Models Essay (Medical Law)

How to write a law essay

Depending on the required work length, writing a law essay can be a long and involved process. START AS EARLY AS POSSIBLE! Many students develop their own style of attacking an essay topic. Generally however it is useful to break the essay-writing process down into the following steps:

1. Analysing your essay topic

Before you can create an effective argument, you must determine exactly what you are being asked to answer. Your lecturer would have chosen his/her words carefully when setting the essay topic so avoid making generalisations and interpreting the question to suit your interests or level of knowledge. Seek clarification from your lecturer where necessary. It is often a good idea to highlight key words in the essay question and use them to structure your essay.

2. Researching

Be thorough in your researching and try to locate as wide a variety of sources as possible i.e. books, journals, texts, internet articles. Make extensive use of the westlaw and lexis nexis databases for tracking down journal articles (see the lawskool research guide). Many law journals are available online these days and you’ll find that printing out web articles is much cheaper than photocopying from the hard-copy journals.
3. Reading/note taking

This will no doubt be the longest part of the essay-writing process. You should have a tentative essay plan in mind at this stage.

- Firstly skim through your sources and try to work out some categories for your notes.
- Now read through each source thoroughly, highlighting your printouts and tabbing your books, as you go.
- Record extensive dot-point notes for each category (either on paper or on your word processor). Write/type out direct quotes verbatim. Ensure that you record all of your references as you go (trust us, this will make your life so much easier later on).

4. Planning

You probably won’t be able to finalise a definitive essay plan until after you have teased out all of the relevant information from your sources. The following diagram provides you with a useful way of planning out your essay.
5. Draft

The hard part! Personal writing styles will differ; some preferring to stick rigidly to their plan and whittle down the essay in chunks; others taking a stream of consciousness approach in order to just get everything up on the screen before worrying about the text making any sense. Try to follow your plan but by no means worry about writing in perfect English at this stage. That’s what the next step is for. Make liberal use of direct quotes and ensure that they are properly sourced.

6. Revising and refining

This is where you turn your shambolic 'essay' into a piece of solid gold that you can be proud of hurling through the essay shute on due date day. Be sure that you fully ANSWER THE QUESTION. It is imperative that there is a logical argument flowing through your entire essay that is easy for your marker to ascertain. If you have time, take your essay to a university law writing clinic. The dedicated individuals will be happy to read over your essay and give you thoughtful criticism and advice.

6. Footnoting

Everything must be fully referenced in a law essay, not just direct quotes. EVERY SINGLE PARAGRAPH MUST BE REFERENCED. Don't underestimate how long this can take you. Legal referencing is very precise and particular. Find out which legal referencing style your lectures prefer. If you keep a record of all your references as you go along, you will avoid having to frantically fumble through your notes at 2am the morning before its due, trying to work out where you pulled your quotes.

Happy essay-writing!

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“[I]n recent years, there has been a shift from a paternalistic model of medical decision-making, based upon the idea that ‘doctor knows best’, towards an autonomy model, which assumes that a competent adult patient should have an almost absolute right to refuse medical treatment. It would, however, be a mistake to regard patient autonomy as the overriding value in all medical decision-making” (Jackson, Medical Law, (OUP: Oxford 2nd ed. 2009), at 30-31)

Discuss…

The Decisions of Health-Care Professionals: Paternalism versus Autonomy

There has been a shift from a paternalistic model of medical decision-making towards a model based on autonomy. This can be seen by outlining the features of these models, scrutinising the ethical principles identified by Beauchamp and Childress\(^1\) in respect of medical decision-making: beneficence\(^2\), non-malfeasance\(^3\), justice\(^4\) and respect for autonomy\(^5\) and by considering provision of treatment information and the patient’s right to refuse treatment.

Paternalistic decision-making is characterised by doctors making decisions that they believe to be in the patient’s best interests, often with minimal consultation of the patient, prior to obtaining consent. This paternalistic approach is characterised by a reluctance to accept a patient’s refusal of treatment. An autonomy-based model, however, focuses on the patient’s wishes and desires and on presenting numerous treatment options to the patient, before obtaining consent and more readily accepting refusal of treatment.

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\(^1\) T Beauchamp and J Childress, *Principles of Biomedical Ethics*, 6\(^{th}\) edn (Oxford: Oxford University Press, 2009)

\(^2\) Providing medical benefit to patients.

