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Healthcare resource allocation in the English courts: a systems theory perspective

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Abstract

Engagement with sociological perspectives can enrich an understanding of medical law and provide a basis for critique of certain of its key premises. Since both law and healthcare are frequently conceptualised and analysed as systems, the theoretical frameworks developed by Niklas Luhmann and Gunther Teubner would seem to offer particular promise in this regard. This article explores a particular area of medical law to which an understanding of the social (and political-economic) context of decision-making is of clear importance – adjudication upon the allocation of scarce resources – in order to identify what insights may be gained from an approach grounded in systems theory.

Keywords: judicial review; healthcare; resource allocation; systems theory.

Introduction: medical law and the uses of sociology

There appears little room for argument today that medical law 'has achieved an enduring place at the pedagogical table', alongside more traditional subjects of academic legal study.[1] Yet, notwithstanding its status as a 'vigorous, dynamic and eclectic field of cross-disciplinary and international scholarship',[2] the relative youthfulness of the sub-discipline means that there remains ample scope for innovative investigation of synergies with other fields of inquiry. Such an exercise may serve several valuable goals, including deepening comprehension of emerging and evolving norms, identifying new modes of addressing problems, and illuminating potential pathways for future development.

A related, but arguably distinct, rationale for embarking upon such exploration might be located in a sense of discomfiture with certain of the foundational tenets of medical law, the objective being the critical reassessment of the validity of these in light of the understandings which may be gleaned from beyond its boundaries. One such matter which has been subject to such analysis is the centrality accorded to bioethical principles as yardsticks by means of which the normative structures of medical law may be understood and evaluated.

This critique of 'bioethics-centrism' has emerged from various quarters. From the social sciences, the argument is posited that the 'highly rational, formal, largely deductive mode of

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1 I Freckleton, 'The Emergence and Evolution of Health Law' (2013) 29 Law in Context 74, 97.

2 Ibid.

argumentation' which bioethics embodies cannot readily be translated into practical scenarios:[3] hence, that 'applied ethics' rests upon the naive and mistaken premise that 'social reality cleaves down neat philosophical lines, with theoretical categories matching those in social reality: i.e. that what a philosopher says is the doctor–patient relationship actually represents the relationship between doctors and their patients in all settings'.[4]

Comparable voices can be heard emanating from within the legal academy. For Montgomery, the traditional conception of 'medical law [as] a species of applied ethics, implying a staged process of applying ethical principles to a problem and deriving the necessary legal rules from that application'[5] has resulted in a disjuncture between theory and practice. He therefore calls for a 'new paradigm' for medical (or healthcare) law,[6] in which medical law is set in its 'institutional context',[7] and which makes use of norms created by and within the medical professions and the NHS, rather than viewing these as 'forces to be constrained' by the application of external rules.[8] Similarly, Veitch argues that it is:

> . . . essential to complement the existing, and dominant, critical form of analysis within the academic medical law literature – one based on ethics and the ethical supportability of court decisions and laws – with one whose critical eye is directed towards the more mundane, though by no means less important, institutional apparatus that structures aspects of how the courts function in this area.[9]

Most recently, Harrington has proposed a rhetorical analysis of medical law, challenging the perceived orthodoxy that 'ethics is held to be the truth of the law in this area: that which the law must strive for, though often failing in doing so'.[10] He focuses instead upon legal speech as 'a site of struggle between rival common-sense notions of the nature of society and its values, and the relationship of both to the law'.[11]

There are important differences between these accounts, but what unites them is both an attentiveness towards the social and political context in which medicine – and medical law – sit,[12] and, relatedly, a critical posture towards the apparent hegemony of bioethics, which is regarded as too detached from lived experience to properly account for practice in the clinic (or the courtroom). This appears to create a distinct space in which understandings drawn from sociology might prove of particular utility. The focus of the latter upon the manner in which 'institutions provide procedures through which human conduct is patterned'[13] allows us better to comprehend, inter alia, 'how ethical questions are not separable from the relations of powers in which ethical dilemmas emerge and are resolved', and 'how individuals draw on existing cultural resources which are embedded

3 R Fox, 'Is Medical Education Asking too much of Bioethics?' (1999) 128 Daedelus 1, 10.

4 A Hedgecoe, 'Critical Bioethics: Beyond the Social Science Critique of Applied Ethics' (2004) 18 Bioethics 120, 130.

5 J Montgomery, 'Time for a Paradigm Shift? Medical Law in Transition' (2000) 53 Current Legal Problems 363, 363.

6 See J Montgomery, *Health Care Law* (2nd edn, Oxford University Press 2003) 4.

7 Montgomery (n 5) 408.

8 Ibid 407.

9 K Veitch, *The Jurisdiction of Medical Law* (Ashgate 2007) 5.

10 J Harrington, *Towards a Rhetoric of Medical Law* (Routledge 2017) 162.

11 Ibid.

12 See Montgomery (n 5) 363, 408; Veitch (n 9) ch 2; Harrington (n 10) 2.

13 P Berger, *Invitation to Sociology: A Humanistic Perspective* (Penguin 1962) 104.

in their everyday experiences as a way of tackling ethical questions'.[14] However, with limited exceptions (including aspects of the work of two of the legal scholars identified above),[15] this disciplinary intersection between medical law and sociology has been sparsely explored.

Considerations of space necessarily preclude this article from undertaking a *comprehensive* exploration of the contribution which sociology can make to a better understanding – perhaps, a thoroughgoing reconceptualisation – of the fundamental tenets of medical law. Rather, it seeks to offer an illustration of the insights that work in this field can offer by focusing upon a discrete subcategory: judicial scrutiny of the allocation of scarce healthcare resources. For at least two reasons, this would appear to be a topic which especially lends itself to being viewed through a sociological lens. First, perhaps more visibly than in any other context within medical law, decisions which fall to be scrutinised by the courts in this field are structured by the *institutional* context in which they are taken: whether funding is made available for a particular treatment sought by a patient will turn upon a series of organisational choices which are reflective of the relations of power both within, and external to, the allocative decision-making body. Secondly, the propensity to resort to litigation regarding allocative choices is explicable, at least in part, by reference to broader *social* trends such as: enhanced health literacy, especially in relation to the introduction of new technologies; the rise of patient pressure groups (supported in some cases by pharmaceutical companies seeking enhanced return on research and development costs); a more consumerist approach to healthcare as a commodity, and so on.

For similar practical reasons, this article will limit its consideration of sociological approaches to those of the 'system theorists', in particular Niklas Luhmann and Gunther Teubner. It is submitted, however, that these contributions are especially apposite to the subject-matter surveyed here. Adjudication of healthcare allocation questions is a practice which sits at the intersection of two forms of social organisation which both can be, and have been, profitably analysed in systemic terms: law and healthcare.[16] As will be discussed more fully below, systems theory provides us with particular insights into the manner in which communication can occur between these ostensibly dissimilar ways of ordering and perceiving the world and, correspondingly, an explanation of the dynamics

14 J López, 'How Sociology Can Save Bioethics . . . Maybe' (2004) 26 Sociology of Health and Illness 875, 881. For further discussions of the relationship between bioethics and sociology, see R DeVries and P Conrad, 'Why Bioethics Needs Sociology' in R DeVries and J Subedi (eds), *Bioethics and Society: Constructing the Ethical Enterprise* (Prentice Hall 1998); R Zussman, 'The Contributions of Sociology to Medical Ethics' (2000) 30 Hastings Center Report 7; R DeVries, 'How Can We Help? From "Sociology in" to "Sociology of" Bioethics' (2004) 32 Journal of Law, Medicine and Ethics 279.

