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Contents

Editorial

The present members of the editorial board wish to say a big ‘Thank You’ to the former editor of the journal, Emerita Professor Patricia Park, for the excellent role she played as editor from the inception of the journal in 1992 to 2018, when it was re-launched.

This volume of the journal features articles from various areas of law such as mental health law, human rights, medical law and criminal law, and intellectual property law.

The first article concerns admission for assessment under the Mental Health Act 1983, as amended by the Mental Health Act 2007. After noting that there is compulsory admission for ordinary assessment (under section 2 of the Act of 1983) and compulsory admission for assessment in an emergency (under section 4 of that Act), the author goes on to consider matters largely missing from the existing literature – namely: evolution of admission for assessment; a comparison of sections 2 and 4 of the Act; some problems relating to section 2 and its conversion to section 3 (which is about compulsory admission for treatment) in circumstances where a patient’s nearest relative does not consent to the section 3 application being made – and then suggestions for reform of the law. Those proposals concern, *inter alia*, the procedure under section 29 of the Act of 1983 regarding displacement of a patient’s nearest relative.

The second paper concerns human rights and people living with HIV/AIDS (PLWHAs). The paper was based on doctoral research conducted in Kenya (one of the countries ‘in the most affected, less industrialised regions of the global south’) at the height of the AIDS crisis in the early 2000s to mid 2000s, which sought to gain insight into how the respondents (PLWHAs) held and articulated ideas about entitlements and obligations. The article notes, *inter alia*, that HIV/AIDS remains a major public health concern in Kenya and that PLWHAs still face various problems that are related to the illness, such as stigma, discrimination and limited access to life-prolonging antiretroviral drugs. It concludes that the implications of HIV/AIDS for persons living with the illness are profound indeed, but that HIV/AIDS has also, arguably, impacted their awareness and perceptions of their entitlements and rights.

The third article concerns euthanasia and the problems that legalising it would pose. It examines the current law on euthanasia and assisted suicide in England and Wales, and notes, among other things, that

euthanasia may seem to be a fair outcome in many cases involving a terminally ill person or one who is going through unbearable suffering, and, so, genuinely wishes to die. But, then, in contrast with the view that some people ought to be rightfully allowed to terminate their life with the help of some other person, there are other persons who would be subjected to involuntary euthanasia because of the pressure that might be put on them should euthanasia be legalised. The paper discusses how the principle of the sanctity of life is not absolute and, as such, would not safeguard the vulnerable from involuntary euthanasia. It laments the absence today of both precise and clear criteria and adequate safeguards on this very controversial matter. The author also evaluates, albeit briefly, the approach of the Netherlands to euthanasia and concludes that to legalise any form of euthanasia in this jurisdiction now would lead, unavoidably, to vulnerable individuals being outrageously killed.

The fourth paper, in the legal comment section, concerns intellectual property law. It discusses the internet blocking order and its extension to incidents of trademark infringement by *Cartier International AG v British Sky Broadcasting Ltd* ([2016] EWCA Civ 658), popularly known as the '*Cartier* case'. An internet blocking order is an order issued by the court where operators and/or users of a website are using the services provided by certain service providers to infringe any intellectual property right/s. The claimants in the case claimed infringement of their registered trademarks by the operators of internet websites which were selling counterfeit goods. They sought an injunction, therefore, to require the defendants to block access to the infringing websites. The order was issued by the Court of Chancery, and upheld by the Court of Appeal when the defendants appealed. The author discusses the reasons for the decisions and expresses deep concern about the vast potential for further expansion of the internet blocking order, where it will go next and its implications for the future.

The last paper is a review of a book on intellectual property law. We warmly welcome reviews of newly published books/materials about any area of law, the teaching of law and legal practice.