\(^3\) Avoiding harm of patients.

\(^4\) This is a moral obligation to act fairly when judging competing claims.

\(^5\) Features of respect for autonomy include consulting patients and obtaining agreement from them, not deceiving patients and providing patients with enough information to enable informed decision-making.
John Harrington has suggested that the traditional paternalistic model saw the ethical principles of beneficence and non-malfeasance\(^6\) as justifying lack of patient knowledge. He states that: 'Knowledge of risks and consequences would distress and thus harm the patient. It might also persuade him to forego therapy and, thus, frustrate the doctor’s beneficent work.'\(^7\) This indicates that the philosophy of medical paternalism is that intervention as prescribed by the doctor would be the best option.

There are problems with the paternalistic approach. First, the lack of information provided to patients meant that it was more difficult to satisfy the capacity test\(^8\) because a patient might not understand or be able to weigh up information if very little of it was available. Secondly, taking a paternalistic stance is likely to engender an outcome-based approach whereby if a decision outcome is perceived to be irrational (e.g. treatment refusal), then the patient could be deemed to be incompetent.\(^9\)

Increased provision of information for patients is not only a satisfaction of the principles of justice and respect for patient autonomy but also a promotion of beneficence and non-malfeasance. Full disclosure of information can also serve to strengthen the trust between the patient and doctor and it is suggested that this may increase the likelihood that the patient will entrust her life into the hands of her doctor and agree to life-saving treatment.

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\(^6\) Primum nil nocere or 'not to do harm' is how John Harrington refers to non-malfeasance.

\(^7\) J Harrington, ‘Privileging the medical norm: liberalism, self-determination and refusal of treatment’ [1996] 16 Legal Studies 348 at 349

\(^8\) This will be discussed later on.

Additionally, some professionals within the health-care system have actively encouraged moving away from paternalistic decision-making towards a more liberal, patient-centred approach which is seen as a ‘partnership.’ Angela Coulter, for example, has indicated that providing patients with more information makes patients less dependent on their doctors and strengthens the relationship of trust and confidence between doctor and patient.  

There are possible explanations for this shift in thinking. Changes in society have necessitated a more relaxed, less paternalistic model of decision-making and some features of an autonomy model serve the interests of paternalism. The changes in society which have necessitated a greater consideration of autonomy include more individuals attaining a higher level of education and thus a greater likelihood that patients will question and challenge medical professionals, increased patient demand for information due to perception about rights (especially post-Human Rights Act 1998) and the increase in readily available sources of information from the media and pressure groups and the increased availability of the internet.  

Furthermore, western countries have increasingly demonstrated a willingness to resort to litigation to satisfy disputes. Individuals have claimed against doctors on the basis of the tort of battery in respect of being treated despite their refusal of medical treatment. Doctors are, therefore, aware of the potential consequences if they fail to take patient autonomy seriously. It can be concluded that there has

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10 http://www.digg.org.uk/reports/reports/2_The_autonomous_patient_angela_coulter.pdf  
11 This is an unlawful touching. A doctor may carry out treatment to the best of his abilities but if he does not obtain the patient’s consent before doing so, it will amount to a battery.  
been a slight shift towards an autonomy-based model, but examining refusal of medical treatment makes it evident that further improvements are needed.

There is a dearth of legal authority reiterating that as long as the patient is competent, there is a right to refusal\textsuperscript{13}. *Re: C (adult refusal of medical treatment)*\textsuperscript{14} provided the basis of the law on capacity and the Mental Capacity Act 2005, s1(2) placed those principles on a statutory footing. It indicates that there is a presumption of capacity: ‘A person must be assumed to have capacity unless it is established that he lacks capacity.’\textsuperscript{15}

In *Re: C*, Thorpe J stated that as long as a patient could 1) take in and retain information, 2) believe it and 3) weigh up the information balancing the risks, that a patient could validly refuse treatment. The fact that the claimant was schizophrenic was a relevant consideration but it needed to be demonstrated that the delusions he suffered caused him to be unable to satisfy the test. Thorpe J stated that: ‘…*C’s capacity is reduced by his mental illness. But for him the decision as to whether it is sufficiently reduced remains marginal in the absence of any direct link between the persecutory delusions and his present condition.*’\textsuperscript{16}

Therefore, even if capacity fluctuates, it is still possible for that patient to be regarded as competent and be capable of refusing medical treatment.