15 Veitch (n 9) 33 argues that 'the sociological type of inquiry allows for reflection on how some changes in the underlying structure of society might relate to aspects of medical law', developing this primarily in chapter 2 of his book, while Harrington (n 10) 21–8 draws upon systems theory to analyse the 'indeterminacies and perplexities' of medical law. Elsewhere, it is the work of Foucault which has been most widely utilised: see e.g. A Sharpe, *Foucault's Monsters and the Challenge of Law* (Routledge 2010); M Flear, *Governing Public Health: EU Law, Regulation and Biopolitics* (Hart 2015); J Fanning, 'Continuities of Risk in the Era of the Mental Capacity Act' (2016) 24 Medical Law Review 415.

16 For discussion of law as a social system, see further below. Amongst an extensive literature of healthcare as a system, see e.g. L Gilson (ed), *Health Policy and Systems Research: A Methodology Reader* (World Health Organization 2012); M Britnell, *In Search of the Perfect Health System* (Palgrave 2015); J Johnson, C Stoskopf and L Shi (eds), *Comparative Health Systems: A Global Perspective* (2nd edn, Jones & Bartlett 2018).

of change which is referable to social and organisational factors,[17] rather than premised upon adoption of a universalist worldview. It therefore promises a distinctive theoretical framing which may function as a corrective to a bioethics-centred approach to the analysis of legal norms and their ongoing development.

The goal of this article, therefore, is to explore judicial decision-making on allocation of scarce healthcare resources in English courts in light of the understandings provided by systems theory, with a view to identifying the insights which the latter may bring to analysis of the former. In order to pursue this, it is necessary first both to outline how the law has evolved in this field, and the manner in which that evolution has 'traditionally' been framed.

A narrative of judicial scrutiny of resource allocation

This section presents a tripartite categorisation of the activity of the English courts in relation to adjudication upon allocative questions in healthcare.[18] While admittedly somewhat crude – especially as there are not neat chronological boundaries between the categories (in particular, the second and third) – such classification is, it is submitted, valuable in directing attention away from the particularities of individual cases, thus facilitating consideration of the broader social and political trends within which the decisions are set, while simultaneously allowing examination of the evolution of relevant jurisprudence.

As Newdick notes, the first judicial review of an allocative decision made within the NHS 'surprisingly' did not occur until 1980;[19] this fact in itself may be framed within a sociological lens, as discussed subsequently. These early cases, up to the decision of the Court of Appeal in *R v Cambridge Health Authority, ex parte B* in 1995,[20] were characterised by judicial deference or 'passivity'.[21] Judges did not consider allocative questions to be wholly non-justiciable, since they retained the capacity to intervene on *Wednesbury* grounds, but this test was applied in a very strict manner with the consequence that allocative decisions were, in effect, insulated from any meaningful judicial scrutiny, even on procedural grounds. This position is perhaps best captured by *R v Central Birmingham Health Authority, ex parte Collier*,[22] where access to intensive care facilities were denied to a child with a life-threatening condition who had been placed at the top of a waiting list for treatment. Here, Stephen Brown LJ stated that:

> . . . it is not for this court, or any court, to substitute its own judgment for the judgment of those who are responsible for the allocation of resources . . . The courts of this country cannot arrange the lists in the hospital, and, if it is not evidence that they are not being arranged properly due to some unreasonableness

17 Although systems theory might be viewed as taking a 'macro' perspective on society, nonetheless 'in Luhmann's grand theory of societal evolution organizations are of pivotal importance . . . Today, most societal systems are represented by specific organisations, and, vice versa, most organizations are related to a societal system': R Hasse and G Krücken, 'Systems Theory, Societal Contexts, and Organizational Heterogeneity' in R Greenwood et al (eds), *The Sage Handbook of Organizational Institutionalism* (Sage 2008) 539, 548.

18 This analysis therefore differs from that of Wang, who offers a two-stage account: see D Wang, 'From *Wednesbury* Unreasonableness to Accountability for Reasonableness' (2017) 76 Cambridge Law Journal 642, 644–52. See further below.

19 C Newdick, *Who Should We Treat?* (2nd edn, Oxford University Press 2005) 95, referring to *R v Secretary of State for Social Services, ex parte Hincks* (1980) 1 BMLR 93.

20 [1995] EWCA Civ 49.

21 Newdick (n 19) 98.

22 [1988] Lexis Citation 1301.

> in the *Wednesbury* sense on the part of the authority, the courts cannot, and should not, be asked to intervene.

A different approach to the judicial role in this field may be traced to the decision of the High Court in *ex parte B*,[23] with the principles which were articulated by the courts in a series of subsequent cases eventually being placed upon a statutory footing by secondary legislation accompanying the publication of the *NHS Constitution* in 2009.[24] Here, judicial scrutiny is of a considerably more intensive quality than was previously the case: Newdick labels it 'hard look'.[25] However, while the 'trigger' for review remains the most substantive of the grounds of judicial review – irrationality – the obligations imposed upon the allocative decision-maker by law (whether common law, or statute/*NHS Constitution*) are procedural in character. These take two forms. First, the decision-maker is required – in the words of Laws J in *ex parte B* – to 'explain the priorities which have led them to decline to fund the treatment':[26] that is, in effect, to provide reasons for the decision not to fund a particular intervention. Secondly, a procedure must be in place whereby an individual can put forward factors which constitute their particular case as exceptional, thereby warranting departure from a general policy not to provide access to a treatment or service.[27] This provides for a mode of participation in the process of allocation, understood in a Fullerian sense as the presentation of proofs and reasoned argumentation for a decision in favour of the patient.[28]

In both of the preceding instances, the approach adopted by the courts is relatively unambiguous, but there is a further category of case in which the position is less clear-cut. Here, the basis of challenge lies in the application and interpretation of the evidential base upon which allocative choices are premised. The NHS Constitution includes a right, said to be rooted in administrative law, 'to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence'.[29] In this context, however, rationality is framed by some courts in a more substantive manner than in the cases previously discussed, turning upon the relevancy of considerations, the existence of evidence reasonably capable of supporting the decision, and the analysis and application of that evidence. Hence, in *R (Otley) v Barking and Dagenham NHS Primary Care Trust*,[30] the refusal to provide funding for a cancer drug was held to be unlawful, inter alia, on the basis of a misapplication of evidence on clinical effectiveness contained in guidance produced by (what was then) the National Institute for Health and Clinical Excellence (NICE); in *R (Ross) v West Sussex Primary Care Trust*,[31] the Trust had acted unlawfully because it had failed 'to understand the strength of the evidence in favour of treating [the patient]' in light of a 'fundamental misunderstanding

23 [1995] 1 FLR 1055. This decision was overturned by the Court of Appeal (n 20), but it nonetheless laid the basis for future jurisprudence in the area: see K Syrett, 'Institutional Liability' in J Laing and J McHale (eds), *Principles of Medical Law* (4th edn, Oxford University Press 2017) [7.71].

24 See now National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, SI 2012/2996, regs 34, 35.

25 Newdick (n 19) 100.

26 Above (n 23) 1065.

27 The process is known (in England) as the Individual Funding Request. For an example, see NHS England, *Commissioning Policy: Individual Funding Requests* (NHS England 2017).