Dr Benjamin Andoh, Editor

Admission for Assessment under the Mental Health Act 1983

Dr Benjamin Andoh

Abstract

There are two types of involuntary admission to hospital for assessment under the Mental Health Acts – admission for ordinary assessment and admission for assessment in an emergency. Loosely speaking, assessment may be said to be a kind of psychiatric evaluation; but it is distinct from treatment. Although the issues arising from involuntary admission for assessment have been considered in various secondary sources, largely missing from the literature are: a comparison of sections 2 and 4 of the Mental Health Act 1983 (governing admission for ordinary assessment and admission for assessment in an emergency, respectively); consideration of the problems relating to the transition of a patient's admission from section 2 to section 3 of the Mental Health Act 1983; and suggestions to address those problems. This article aims to fill that gap. It looks at, first, the evolution of admission for assessment; secondly, the present position (including a comparison of sections 2 and 4 of the Mental Health Act 1983); thirdly, certain problems concerning section 2; and, lastly, proposals for reform of the law.

Keywords: admission for assessment; section 2 of the Mental Health Act 1983; section 4 of the Mental Health Act 1983; section 29 of the Mental Health Act 1983; section 66(1) of the Mental Health Act 1983

Introduction

Compulsory admission of a mental patient to hospital for assessment is of two types, namely, admission for ordinary assessment under section 2 of the Mental Health Act 1983 and admission for assessment in an emergency under section 4 of the Mental Health Act 1983. Under section 2 the assessment may be for up to 28 days, whereas under section 4 it may

be for only up to 72 hours. These two sections cover 'civil admissions' (that is, the admission of patients not concerned in criminal proceedings). Assessment may be defined loosely as a type of (psychiatric) evaluation, usually looking at whether the person concerned is suffering from a mental disorder (as defined now by the Mental Health Act 2007), what the type of mental disorder that he/she is suffering from is, and whether that person needs any treatment and how they may respond.

Of course, there are accounts of admissions for assessment and for treatment in various secondary sources.[1] However, largely missing from the literature are a focus on the comparison of sections 2 and 4 of the Mental Health Act 1983 (MHA 1983); consideration of the problems relating to section 2, in particular; and suggestions on how to address those problems. This article aims to fill the gap. After this introductory part, the paper looks, first, at the evolution of admission to hospital for assessment, secondly, at the present position (including a comparison of sections 2 and 4, as well as a consideration of some problems relating to section 2), and, lastly, at proposals for reform of the law.

I. Evolution of admission for assessment: the pre-1982 position

Before the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954–1957 (the Percy Commission) reported in 1957 – the recommendations of which Report were embodied in the Mental Health Act 1959 – compulsory admission to hospital for assessment ('observation', to use the terminology of the said Report of 1957) was unknown. Actually, prior to the passing of the Mental Health Act 1959, the only mode of admission that was nearest to admission for assessment in an emergency was the urgency order under the Lunacy Act 1890, s.11, which (though not applicable to pauper lunatics) could be signed by the spouse or other relative of the alleged patient,[2] required one medical certificate and lasted for up to seven days.

Paragraph 42 of the Royal Commission's Report[3] contained the Commission's recommendation for compulsory admission to hospital for

[1] See, for example, B. Hale (with P. Gorman, R. Barrett and J. Jones), *Mental Health Law*, 6th edition (London: Sweet and Maxwell, 2017); P. Bartlett and R. Sandland, *Mental Health Law, Policy and Practice* (Oxford: Oxford University Press, 2014); and L. Gostin, P. Bartlett, J. McHale and R. MacKay (eds), *Principles of Mental Health Law and Practice* (Oxford: Oxford University Press, 2010), ch. 12.

[2] Before 1930, patients were known as 'lunatics', but as a result of the terminological changes brought in by the Mental Treatment Act 1930, 'lunatic' became 'patient'; see s.20(5), Mental Treatment Act 1930).

[3] (London: HMSO, 1957), Cmnd. 169.

observation for up to 28 days, for which two medical recommendations were required, and admission for observation in an emergency, for which only one medical recommendation was required. These recommendations, among others, were put into effect by the Mental Health Act 1959 (MHA 1959), ss.25 and 29.

