (moral) to respect individual liberty. The mere fact that reported decisions reflect a minimal or rationalised disclosure requirement, does not render this 'right'. If real emphasis were to

8. at p 89.
9. [1957] 1 WLR 582.
10. (1954) Times, 2 July.
11. See, for example, McLean, S.A.M., 'The Right to Consent to Medical Treatment' in Campbell, Goldberg, McLean and Mullen (eds), *Human Rights: From Rhetoric to Reality* (Oxford, Basil Blackwell, in press).
12. Buchanan, A., 'Medical Paternalism' 7 Philosophy and Public Affairs 340.
be placed on individual freedom of choice rather than on the good of medical intervention, deeper analysis of these decisions would inevitably lead to considerable criticism.

Despite these criticisms, Professor Skegg has produced an extremely well-researched book. Although one might wish for a more argumentative style, there is no doubt that he has thoroughly and thoughtfully, if a little legalistically, presented the facts. However, although the book has great merit, it occasionally leaves one wishing for less information and more analysis. The law may well say certain things about medical practice – Mrs Sidaway may well have lost her case – but the questions surrounding medicine and the attitude of the law to medical practice remain.

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