In *Airedale NHS Trust v. Bland*, Lord Bingham MR stated: ‘*A medical practitioner must comply with clear instructions given by the adult of sound mind as to the*…

\textsuperscript{13} If the patient is deemed to be competent, refusal to treatment must be respected. One situation where a refusal would not be permitted would be under public health grounds (e.g. control of an infectious disease).

\textsuperscript{14} [1994] 1 All ER 819 (Fam Div)

\textsuperscript{15} This means that there is a presumption that all patients are competent and can give valid consent or refusal unless the presumption is rebutted

\textsuperscript{16} [1994] All ER 819 (Fam Div)
treatment to be given or not given… whether those instructions are rational or irrational." Lord Mustill expanded on this further: ‘If the patient is capable of making a decision on whether to permit treatment… his choice must be obeyed even if on any objective view it is contrary to his best interests.’ These judgments indicate that a doctor must adhere to a patient’s refusal even if the reasonable man would consent to treatment. It could be argued that legal opinion has also driven the medical profession away from notions of medical paternalism towards the ideal of patient autonomy in the decision-making process. These judicial observations therefore indicate that doctors should not take an outcome-based approach towards decision-making, i.e. decide that a patient can only be competent if the treatment decision she has made is a rational one. This can be seen in respect of a female patient who refuses a caesarean section even where it will save her life and that of her unborn child: ‘Pregnancy… does not diminish entitlement to decide whether or not to undergo medical treatment… Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant.’ In the context of caesarean sections the legal status of the foetus is crucial. English Law indicates that the foetus has no right to life. This approach has been confirmed at European level in Vo v. France which indicates that the foetus does not have the right to life under Article 2 of the European Convention on Human Rights (ECHR). So, whilst an expectant mother may have a moral

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17 [1993] AC 789 at 808
18 [1993] AC 789 at 891
21 [2004] App no. 53924/00
obligation to act in the best interests of her unborn child, she has no legal
obligation to do so. Even in countries where foetuses do have limited protection
of their interests, the mother’s right of autonomy will outweigh the
interests of her child. The mother is a human being in existence (and thus her
right to life-saving treatment) whereas the foetus is perceived as a ‘potential
person’. The caesarean cases tend to come to court either because the doctors argue
that the patient is incompetent and request a declaration of lawfulness so that it
is possible to operate without being sued. The other situation is when the woman
commences litigation after the doctor has indicated that he will operate against
her wishes and argues that there has been a battery. This indicates that doctors
are perhaps not as respectful of patient autonomy as they should be.

Even though there is some evidence of judges advocating an approach based on
autonomy, judges seem to agree with the clinical decisions of doctors. The
justification has ranged from arguing that a woman in labour is incompetent to
saying that a woman with a phobia of needles can be regarded as temporarily
incompetent. Interestingly, St. George’s Health Care Trust v. S is the only UK
case where the woman sued for battery after the caesarean section (as against
before it), successfully. If the decision had come to court prior to the caesarean

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22 The American Convention of Human Rights 1978, the Eighth Amendment of the Irish
Constitution 1983 and the Criminal Code of Canada s223 all regard the foetus as having the right
to life. In the USA in 2004, Melissa Rowland was charged with murder of her stillborn child, who
would have survived if she had consented to a caesarean section.
http://news.bbc.co.uk/1/hi/world/americas/3504720.stm
23 Bonnie Steinbock, Life Before Birth: The Moral and Legal Status of Embryos and Fetuses,
(USA: Oxford University Press, 1996) p68
section we can speculate that the outcome of the case might well have been different.

Re: *MB (An Adult: Medical Treatment)*\(^{24}\) demonstrated that the courts support doctors in their paternalism and tend to err on the side of caution and in favour of the survival of the foetus even if the foetus has no rights. This suggests that in less clear-cut situations patient autonomy will be afforded less weight and unofficially, the foetus’s interests will be considered; albeit argued in the sense that it is in the mother’s best interests to deliver a healthy baby.