1. Admission for Observation (s.25, MHA 1959)

A patient could be admitted for observation on two grounds: firstly, he must have been suffering from mental disorder of a nature or degree that warranted detention in hospital for a limited period; and, secondly, his detention must have been for his own health or safety, or for the protection of other people (s.30(2), MHA 1959).

In addition, an application must have been made to the hospital managers by either his nearest relative or by a mental welfare officer (the equivalent of 'approved social worker' under the MHA 1983, and of 'approved mental health professional' under the MHA 2007); and the application must have been supported by two written medical recommendations, each stating that the two grounds for detention for observation had been satisfied (s.25(3), MHA 1959). The applicant must also have personally seen the patient within 14 days before the date of the application (s.27(3), MHA 1959).

The medical recommendations must have been signed before or on the date of the application and the medical practitioners must have personally examined the patient together; otherwise, not more than seven days must have elapsed between the two recommendations (s.28(1)).

The period of detention under section 25 (that is, under an admission for observation) was up to 28 days. After that period the patient should not be compulsorily detained. However, before the end of the period, an application, for example, under section 26 (that is, for admission for treatment) could be made to authorise further detention (see s.25(4), MHA 1959).

Another requirement was that one of the recommending doctors must have been approved by a local health authority as having special experience in diagnosing and treating mental disorder, and he, or the other one, must have been previously acquainted with the patient (s.28(2), MHA 1959). Also, only one of them could be on the staff of the admitting hospital (s.28(3)), except where the patient was a private patient.

To safeguard the patient against being compulsorily detained in hospital (for whatever reasons), the following persons were not allowed to give a medical recommendation:

(a) the person who made the application to the hospital managers

(b) a partner of the applicant or any of the recommending doctors

(c) any person employed as an assistant by the applicant or by any of the recommending doctors

(d) any person in receipt, or with an interest in the receipt, of any payments made for the patient's maintenance

(e) a doctor on the staff of the admitting hospital, if the patient was a private patient

(f) the spouse, any parent, father-in-law, mother-in-law, son, son-in-law, daughter, daughter-in-law, brother, brother-in-law, sister or sister-in-law of the patient or any of the recommending doctors, or of any other person aforementioned (s.28(4)).

2. Emergency admission for observation (s.29 MHA 1959)

In an emergency, however, the application by a patient's relative or a mental welfare officer for compulsory admission for observation could be supported by only one medical recommendation. The applicant must have personally seen the patient within three days ending with the date of the application (s.29(4)). Also, the application must have stated that the patient needed to be admitted and detained under section 25 as a matter of urgent necessity and that undesirable delay would be involved by complying with the provisions of the Act relating to applications for admission under that section (s.29(2), MHA 1959).

As long as the medical recommendation was given by a qualified medical practitioner who, if practicable, was previously acquainted with the patient (he did not need to be an approved psychiatrist) and he was not disqualified by section 28(4) as a recommending doctor, the emergency application for admission for observation was operative for up to 72 hours, starting from the time of the patient's admission to hospital. If, however, during that period, the second medical recommendation required under section 25 was received by the hospital managers and both medical recommendations complied with all the requirements regarding medical

recommendations (with the exception of that about when the second recommendation should be signed), then the patient could be detained for observation for up to 28 days (s.29(3), MHA 1959).

II. The present position

The provisions of the MHA 1959 regarding admission for observation and admission for observation in an emergency were retained – with minor modifications (such as replacement of the term 'mental welfare officer' with 'approved social worker') – by the Mental Health Act 1983 (MHA 1983), which consolidated previous legislation, including the Mental Health (Amendment) Act 1982. (The Mental Health Act 2007 (MHA 2007) replaced the term 'approved social worker' with 'approved mental health professional' (AMHP).) The provisions of sections 2 and 4 of the MHA 1983 – which are similar to sections 25 and 29 of the MHA 1959 as regards their grounds, criteria, procedure and duration – will now be considered.