28 See L Fuller, 'The Forms and Limits of Adjudication' (1978) 92 Harvard Law Review 353, 364.

29 Department of Health, *The NHS Constitution for England* (Department of Health 2015) 7.

30 [2007] EWHC 1927 (Admin).

31 [2008] EWHC 2252 (Admin).

of the results' of randomised controlled trials of the treatment;[32] and because it 'fell into error when considering [the] cost-effectiveness' of the drug;[33] and, in *R (Rose) v Thanet Clinical Commissioning Group*,[34] albeit *obiter*,[35] Jay J considered that departure from (non-binding) NICE guidelines in respect of the strength of the clinical evidence base for a treatment amounted to 'an irrational conclusion and, in particular, one whose reasoning is without foundation'.[36]

However, in other cases, courts have taken a more deferential stance towards the allocative decision-maker's analysis and application of evidence. Thus, in *R (AC) v Berkshire West Primary Care Trust*,[37] the Court of Appeal ruled that the Trust was entitled to take the view that the evidence of clinical effectiveness was insufficiently strong to warrant funding breast augmentation surgery for transsexual patients, while in *R (British Homeopathic Association) v NHS Commissioning Board*[38] (a case turning on the fairness of a consultation process rather than rationality), it was held that 'it would not be appropriate for the court to pass judgment on the legitimacy or otherwise of the view that homeopathy works', notwithstanding acceptance by the Board 'that there is a body of opinion, to which some practicing clinicians adhere, that homeopathy works (and that there is evidence to that effect)'.[39] It should be noted, also, that three challenges to recommendations made by NICE turned on procedural grounds relating to the accessibility of the economic models on which NICE decisions rested and on the provision of adequate reasons, rather than on the Institute's understanding and application of evidence and the selection and weighing of data.[40] Yet, even within this small subcategory of allocation case, there is judicial ambivalence regarding adoption of a substantively deferential position.[41] Albeit *obiter*, the Court of Appeal in *R (Servier Laboratories Limited) v NICE* 'was by no means convinced' that the Institute's rejection of post-clinical trial subgroup data in its evaluation of clinical effectiveness of a drug was rational, attaching particular weight to the fact that the European Medicines Agency had taken account of such data when carrying out its regulatory functions.[42]

32 Ibid [83].

33 Ibid [88].

34 [2014] EWHC 1182 (Admin).

35 The claimant lost the case on the basis that her challenge was not to the general funding policy, but rather to the 'legally unobjectionable' decision not to reopen her individual funding request on grounds of exceptionality, given that she had presented no new clinical information to justify such reopening: ibid [78]–[80].

36 Ibid [104].

37 [2011] EWCA Civ 247.

38 [2018] EWHC 1359 (Admin).

39 Ibid [61].

40 *R (Eisai Ltd) v NICE* (2007) EWHC 1941 (Admin)/(2008) EWCA Civ 438; *R (Servier Laboratories Ltd) v NICE* (2009) EWHC 281 (Admin)/[2010] EWCA Civ 346; *R (Bristol-Myers Squibb Pharmaceuticals Ltd) v NICE* [2009] EWHC 2722 (Admin). For discussion, see K Syrett, 'Health Technology Appraisal and the Courts: Accountability for Reasonableness and the Judicial Model of Procedural Justice' (2011) 6 Health Economics, Policy and Law 469.

41 A stance which is best captured by the following *dictum* of Holman J: 'It is important to stress at the outset that NICE is the specialist, expert body, charged with making appraisals and decisions of this type. The court is not. I have neither the right, still less the expertise, to review the decisions as to their substance.': *R (Servier Laboratories Ltd) v NICE* [2009] EWHC 281 (Admin), [6].

42 *R (Servier Laboratories Ltd) v NICE* [2010] EWCA Civ 346, [51].

Ways of seeing:[43] analysing the narrative

How might this narrative be interpreted? A standard framing is to view it as reflective of evolving jurisprudence: developments and modifications in the selection and application of grounds of judicial review understood within the broader context of English public law.[44] This is the approach taken by Newdick,[45] who considers the case law on access to hospital care under the three main heads of review articulated by Lord Diplock in the *GCHQ* case,[46] and within the category of irrationality (under which most of the cases discussed above fall), outlines a trend – noted above – from 'judicial passivity' to 'the hard look'. He attributes the latter shift to changing understandings of the meaning of the irrationality ground, citing a *dictum* of Lord Woolf MR, in which the judge identified 'two faces' of irrationality: 'the barely known decision which simply defies comprehension' (which underpins the passive stance) and 'a decision which can be seen to have proceeded by flawed logic' (which underpins the more interventionist 'hard look' form of scrutiny).[47]

This interpretation satisfies some of the criteria outlined in the work of the legal academics cited in the first section of this article – for example, it provides a response to Veitch's questions: 'If some judges are willing to be more proactive, then how, precisely, have they been so? What techniques have they used to assert their power . . . ?'[48] It is notable, however, that Newdick attributes the change in the judicial approach to irrationality to broader doctrinal developments in public law – especially a greater emphasis on the requirement for administrative bodies to give reasons for decisions[49] – rather than to any changes in the social and political context of allocative decision-making. Furthermore, this account stops short of analysing the developing law in terms of the ethical principles which might be said to underpin it, as much medical law scholarship tends to do.[50]

In this regard, the work of the present author provides an alternative reading, although in a manner which is somewhat distinct from the ethically informed analyses offered in respect of other topics in the field of medical law. Hence, it is argued that the shift towards a procedural form of review, post-*ex parte B*, can be understood as a way of judicially enforcing the 'accountability for reasonableness' model developed by Norman Daniels and James Sabin.[51] This model is ethically informed in so far as it centres upon

43 See J Berger, *Ways of Seeing* (BBC and Penguin 1972).

44 See further the discussion of the work of Daniel Wang below, especially (n 59) and accompanying text.

45 Newdick (n 19) 94–109.

46 *CCSU v Minister for Civil Service* [1985] AC 374.

47 *R v North & East Devon Health Authority, ex parte Coughlan* [1999] EWCA Civ 1871, [65]. Note, however, that Arvind and Stirton argue that the first reading of *Wednesbury*, which is generally taken to reflect the orthodox judicial position, was inconsistent with the 'juristic consensus' of the 1960s, 'in which it was taken for granted that the legal system must provide redress going to the merits of the case', and that it only became dominant with the influence of Lord Diplock over the evolution of English public law in the 1970s and 1980s: T Arvind and L Stirton, 'The Curious Origins of Judicial Review' (2017) 133 Law Quarterly Review 91, 95–6.

48 Veitch (n 9) 4.

49 Newdick (n 19) 97.

50 Of course, this is not to say that Newdick is oblivious to such principles: merely that they do not form part of the account he presents in this specific context. For discussion elsewhere in his book, see ibid, especially chs 1 and 2.

51 See e.g. N Daniels and J Sabin, *Setting Limits Fairly: Learning to Share Resources for Health* (2nd edn, Oxford University Press 2008) discussed in K Syrett, *Law, Legitimacy and the Rationing of Health Care: A Contextual and Comparative Perspective* (Cambridge University Press 2007) 100–8; also K Syrett, 'NICE and Judicial Review: Enforcing "Accountability for Reasonableness" through the Courts?' (2008) 16 Medical Law Review 127. See also Wang (n 18).