Re: *B (adult: refusal of medical treatment)*\(^{25}\) is an example of physicians taking a paternalistic approach and failing to respect patient wishes. It demonstrates the courts’ clear limits on how far paternalism should extend. Even if death is a certain result of discontinuation of treatment, then patient autonomy will outweigh a doctor’s clinical judgment that treatment is in the best interests of the patient. The rationale behind this is that a patient’s well-being is far wider than purely medical interests. Social, psychological, moral and religious factors that may affect the patient will be considered in weighing up whether treatment is in the patient’s best interests.

The emerging phenomenon of advance directives\(^ {26}\) has also caused some mischief. If patients refuse medical treatment in their directives and later become incompetent, this refusal may be challenged by doctors or relatives and the directives are not always accepted as valid by the courts. There is also evidence

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\(^{24}\) [1997] 2 FCR 541

\(^{25}\) [2002] EWHC 429 (Fam)

\(^{26}\) This is where a patient states her wishes in a written document in the event that she is no longer competent to make treatment decisions for herself.
that medical practitioners and the courts will not always respect previously
expressed wishes if they are linked to religious beliefs. This can be seen in the
case of *Re: T (Adult: Refusal of Treatment)*\(^{27}\), where a former Jehovah’s Witness
had previously indicated her refusal to receive blood products as part of her
medical treatment.

Kennedy and Grubb suggest that: ‘Judicial decisions to override the desire of
patients with certain religious beliefs not to receive blood transfusions may rest in
part on the court’s view that the patient’s decision is not reasonable. When life is
at stake and a court believes that the patient’s decision is unreasonable, the
court may focus on even the smallest ambiguity in the patient’s thinking to cast
doubt on the patient’s competency so that it may issue an order that will preserve
life or health.’\(^{28}\)

Every patient is in principle presumed to be capable of refusing food.\(^{29}\) Anorexics
are therefore competent to consent to and refuse medical treatment but refusal of
food is seen as a manifestation of the illness and thus renders such patients
unable to give valid refusal to force-feeding.\(^{30}\) Although this is done in the
patients’ best interests, as Penney Lewis points out, this force-feeding could
ultimately damage the relationship of trust and confidence between patient and
physician which raises serious questions as to when and how often it is
appropriate to force-feed anorexics.\(^{31}\)

\(^{27}\)[1993] Fam 95 (CA)

University Press, 2000) p. 600

\(^{29}\) One exception to this can be seen in the context of prison hunger strikes as demonstrated by X
v. Federal Republic of Germany [1984] 7 EHRR 152

\(^{30}\) Re: W (A Minor) (Medical Treatment: Court’s Jurisdiction) [1993] Fam 64

The more serious the medical condition is and thus the treatment that is needed, the more important patient autonomy should be but as we have seen from the refusal cases, in practice, it is the opposite.

Patient autonomy\(^{32}\) is just one of many values contemplated by medical practitioner. Other values include sanctity of life\(^ {33}\) and balancing the interests of a number of other patients (e.g. allocation of resources). Sanctity of life encompasses the idea that every human life is of the utmost value and should be protected. Sometimes doctors have taken this viewpoint too far though, as can be seen from \textit{Re: B}. Although, there is no evidence to prove this, it is probable that in caesarean section cases like \textit{Re: MB} doctors are concerned with protecting the life of the unborn child. Whilst doctors place great weight on sanctity of life, conversely, there is no absolute right to life-prolonging treatment either as can be seen by \textit{R (On Application of Burke) v. General Medical Council}\(^ {34}\) and by considering the issue of resource allocation.

Resource allocation is considered under the ethical principle and value of ‘justice.’ Doctors, particularly those working in the cash-strapped NHS, are acutely aware that difficult decisions have to be made in respect of deciding which patients will and which patients will not, receive medical treatment. Therefore, whilst autonomy is important in respect of refusal to medical treatment, it can also be an issue when patients request expensive treatment.

\(^{32}\text{This is encompassed in Article 8 of the European Convention on Human Rights.}\)


\(^{34}\text{[2004] EWHC 1879 (Admin)}\)
which they believe that they are entitled to receive. Legal decisions indicate that for the most part, this is a matter to be dealt with by hospital trusts.\(^{35}\)

There is some indication that the autonomy of the patient is being afforded more weight. However, examining the cases makes it clear that the right to refuse medical treatment is far from absolute and that autonomy is merely one of several considerations weighed up by medical practitioners in the decision-making process.

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