Section 2 of the MHA 1983 provides for compulsory admission for assessment (or assessment and afterwards medical treatment) and detention for that purpose for up to 28 days. The grounds for the application are: (a) the patient is suffering from mental disorder of a nature/degree warranting detention in hospital for assessment (or for assessment followed by medical treatment); and (b) the patient must be detained as such in the interests of his/her own health/safety or in order to protect other persons. The application may be made by either the patient's nearest relative or an approved mental health professional,[4] and requires two medical recommendations.[5]

Section 4 of the MHA 1983 also provides for compulsory admission of a patient for assessment, but in cases of urgent necessity. This emergency application must include a statement that admission and detention of the patient under section 2 is of urgent necessity, and that compliance with the provisions of section 2 would involve undesirable delay. Hence, only one medical recommendation is required. The application may be made by the patient's nearest relative or by an approved mental health professional. The power of detention under this

[4] S.11(1), MHA 1983. As already stated, this new term under the MHA 2007 replaced 'approved social worker'.
[5] See, for example, *R v Wilson (ex p. Williamson)*, *The Independent*, 19 April 1995, and *MH v UK* ((11577/06) (2014) 58 EHRR 35; [2014] MHLR 249; (2014) 136 BMLR 17).

section lasts for up to 72 hours, unless it is converted to section 2 by the provision of a second medical recommendation.[6]

Therefore, the assessment in either case has the objective of determining whether the criteria for detention in hospital are satisfied and, where they are, whether application for further detention of the patient ought to be made (para. 14.33, Code of Practice, MHA 1983 (2015)). But there are some related matters that must be noted in order to enhance our understanding of admissions for assessment.

First, section 12A of the MHA 1983 regarding 'conflicts of interest', that is to say, persons not allowed to give a medical recommendation, is similar to section 28(4) of the MHA 1959, although it has improved the list of areas of conflicts of interest. Following the MHA 2007, the Mental Health (Conflicts of Interest) Regulations 2008 were made. Regulations 4, 5, 6 and 7 specify the circumstances in which a potential conflict of interest would arise.[7] As is well documented,[8] some relatives in the past, who wanted to take control of their mentally disordered relatives' financial assets, etc., often arranged with medical practitioners to have those relatives admitted to hospital involuntarily. So, these Conflicts of Interest Regulations may be properly described as 'anti-conflict-of-interests provisions', because what they do is generally not permit medical recommendations, etc., to be made in circumstances where there is likely to be a conflict of interest on any of the specified grounds.

Secondly, regarding section 4, for an emergency to arise, there must be evidence of (a) immediate and considerable risk of physical or mental harm to the patient or to other persons, and/or (b) risk of serious harm to property, and/or (c) the need for the patient to be restrained physically. This is clearly stated by paragraph 6.3 of the Code of Practice 2015. If, therefore, the section is used when there is no genuine emergency, but rather, because it is administratively convenient, that would constitute abuse of the section. There would similarly be abuse of the section if the only reason for using it was because a second medical recommendation could not be obtained or because it was more convenient for the second

[6] S.4(4), MHA 1983. Actually, in *R (Bradenburg) v East London and City Mental Health NHS Trust* [2004] AC 280, the patient's admission under section 4 of the MHA 1983 was converted to section 2 on the same day.

[7] Regulation 4 covers potential conflicts of interest for financial reasons; regulation 5, potential conflicts of interest for business reasons; regulation 6, potential conflicts of interest for professional reasons; and regulation 7, potential conflicts of interest on the basis of a personal relationship.

[8] See, for example, N. Walker and S. McCabe, *Crime and Insanity in England*, vol.1, 1st edition (Edinburgh: Edinburgh University Press, 1979).

medical practitioner to examine the patient in hospital instead of somewhere else.