(distributive) *justice*, but it is purportedly neutral as to the ethical *substance* of allocative choices – for example, whether these seek to give effect to utilitarian or egalitarian considerations.[52] This is because there appears to be no societal consensus upon the appropriate ethical basis for allocating scarce healthcare resources,[53] and thus the best that can be achieved is a fair process for making such decisions which will ensure that they are publicly regarded as legitimate.

Those critics of 'bioethics-centrism' whose work was outlined earlier in this article might feel some discomfiture with an analysis which understands legal developments in the light of one of Beauchamp and Childress' famous four principles of biomedical ethics (albeit one which, being procedural in orientation, lacks the absolute, universal quality of other ethical principles which may be at play in medical law cases).[54] However, the present author has sought additionally to situate the 'accountability for reasonableness' thesis within the socio-political context of a changing NHS. In particular, a shift from implicit to explicit modes of priority-setting has been viewed as the backdrop for the evolution from judicial passivity to procedural scrutiny, with the judicial stance serving to reinforce the legitimacy of the prevailing form of allocation.[55]

More recently, a further reading of the development of the case law has been offered by Wang. This also attaches strong weight to judicial compliance with 'accountability for reasonableness' as an underlying driver for the evolving jurisprudence. However, it seeks to distinguish itself from the work of the present author in that it confers primacy upon the legal norms, rather than regarding these as having been shaped by the surrounding socio-political environment. Arguing against the latter position, on the basis that 'correlation is not causation',[56] Wang claims that 'it is actually the rigorous judicial scrutiny of rationing decisions that has driven the NHS to be more explicit about the reasons and procedures leading to the denial of treatment, rather than the other way round',[57] drawing attention also to the need for NHS decision-makers to make decisions 'judge-proof', that is 'to avoid, respond to, and comply with judicial review'.[58] He regards the broader development of English public law, especially 'the affirmation of the language of rights' and a growing tendency to require reasons to be presented for decisions,[59] as a 'better . . . explanatory variable' for the evolving law in this field than a shift from implicit to explicit rationing.[60]

Wang's critique of the conflation of correlation and causation appears somewhat at odds with his opinion that judicial scrutiny is the driving force underpinning increasingly explicit decision-making within the NHS, although elsewhere he is more guarded, noting that isolating the impact of litigation upon bureaucracies which are subject to multiple pressures is problematic, and claiming more modestly 'that courts interacted within a

52 It might be argued that the 'relevance' condition of the 'accountability for reasonableness' model, which requires that decisions be based upon criteria which fair-minded people will accept as pertinent to allocation of scarce healthcare resources, has a substantive character: see e.g. Syrett (n 51) (2007) 104–5; Syrett (n 40) (2007) 481.

53 For a critical perspective on this position, see R Ashcroft, 'Fair Process and the Redundancy of Bioethics: A Polemic' (2008) 1 Public Health Ethics 3.

54 T Beauchamp and J Childress, *Principles of Biomedical Ethics* (7th edn, Oxford University Press 2012) ch 7.

55 See K Syrett, 'Impotence or Importance? Judicial Review in an Era of Explicit NHS Rationing' (2004) 67 Modern Law Review 289, especially at 297.

56 Wang (n 18) 644.

57 Ibid 652–3.

58 Ibid 668.

59 Ibid 654–5. Cf Newdick (n 49) and accompanying text.

60 Ibid 656.

"soup of influences" that created a context that made rationing more explicit'.[61] What is most interesting about his analysis, however, is that it demonstrates both the ample scope which remains for debate as to the nature of the interaction between the law and the surrounding socio-political environment in this field, and the continuing primacy of bioethical understandings (in this instance, manifested in the framing of the evolving case law as a shift towards 'accountability for reasonableness').

As argued in the first section of this article, adoption of a systems theory perspective carries the potential to further illuminate these matters, as well as another issue mentioned only passingly by Wang: the (tentative) emergence of a third category of review which is more substantive in character.[62] The remainder of this article will accordingly seek to explore the insights which systems theory can provide in this context.

Applying systems theory to allocative case law

Mele, Pels and Polese have provided a helpful definition of a system as 'an entity, which is a coherent whole such that a boundary is perceived around it in order to distinguish internal and external elements and to identify input and output relating to and emerging from the entity'.[63] A systems approach is holistic, not reductionist: it 'analyses a phenomenon seen as a whole and not as simply the sum of elementary parts'.[64] This makes it a valuable perspective for the analysis of the deeper-rooted causes of broad-ranging shifts that occur over time, such as those analysed in this article. The following discussion will therefore offer an explanation of the salient points of systems theory and will seek to apply these to the developments in allocative jurisprudence outlined above.

(i) Functional differentiation, operational closure and judicial passivity

While originating in biology, systems theory rapidly came to be applied within the social context, with the concept of autopoiesis forming a central organising principle. This connotes 'the process of a system that produces "itself from itself"',[65] that is one in which elements of the system interact with each other to produce and reproduce the system without direct reference to the external environment. Such systems are thus operationally closed: the system defines its own boundary which separates itself from the environment, this giving rise to its autonomous character.

For Luhmann, this autopoietic reproduction takes place by means of communication,[66] the 'core of social systems'.[67] 'What is essential for an autonomous social autopoiesis is the conceptualization of society as a system of meanings, developed through a process of differentiation':[68] that is, the emergence of functionally

61 Ibid 658.

62 Citing *Otley* (n 30) and *Ross* (n 31), Wang merely remarks that 'based on divergent expert opinions, the courts also challenged the health authorities' analysis of the scientific evidence and the conclusion that the claimant's case was not exceptional': (n 18) 650. This seems to understate the distinctiveness of the form of scrutiny exercised by the courts in these cases.

63 C Mele, J Pels and F Polese, 'A Brief Review of Systems Theories and their Managerial Applications' (2010) 2 Service Science 126, 127.

64 Ibid.

65 Ibid 128.

66 See N Luhmann, 'The Autopoiesis of Social Systems' in F Geyer and J Van d Zeuwen (eds), *Sociocybernetic Paradoxes: Observation, Control and Evolution of Self-Steering Systems* (Sage 1986) 174.

67 M Schwaninger and S Groesser, 'Operational Closure and Self-Reference: On the Logic of Organizational Change' (2012) 29 Systems Research and Behavioral Science 342, 344.

68 A Lourenço, 'Autopoietic Social Systems Theory: the Co-Evolution of Law and the Economy' (Centre for Business Research, University of Cambridge Working Article No 409 2010) 3.

differentiated social subsystems,[69] such as law, politics, the economy and religion, which operate to reduce the complexity of the world through the absorption, processing and return of information through their own particular, distinct ways of 'seeing' and 'understanding'. The boundaries of these systems are formed by way of binary codes such as (in the case of law), 'legal/illegal', which serve therefore both to identify the subsystem and to distinguish it from its environment,[70] that is to effect its operational closure. Put differently, those participating in the making of legal communications 'operate on the basis of shared assumptions about "boundary conditions" which demarcate the legal order from other forms of communication: what counts as a legal rule, and what does not'.[71] Meanwhile, elsewhere (for example, in the realms of politics or religion), there exist other shared understandings based around different demarcations of those subsystems from their environment (the legal system then forming part of *that* environment).

While Luhmann did not write as extensively on medicine or healthcare as he did on other fields such as law, with the consequence that 'sociological systems theory has been applied to analyses of health only marginally',[72] he assumed "'treatment of disease", "treatment of ill persons" or "medicine"' to have evolved into a functional social subsystem.[73] The binary code applicable to this context might be obvious – ill/healthy – or might be more complex, for example hindering/promoting health, suboptimal/optimal physical and mental health or, in the public health context, presence/absence of pathogenic factors.[74] As for the medium of communication which applies within the system, Pelikan disputes Luhmann's claim that there is none,[75] and argues that this resides in the science-based system of medical terminology for differential diagnostics, and for the related system of therapies, defined in medical textbooks, handbooks, journals and reviews.[76] This latter point will be revisited below.

An acceptance that medicine/healthcare can be viewed, alongside law, as a social subsystem allows us a means of framing both the non-involvement of the courts at all prior to 1980, and the subsequent highly deferential judicial stance towards allocative challenges in early case law on the topic. The consequence of functional differentiation between operationally closed subsystems, effected through distinctive coding, is that 'the highly specialised types of communication developed within the subsystems of society are no[t] . . . interconnected or interchangeable, and attempts to artificially impose one type of systemic communication on another fail'.[77] Law and medicine (or healthcare) are distinct and autonomous social subsystems, defining themselves with regard to their environment in terms of differing binary codes. The two subsystems 'see things

69 Differentiation on a functional basis is a characteristic of modernity. In previous eras, differentiation took the form of segmentation (e.g. by reference to tribes or families), or stratification (i.e. hierarchical).

70 See N Luhmann, 'Operational Closure and Structural Coupling: The Differentiation of the Legal System' (1991) 13 Cardozo Law Review 1419, 1428.

71 S Deakin and F Carvalho, 'System and Evolution in Corporate Governance' (Centre for Business Research, University of Cambridge Working Article No 391 2009) 11.

72 J Pelikan, 'Understanding Differentiation of Health in Late Modernity by Use of Sociological Systems Theory' in D McQueen, I Kickbusch, L Porvin et al (eds), *Health and Modernity: The Role of Theory in Health Promotion* (Springer 2007) 74, 75.

73 Ibid 88.

74 Ibid 88–9, 92.

75 Ibid 89.

76 Ibid 89–90.

77 H G Moeller, *Luhmann Explained: From Souls to Systems* (Open Court 2006) 33.

differently and there is no possibility of one system being able to internalise the world-view of another'.[78]

In this sense, there is a profound problem of judicial (in)competence:[79] courts are quite simply not suited to determine questions of this type because they do not fit with the manner in which the legal system sees the world. This is well captured by the dictum of Ralph Gibson LJ in *Collier*.[80] The judge bemoans the deficiencies of the allocative decision-making process undertaken by the health authority, but acknowledges that law is utterly impotent to address them:

> If I were the father of this child, I think that I would want to be given answers about the supply to, and use of, funds by this health authority. No doubt the health authority would welcome the opportunity to deal with such matters so that they could explain what they are doing and what their problems are. But this court and the High Court have no role of general investigator of social policy and of allocation of resources.

The existence of functionally differentiated, operationally closed social subsystems, the boundaries of which are defined by codes, gives rise to what Luhmann has described as a 'paradox'. The system is what it is because of what it is not, and every determination of legality within the legal system contains within it the possibility that it might have 'gone the other way'.[81] But this paradox must be managed by the system, since to expose it would result in a form of existential paralysis: as Luhmann writes, 'one can neither ask nor answer the question (because it would lead to a paradox) as to whether the distinction between legal and illegal itself is legal or illegal'.[82] Such management (or 'deparadoxification') takes place through a process of concealment, which will commonly take the form of a 'mix of distinctions within the law and displacements to other decision-makers'.[83]

This process can be seen in operation in the early judicial review case law. The differentiation between law and healthcare is not manifested in *complete* abdication by the courts of any form of adjudicative role whatsoever, since this would amount to an acknowledgment of the (arbitrary) distinction between law and non-law and thus exposure of the 'paradox'. Rather, a strategy of concealment is adopted, beneath the 'ample cloak' of the *Wednesbury* principle.[84] This enables judges to define such matters within the terms of the system's binary coding of legal/illegal and, simultaneously, to displace decision-making in practice to those operating within the healthcare system by adopting the most restrictive reading of this ground of review, which in effect divests the courts of the task of reaching a determination on the issues of allocation.

(ii) Structural coupling and judicial interventionism

Systems theory thus provides an alternative perspective which can assist in explaining a phenomenon which is relatively well understood – the standpoint of judicial passivity, and

78 M King and C Thornhill, *Niklas Luhmann's Theory of Politics and Law* (Palgrave Macmillan 2005) 25.

79 For a discussion of the various forms of judicial (in)competence, see Syrett (n 51) (2007) 128–34.

80 Above (n 22).

81 Harrington (n 10) 22.

82 N Luhmann, L*aw as a Social System* (K Ziegert trans) (Oxford University Press 2004) 177.

83 Harrington (n 10) 23.

84 The phrase derives from J Jowell and A Lester, 'Beyond Wednesbury: Substantive Principles of Administrative Law' [1997] Public Law 368, 371.

the rationales for this position.[85] However, the particular value of adopting a sociological approach to medical law surely lies primarily in its capacity to cast fresh light on issues which are less settled, such as the basis for a shift to a more interventionist judicial stance on allocation questions. In order to explore its contribution in this regard, it is necessary to outline additional elements of the theory.

As a starting point, it is important to note Luhmann's statement that 'closure must not be misunderstood as isolation'.[86] While social subsystems are operationally closed, they are cognitively open – they have ongoing contact with the external environment and can receive information from it, but (as discussed in the preceding section) this information is processed in forms which are specific to its own 'way of seeing' (its code), and is then returned to the environment as a communication from, and in the terms of, that subsystem (such as a legal ruling).

Central to processes of interaction between a social subsystem and the other social subsystems which constitute its environment is the notion of 'structural coupling', which captures the 'idea of highly selective connections between systems and environments'.[87] 'This designates that different systems may co-evolve over time and systematically communicate about the same themes and within specific contexts, but in their specific and different codes.'[88] Some examples may be of assistance in understanding this concept. A structural coupling between the distinct subsystems of law and politics is effected through constitutions: 'a constitution is the paradox that brings together law and politics precisely by keeping them separate (namely, by allowing both law and politics to restrict the influence on each other)',[89] structural coupling between the subsystems of law and the economy is effected through mechanisms such as contract and property;[90] and structural coupling between politics and the economy through mechanisms such as taxes and tariffs.[91]

It should be noted that, in each of these cases, notwithstanding the coupling, the different subsystems are and remain separate, with the information emanating from the external environment being 'sorted' into the subsystem's distinct code. Thus, external pressures generated from the environment do not operate as direct inputs into the subsystem – Luhmann writes that 'the twin concepts of closure and structural coupling exclude the idea of information "entering" the system from the outside'.[92] Rather, structural coupling 'can only trigger irritations, surprises and disturbances',[93] which may

85 It is highly possible that systems theory can also offer an additional explanatory framework for the wider pattern of judicial deference to medical judgement characteristic of medical law in the *Bolam* era, but this is beyond the limited scope of this article. For a well-known critique of the position adopted by the courts, see The Right Honourable the Lord Woolf, 'Are the Courts Excessively Deferential to the Medical Profession?' (2001) 9 Medical Law Review 1.