Thirdly, in the case of section 2 it is crucial to note that failure to adhere to the provisions of section 2(4) would result in abuse of the section 2 as a whole. In short, the effect of section 2(4) is that, after 28 days, another detention under section 2 is not possible. Indeed, *R v Wilson* (*ex parte Williamson*) illustrates this point nicely. Therefore, section 2 is a 'non-renewable section'.[9] After the 28 days of section 2 have expired, the patient becomes informal or must be discharged. While informal, they may be subjected to sections 5(4) or 5(2): section 5(2) authorises an approved clinician to 'hold' the patient in hospital for up to 72 hours by furnishing a report to the hospital managers, while section 5(4) authorises a nurse of the prescribed class to hold the patient in hospital for up to six hours, pending the arrival of the approved clinician.[10] If section 3 is deemed necessary while the patient is informal, the section 3 application, if made by the AMHP, will not proceed smoothly unless the nearest relative consents. However, if the nearest relative refuses to consent, they can be displaced via section 29. (The lesson to be learnt here, therefore, is that the hospital must act quickly to use section 29 within 28 days of the section 2, and then the section 3 can be implemented after the court has decided the section 29 issue.)

Sections 2 and 4 will now be compared, before a consideration of certain problems arising from them.

III. Comparison of the two sections

The two sections are similar in several ways. First, they are both compulsory 'civil admissions', that is, involuntary admissions of patients who are not involved in criminal proceedings.[11] Secondly, their purpose is assessment. Thirdly, because patients admitted under those two sections are compulsory patients, they have, as well as their common-law rights as ordinary citizens, particular rights under the Mental Health Act 1983; and, according to s.132, MHA 1983, the hospital managers have a duty to inform them, orally and in writing, about those rights when they are admitted to hospital. Fourthly, the grounds for applying for admission

[9] M. Piller, 'Mental Health and Compulsion', *Journal of Mental Health Law*, February 2000, 16.
[10] It is possible for even a section 3 application to be made if all the requirements of that section are satisfied.
[11] Being compulsory (or 'sectioned') patients, patients under sections 2 and 4, MHA 1983 are subject to restrictions under the Act, for example, interference with their mail (s.134(1) and (4), MHA 1983), etc.

under the two sections are similar: (a) the patient is suffering from mental disorder of a nature/degree warranting detention in hospital for assessment; and (b) the patient must be detained as such in the interests of his/her own health/safety or to protect other persons, except that, as regards section 4, where the application is made in an emergency, the patient cannot generally be given treatment without his/her consent. Fifthly, the application for admission under either section may be made by the patient's nearest relative or by an approved mental health professional. Sixthly, medical recommendations must support the application for admission, although two are required for section 2.[12] Seventhly, as regards both sections, the patient's nearest relative can apply for discharge of the patient, although this is subject to a medical veto. Eighthly, no leave of absence is granted to patients admitted under the two sections, because they are in hospital primarily for assessment. Ninthly, both sections are non-renewable; s.2(4), MHA 1983 and *R v Wilson (ex parte Williamson)* show this clearly in the case of section 2. Tenthly, both sections can be converted; section 4 can be converted into section 2, if a second medical recommendation is provided within the 72-hour duration of that section, or into section 3, if all the requirements of that section are met within those 72 hours; and section 2 can also be converted but into section 3 if the requirements of section 3 are met within the 28-day duration of the section 2. Lastly, patients under both sections 2 and 4 may be retaken and returned to hospital if they abscond, although the periods within which they may be retaken are different.

However, there are also some important differences between s.2 and s.4, MHA 1983. Those differences include the following:

(i) Whereas section 2 is for normal or usual assessment, section 4 is for emergency assessment or assessment in an emergency.

(ii) The duration of each section is different – section 2 lasts for up to 28 days, but section 4 up to 72 hours. However, it is important to note here that, if a section 4 is converted to section 2, the period of time the patient has already spent in hospital will count towards the 28-day period under section 2.

[12] One reason for noting this similarity is historical. Before 1959 (when the Lunacy Act 1890 applied), admission to a mental hospital (then known as an asylum) was scarcely without certification by a justice. But the Mental Health Act 1959 replaced the legalistic tendencies of the law with domination by the medical profession so that, since that Act came into effect, some medical recommendation was required for all compulsory admissions to hospital, including the admission of patients involved in criminal proceedings.

(iii) The right of a compulsory patient to apply to the First-tier Tribunal (Mental Health Tribunal) can be exercised by a section 2 patient within the first 14 days of admission (under s.66(1)(a), MHA 1983), but not by a section 4 patient.