86 Luhmann (n 82) 80.

87 Luhmann (n 70) 1432.

88 I-J Sand, 'The Interaction of Society, Politics and Law: The Legal and Communicative Theories of Habermas, Luhmann and Teubner' (2008) 53 Scandinavian Studies in Law 45, 53.

89 A Philippopoulos-Mihalopoulos, *Niklas Luhmann: Law, Justice, Society* (Routledge 2010) 143. See also Luhmann (n 70) 1436.

90 Luhmann (n 70) 1435.

91 N Luhmann, *Theory of Society* vol 2 (R Barrett trans) (Stanford University Press 2013) 111.

92 Luhmann (n 70) 1432.

93 Luhmann (n 82) 383.

(or may not) eventuate in *internally constructed* processes of adaptation and mutation.[94] Mechanisms of structural coupling thus provide spaces through which 'perturbation' from the environment is experienced, providing the subsystem with a 'chance to learn and transform its structures'.[95] Hence, as Teubner notes, 'co-evolving systems exert an indirect influence on each other'.[96]

These further features of systems theory provide a framework through which it is possible to interpret a number of aspects of the evolving jurisprudence on allocative matters.

First, they suggest that 'legal and social changes are . . . related but distinct processes. Legal change reflects an internal dynamic which, nevertheless, is affected by external stimuli and, in turn, influences the external environment.'[97] An autopoietic approach 'does not rule out causation: it assumes a complex causal relationship between subsystems, thus rejecting the view of *linear* causation in favour of one based on mutual influence'.[98] This tends to support Wang's more modest claim relating to the 'soup of influences',[99] in which law and the health system interact with each other to construct an environment in which allocative decisions are more explicit in character. The two subsystems underwent a process of *co-evolution* and thus attempts to locate the 'drivers of change' either in the shift to explicit rationing processes in the NHS (a position which is attributed by Wang to the present author), or the development and articulation of public law principles (Wang's claim) are equally misplaced, premised as they both are on an input/output model. It is simply not possible, in Luhmannian social systems theory, for a change in the character of resource allocation to directly modify the legal approach (or, correspondingly, for a change in the legal regime to directly alter the manner in which rationing takes place): 'only the law decides on this'.[100]

However, as we have seen, a social subsystem is far from isolated from its environment and can (although not necessarily *will*) be affected by 'perturbations in the other social system [which] will trigger there some changes governed by the internal logics of this world of meaning'.[101] In the context explored here, this raises a second issue: that is, the mechanisms through which the subsystems of law and medicine/healthcare are structurally coupled, such coupling being the locus of perturbation which may 'provoke change on the other side'.[102] In particular, given that the initial period surveyed here was analysed as characterised by closure, rather than coupling, we might ask whether structures of coupling have emerged over the period dating from the *Hincks* case in 1980.

Epistemological developments in the field of medicine appear to provide the key here. In recent decades, both in the UK and elsewhere, the practice of 'evidence-based

94 Deakin and Carvalho (n 71) 21 define 'mutation' as that which 'occurs by "rearranging" the available components and coupling them with the "new" informational components that represent the "new facts" that caused the pressure for mutation'.

95 Luhmann (n 70) 1433.

96 G Teubner, *Law as an Autopoietic System* (Blackwell 1993) 61.

97 G Teubner, 'Substantive and Reflexive Elements in Modern Law' (1983) 17 Law and Society Review 239, 249.

98 Lourenço (n 68) 10. Emphasis in original.

99 Above (n 61) and accompanying text.

100 Harrington (n 10) 24 discussing *Gillick v West Norfolk and Wisbech Health Authority* [1986] 1 AC 112: 'a change in medical opinion regarding the need for teenage contraception could not of itself have changed the corresponding legal regime'.

101 G Teubner, 'Legal Irritants: Good Faith in British Law or How Unifying Law Ends up in New Divergences' (1998) 61 Modern Law Review 11, 28.

102 Ibid.

medicine' (EBM) has secured hegemonic status, gradually (albeit not wholly) supplanting a more experiential approach of clinical judgement, rooted in trial and error, and personal observation. EBM, defined as 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients',[103] is, in principle, scientific, objective and data-driven (as discussed further below). When initially applied to the allocative context in the NHS during the early 1990s, EBM facilitated the elimination of 'waste' on clinically ineffective treatments.[104] Subsequently, stimulated by the development of the sub-discipline of health economics[105] and the emergence of 'the first cousin of EBM',[106] health technology assessment (HTA) (in which regard the UK was a pioneer through the establishment of NICE in 1999), it additionally afforded a basis for prioritising certain treatments and services over others on grounds of cost-effectiveness.

Of course, evidence and its attendant discourse has always been central to the 'world of meaning' of law. EBM thus opened up a distinct space for structural coupling between this subsystem and that of medicine/healthcare. A particular mechanism by which such coupling was realised was the clinical guideline, a specialised form of the science-based medium of communication identified by Pelikan.[107] Guidelines, regarded as the 'main vehicle for implementing EBM',[108] function within the medicine/healthcare subsystem as statements of recommended best practice with a view to enhancement of the quality of healthcare and the minimisation of clinical variation; this was especially the case following the establishment of NICE in 1999 given that these were stated as the Institute's primary objectives.[109] Within the legal subsystem, in accordance with its distinct coding, they provide presumptive evidence of what constitutes a lawful standard of care or, in the allocative context, of a rational exercise of administrative discretion.[110]

This brings us to a third issue, which is to identify the manner in which the legal subsystem responded, by means of its own processes and operations, to the perturbation in the medical/healthcare subsystem caused by the shift to this new basis for clinical practice. Here, it is important to understand EBM, and latterly HTA, as rationalist forms of activity in so far as they seek to determine 'the one best option' in a given situation, following an identification of the issue, an analysis of the alternative means of addressing it, an evaluation of the consequences of adopting each of the alternatives, and a

103 D Sackett, W Rosenberg, J Muir Gray et al, 'Evidence Based Medicine: What It is and What It isn't' (1996) 312 British Medical Journal 71, 71.

104 See e.g. NHS Management Executive, *Improving Clinical Effectiveness* (NHS Management Executive (EL (93)115) 1993).

105 For discussions, see e.g. J Hurst, 'The Impact of Health Economics on Health Policy in England, and the Impact of Health Policy on Health Economics, 1972–1997' (1998) 7 Health Economics S47; J Coast, 'A History that Goes Hand in Hand: Reflections on the Development of Health Economics and the Role Played by Social Science & Medicine, 1967–2017' (2018) 196 Social Science and Medicine 227; E MacKillop and S Sheard, 'Quantifying Life: Understanding the History of Quality-Adjusted Life-Years (QALYs)' (2018) 211 Social Science and Medicine 359.

106 M Kelly and T Moore, 'The Judgement Process in Evidence-based Medicine and Health Technology Assessment' (2012) 10 Social Theory and Health 1, 2.

107 Above (n 76) and accompanying text.

108 M Field and K Lohr (eds), *Clinical Practice Guidelines: From Development to Use* (National Academy Press 1992) 2.

109 For discussion, see K Syrett, 'NICE work? Rationing, Review and the "Legitimacy Problem" in the New NHS' (2002) 10 Medical Law Review 1.

110 For a general discussion of the relation between clinical guidelines and the law, see J Tingle and C Foster (eds), *Clinical Guidelines: Law, Policy and Practice* (Cavendish 2002).

comparison of the consequences with the objectives.[111] Priority-setting decisions in healthcare which are explicitly premised upon these approaches can therefore be seen as manifestations of rationalist policy-making.[112]

The social subsystem of law also obliges decision-making to be characterised by rationality, through the mechanism of judicial review. Hence, although guidelines may constitute the primary *mechanism* through which coupling is brought about, the underpinning of that coupling resides in a shared commitment by both subsystems to the value of rationality. Unsurprisingly, therefore, the perturbation in the legal subsystem, experienced through forms of coupling centred upon the collection and application of evidence, manifests itself in an adaptation of law's construction of the ground of irrationality as the basis of what it regards as an inappropriate (and therefore unlawful) mode of decision-making. Thus, as the earlier narrative outlines, there has been a shift in the law's stance on what constitutes an irrational decision in the healthcare allocation context, from an egregious decision which is 'outrageous in its defiance of logic',[113] to the more frequently witnessed one which is seen to be based upon 'flawed logic'. But this evolution takes place within the terms and processes established by the legal subsystem, not as a direct input from the medicine/healthcare subsystem. Hence, if (following Newdick) we take Lord Woolf's dictum in *Coughlan* as expressive of this evolution,[114] it is notable that 'the second face' of irrationality is justified on the basis of (admittedly imprecise) legal precedent ('as it has developed in modern public law') and of existing – not novel – jurisdictional reach ('another aspect of the decision which is equally the concern of the law').[115] This fits with Teubner's notion of 'self-referential closure' as characterising an autopoietic system of law, signifying:

> . . . the circular relation between legal decisions and normative rules: decisions refer to rules and rules to decisions . . . references to external factors, e.g. politics or religion, are replaced by references to legal rules (stemming from court decisions, doctrinal inventions, or legislative acts).[116]

The preceding account offers a way of comprehending the broad shift from judicial deference to interventionism and the legal means by which this is achieved, but it does not specifically enable us to distinguish between, and understand, the variants of 'hard look' scrutiny which, as outlined above, range from the procedural to the much more substantive. However, deeper investigation of the nature of EBM as a rationalist activity can be of assistance in this regard.

EBM may be understood, in Weberian terms, as an illustration of instrumental rationality, 'that is determined by expectations as to the behaviour of objects in the

111 See C Lindblom, *The Policy-Making Process* (Prentice Hall 1968) 12. The close correlation to EBM can be seen from the description of the core of the practice of the latter as consisting of five steps: (i) formulation of clinical questions; (ii) searching for the best evidence; (iii) critically appraising this evidence; (iv) applying this evidence to patients; and (v) evaluating the impact of this application: R Upshur and C Tracy, 'Legitimacy, Authority, and Hierarchy: Critical Challenges for Evidence-based Medicine' (2004) 4 Brief Treatment and Crisis Intervention 197, 198.

112 See J Russell and T Greenhalgh, 'Being "Rational" and being "Human": How National Health Service Rationing Decisions are Constructed as Rational by Resource Allocation Panels' (2014) 18 Health 441; T Tenbensel, 'Health Prioritisation as Rationalist Policy Making: Problems, Prognoses and Prospects' (2000) 28 Policy and Politics 425.

113 *CCSU* (n 46) 410 (Lord Diplock).

114 See above (n 47) and accompanying text.

115 *Coughlan* (n 47) [65] (Lord Woolf MR).

116 G Teubner, 'Autopoiesis in Law and Society: A Rejoinder to Blankenburg' (1984) Law and Society Review 291, 295.

environment and of other human beings; these expectations are used as "conditions" or "means" for the attainment of the actor's own rationally pursued and calculated ends'.[117] As Schwandt argues:

> [This form of] rationality is monological and a matter of having the correct procedure for constructing descriptive, interpretive, and/or evaluative statements, assertions or claims about various kinds of "objects" that are evaluated. This approach, in turn, is wedded to a model of strategic political action aimed at "solving problems" in social programming. Administrators and policymakers seek to manage economic and social affairs "rationally" in an apolitical, scientized manner.[118]

Hence, under this approach, the focus is upon the gathering of 'better evidence of "what works" in terms of policy intervention':[119] the best such evidence being 'that which is derived through quantitative methodologies, empirically-tested and validated'.[120] In the case of EBM, this is manifested in a hierarchy of evidence reflective of the propensity of the method to avoid bias, in which epidemiological evidence derived from systematic reviews and meta-analyses of randomised controlled trials sit at the top, and unsystematic clinical observations lie at the foot.[121]

With this analysis in mind, we might plausibly read contentious judgments such as *Ross* and *Otley* and *obiter dicta* in *Rose* and *Servier Laboratories*, where judges connect irrationality with a misunderstanding or misapplication of, or departure from, evidence, merely as further instances of law's adaptation to the external stimulus of EBM through its own internal processes for 'seeing' and 'understanding' the environment. These judges articulate a 'legal construction of social reality',[122] through continued invocation of the ground of irrationality, but they choose to do so in a way which explicitly foregrounds EBM's objective, quantitative and rationalist forms of knowledge as the bases of logical – and therefore lawful – decisions. It might, perhaps, be said that there is evidence of especially close structural coupling between the subsystems of healthcare and law in these cases.

However, this particular filtering of the external pressures of EBM into the normative structures of the law is far from unproblematic. Drawing on the notion of the self-referential closure of a system,[123] Deakin and Carvalho observe that:

> . . . the essential characteristic of the order of the legal system as a system of communication is the importance of its internal congruence . . . the agents who participate in the making of legal communications do so on the basis of a set of shared understandings about the nature of the legal system. It is on this basis that the legal system can be said to "reproduce itself" over time.[124]

The question which arises, therefore, is whether the approach taken in these cases complies with 'shared understandings'. Of course, in one sense it does so, since it falls under the head of irrationality and, as noted above, Lord Woolf's explanation of the

117 M Weber, *Economy and Society: An Outline of Interpretive Sociology*, G Roth and C Wittich (eds) (Berkeley University of California Press 1978) 24.

118 T Schwandt, 'Evaluation as Practical Hermeneutics' (1997) 3 Evaluation 69, 74

119 I Sanderson, 'Getting Evidence into Practice: Perspectives on Rationality' (2004) 10 Evaluation 366, 368.

120 I Sanderson, 'Evaluation, Policy Leaning and Evidence-Based Policy Making' (2002) 80 Public Administration 1, 6.

121 G Guyatt, D Sackett, J Sinclair et al, 'Users' Guides to the Medical Literature. IX. A Method for Grading Health Care Recommendations' (1995) 274 Journal of the American Medical Association 1800.

122 The phrase is that of Teubner (n 97) 249.

123 See above (n 116) and accompanying text.

124 Above (n 71) 9.

'second face' of this ground may be viewed as an exercise in self-reference. From another standpoint, however, the more expansive reading of the ground, which (as argued previously) appears more substantive in orientation than is usual, does not appear wholly consistent with a broadly shared understanding permeating most of the remainder of the case law on allocation of scarce healthcare resources – from the decision of the High Court in *ex parte B* onward – that the focus of review should lie with the *process* of decision-making. This lack of congruence affords an explanation for the ambivalent stance of the courts in the third category of allocative case identified previously in this article: other judges do not share the same understandings as to the nature and scope of the irrationality ground as their brethren presiding in these cases.