(iv) Whereas a section 4 patient must be admitted within 24 hours of the time of the medical examination or the time the application is made, whichever is the earlier, an admission under section 2 has to be arranged within 14 days of the last medical examination.

(v) Another difference regards the number of medical recommendations required (only one is required for section 4, but two are required for section 2, where the two doctors must also have seen the patient within five days of each other).

(vi) The periods within which a section 2 patient and a section 4 patient may be retaken if they abscond from hospital are also different. A patient detained under sections 2 or 4 of the 1983 Act can be retaken only if the period for which he is liable to be detained has not expired; this period is 28 days for section 2 patients and 72 hours for section 4 patients.[13]

(vii) A section 4 patient can only be discharged by the responsible clinician, whereas a section 2 patient can be discharged by the responsible clinician as well as the patient's nearest relative (if the responsible clinician does not object), or by the Mental Health Review Tribunal (MHRT).[14]

(viii) Lastly, as regards treatment:
   (a) A section 4 patient cannot be given treatment without his/her consent unless the treatment is required in an emergency or the patient does not have capacity, in which case the treatment must be in their best interest.
   (b) Conversely, a section 2 patient's consent is, generally, not required for treatment to be given to him or her; the exception to this is where the treatment in question requires such consent (for example, electro-convulsive therapy (ECT)[15]).

[13] So, for example, if a section 2 patient absconds after spending eight days in hospital, he/she can be retaken only within 20 days; but a section 4 patient who absconds after spending 10 hours in hospital can be retaken within 62 hours.
[14] See, for example, *R (Bradenburg) v East London and City Mental Health NHS Trust* [2004] 2 AC 280.
[15] Loosely called electric shock treatment.

Sections 2 and 4, therefore, have certain things in common, but there are some differences between them. Besides that, some of the problems with section 2 were identified during perusal of the primary sources. These will now be discussed.

IV. Some problems with s.2, MHA 1983

1. Suspension of the section 2 period during section 29 proceedings

When county court proceedings are commenced for displacement of the nearest relative of a section 2 patient (under s.29, MHA 1983) for the purpose of admission of the patient under s.3, MHA 1983, the 28-day period of detention under section 2 is suspended till the matter of displacement has been finally decided. This extended period can, however, be a long time, depending on the circumstances, and so may be problematic. A quick look at the procedure that is followed when an application is made under s.29, MHA 1983 will help us understand better this problem relating to the extension of the 28-day period of section 2. The section 29 procedure itself is, generally, an accelerated one.

First, the application is made by a lawyer representing the social services concerned. If the application is made in the morning, sometimes it is possible to go before a county court judge in the afternoon of that day; if not, then that can be done on the morning of the next day. Any delay is likely to be on the part of the social services, because an AMHP must first make a report. (If the AMHP's licence has expired, then the social services must act promptly to get it reissued, or get another AMHP to do the report.) The application papers must also include two medical reports. The application is then served on both the nearest relative and the patient.

The next stage is an interim decision by a county court judge. A date is then fixed for a hearing. In most cases the matter is concluded in a week or two weeks. But because the nearest relative may wish to instruct a solicitor and get medical evidence as well, the date of the hearing may be put back, so the usual up-to-two-weeks period for concluding the matter of displacement may be exceeded.

Therefore, after the interim decision, depending on what the nearest relative does, there will be a full-blown hearing. The hearing can last about a month or more – if not within a month, then a little over one month. Any adjournment will depend on:

(i) the nearest relative and what he/she does

(ii) the number of people involved in the case and their availability.[16]

So, depending on the circumstances of each case (including whether there is an appeal against the county court's decision), the section 2 period of detention, as suspended, can last quite a long time (up to six months or even more, as shown by *MH v UK* (2014) 58 EHRR 35, discussed below). This can be a real problem from the patient's perspective and also that of civil libertarians concerned about the possibility of a double or treble 'extension' of the 28-day period as a result of the section 29 procedure. Therefore, to improve the present position, it is suggested that there should be a statutory provision for a speedy section 29 procedure.