This connects closely to a further, and final, question about the possible future direction of judicial activity in this decision-making context. What might insights from systems theory tell us about the likelihood of judges continuing to cleave to the 'traditional' approach to allocative choices, in which the emphasis is primarily upon procedural aspects of the decision, as against a more substantive reading in which the understanding and application of evidence is much more closely scrutinised?

As we have seen, since the legal system is cognitively open to its environment, it possesses the capacity to adapt to external stimuli experienced via mechanisms of structural coupling. But systems theory teaches us that such adaptation is neither automatic nor complete, since 'the scope for legal variation is constrained by the need to maintain the legal system's autonomy and internal consistency'.[125] It follows that there is no inevitability that a more substantive reading of irrationality in this context will eventually secure hegemonic status, even though it may constitute a 'better fit' with the environment (at least so long as EBM retains *its* hegemonic status). The key, rather, is 'how far [the revised reading] operate[s] consistently with the internal categories of legal analysis'.[126] Here, it is pertinent to remind ourselves that, while judicial scrutiny of healthcare allocation has been analysed in this article as if it were a discrete, autonomous field, it functions in reality merely as a subset of the broader law of judicial review.[127] Both congruence, and the scope of adaptation, can therefore only fully be understood by reference to that wider jurisprudential context. This is because:

> . . . it is a feature of legal orders that the meaning which they create refers to a shared perception that individual legal communications are linked together to form a coherent body of norms. In other words, for the agents who operate within and by reference to it, an understanding of the legal system cannot be obtained from an analysis of isolated elements, but derives from the process of self-observation of the system as a 'whole'.[128]

Accordingly, it is necessary to look beyond the law on healthcare allocation to ascertain whether that which has been identified here as a more substantive reading of the irrationality ground links coherently with norms elsewhere; if it does so, then there is much greater likelihood of future development in this direction. The position here is somewhat unclear. Historically, close scrutiny of the evidential basis for a decision has not

125 S Deakin, 'Legal Evolution: Integrating Economic and Systemic Approaches' (Centre for Business Research, University of Cambridge Working Article No 424 2011) 17.

126 S Deakin, 'Juridical Ontology: The Evolution of Legal Form' (2015) 40 Historical Social Research 170, 177.

127 See further above (n 44) and accompanying text.

128 Deakin and Carvalho (n 71) 9.

formed an important part of the court's role in a judicial review case.[129] However, there are indications that this may be changing, in particular because of the increased use of the proportionality standard. Since this test can be seen to 'reflect appropriate means-end rationality',[130] it is inevitable that 'judicial assessments of proportionality often depend upon complex empirical questions'.[131] A growing (albeit incomplete) convergence between this standard and the ground of irrationality, which has support from some academics and judges,[132] would point to the potential for increasing coherence between the more substantive mode of judicial interventionism grounded upon close scrutiny of the evidential basis for decisions, and broader systemic norms: but there remains some distance to travel. Consequently, the ambivalent judicial stance outlined previously seems likely to persist for the time being.

Conclusion

The last point serves as a valuable reminder that an approach to the understanding of medical law (or any other field of law) which is informed by understandings drawn from systems theory need not, and should not, render 'traditional' doctrinal legal analysis redundant. This is unsurprising, because Luhmann considers legal argumentation, which includes the reasoning of judges deciding a case in a particular way, to amount to one of the principal ways in which communication – which lies at the heart of his theory – occurs within the legal system.[133]

That said, systems theory adds an important dimension to a purely doctrinal approach, in the form of its attentiveness to the social context in which law sits. Superficially, this seems paradoxical given the emphasis of the theory upon the autonomy of systems, including law, but it must be remembered that the autonomous nature of a system comes about by way of *differentiation from a surrounding environment*, and that systems are cognitively open to that environment. This provides a means of comprehending legal change, which is triggered through structural coupling. The argument posited in this article is that an increased focus upon evidence as the basis for decisions in healthcare, manifested in particular in clinical guidelines and founded upon instrumental rationality, coupled the systems of medicine/healthcare and law together and simultaneously operated as a perturbation to the legal system.

However, systems theory also rejects a straightforward 'input–output' (or 'stimulus–response') model of interaction with the environment. This casts doubt upon analyses which seek to explain developments in legal norms as *caused* by external pressures (or vice versa), such as shifting approaches to allocative decision-making in the NHS. Rather, the pressures from the environment (such as those created by the rise of EBM) are received within and constructed by the legal system's own normative criteria, since 'the legal system models the environment in its own terms'.[134] In the field surveyed here, this is

129 See J Tomlinson and K Sheridan, 'Judicial Review, Evidence, and Systemic Unfairness in the UK' (*IACL-AIDC Blog*, 3 September 2018) <https://blog-iacl-aidc.org/blog/2018/9/3/judicial-review-evidence-and-systemic-unfairness-in-the-uk>.

130 M Cohen-Eliya and I Porat, *Proportionality and Constitutional Culture* (Cambridge University Press 2013) 126.

131 A Carter, 'Constitutional Convergence? Some Lessons from Proportionality' in M Elliott, J Varuhas and S Stark (eds), *The Unity of Public Law?: Doctrinal, Theoretical and Comparative Perspectives* (Hart 2018) 373.

132 See e.g. P Craig, 'The Nature of Reasonableness Review' (2013) 66 Current Legal Problems 131; *Kennedy v Charity Commission* [2014] UKSC 20, [54] (Lord Mance JSC); *Pham v Home Secretary* [2015] UKSC 19, [94] (Lord Mance JSC), [104]–[109] (Lord Sumption JSC).

133 See King and Thornhill (n 78) 45.

134 R Lempert , 'The Autonomy of Law: Two Visions Compared' in G Teubner (ed), *Autopoietic Law: A New Approach to Law and Society* (Walter de Gruyter 1988) 153.

manifested in developments in the ground of irrationality in respect of questions of healthcare allocation, but the consistency of certain of these developments with the wider body of norms is questionable, giving rise to some uncertainty as to the future pattern of evolution in view of the importance of internal congruence to the effective operational performance of the legal system.

In sum, this article has sought to demonstrate that a systems theory perspective can assist in building an enhanced understanding of this area of medical law. However, the utility of this approach surely extends well beyond this particular context. To illustrate this, a final point may be considered:

> For Luhmann . . . 'truths', which assume the existence of some external, objective arbiter of rightness . . . stand in the way of any 'sociological' understandings of the contingent nature of society. They are remnants of the Enlightenment notion of 'perfection' through which precise external causes could be identified for each evident imperfection in society, and 'naturally good' and 'naturally bad' explanations and solutions could be readily distinguished from one another.[135]

Systems theory therefore teaches us, through its foundation in the functional differentiation of society, that no single 'view of the world' predominates. Here lies the basis of a further challenge to a view of medical law which takes bioethics as central.[136] It is through a capacity to yield insights of this type that systems theory demonstrates its value, and it is submitted, therefore, that it is worthy of careful consideration by anyone seeking to analyse and explicate the present terrain, or to map the future trajectory, of medical law.

135 King and Thornhill (n 78) 3.

136 It is perhaps pertinent to note here that Luhmann regarded the systems of *morality* and law as functionally differentiated: see N Luhmann, 'Politicians, Honesty and the Higher Amorality of Politics' (1994) 11 Theory, Culture and Society 25, 29.