One way of doing this is a statutory amendment of section 29 in the following way:

(a) The displacement proceedings should be completed within three months (90 days), and any party who, for no sufficient or justifiable reason, prolongs (or causes delay in) the proceedings will have judgement by default recorded against them.

(b) The practicalities of the amendment can be worked out by Parliament itself or be commissioned by Parliament to some appropriate body to work out.

(c) If the default judgement goes against the nearest relative (NR), then that NR is replaced, the section 3 can go ahead, and the patient gets treated properly. However, if the default judgement is against the local authority (responsible for the social services), then, because the patient needs to be treated in hospital, the court must order that local authority to nominate another nearest relative or AMHP within 24 hours, so that the original nearest relative can be replaced by that nominated person. Then admission under section 3 can go ahead without further delay. Additionally, the court should be given power to fine considerably the local authority concerned, in order to deter such delays by local authorities.

[16] The main participants are the nearest relative, the AMHP, two doctors, the lawyers of the social services and the lawyers and witnesses (medical), if any, of the nearest relative (interview with a retired senior solicitor of a London borough council with special responsibility for the borough's social services (9 January 2018)).

2. Is s.2, MHA 1983 compatible with Art. 5(4), ECHR 1950?

This issue (among other related ones) came up in *MH v UK* ((2014) 58 EHRR 35). Because the case went beyond the House of Lords to the European Court of Human Rights (ECHR), and in order to appreciate its significance, it is worth looking at in some detail. The applicant in that case, MH, was born in 1970 with a severe disability (as a result of Down's syndrome). She was taken to hospital on 31 January 2003 under s.135(1), MHA 1983 and then admitted under section 2 of the Act. Her mother, who was her nearest relative, exercised her right under s.23(2)(a), MHA 1983 to discharge her from hospital, but that was promptly vetoed by the responsible medical officer by issuing, under s.25(1), MHA 1983, a barring order, that is, a report certifying that, if MH were discharged, she would be likely to behave in a way dangerous to herself or to other persons. That order in effect nullified the nearest relative's purported discharge of MH from hospital, and also barred her from discharging MH under s.23, MHA 1983 for six months.

During the first 14 days of MH's detention, she (MH) could apply to the MHRT but did not do so because she lacked capacity. After those 14 days her solicitors, on 6 March 2003, asked the Home Secretary to refer her case to the Tribunal under his powers under s.67, MHA 1983. The Home Secretary so referred her case, but the Tribunal refused to discharge her. Then one week before the expiration of the 28 days of detention allowed under section 2, a local authority social worker asked for the consent of MH's mother to the making of an order for guardianship of MH.[17] Her mother refused to consent, so the social worker applied to the county court under section 29 for her displacement as MH's nearest relative. Upon the application being made, the 28-day maximum period of detention under section 2 became automatically suspended (or extended), under section 29(4), until the court could finally decide the issue.

Later, on 25 May 2003, MH's mother (in the capacity of MH's 'litigation half') started proceedings for judicial review against the Secretary of State, etc. She sought: (a) a declaration that s.66(1), MHA 1983, regarding applications to the Tribunal for discharge, was incompatible with Article 5(4) of the European Convention for Human Rights 1950 because it placed on the applicant the burden of applying to the Tribunal; (b) a declaration that s.66(1), MHA 1983 was also

[17] If an application for admission for treatment under s.3, MHA 1983 or for guardianship under s.7, MHA 1983 is made by an AMHP, then the nearest relative must consent (see s.11(4), MHA 1983).

incompatible with Article 5(4) of the European Convention for Human Rights 1950 because, after the barring order against her mother/nearest relative had been made under s.25(1), MHA 1983, she (the applicant) or her mother did not have any right to apply to the Tribunal; and (c) a declaration that s.29(4), MHA 1983 was incompatible with Article 5(1) of the ECHR 1950, in that it authorised MH to be indefinitely detained until the section 29(1) application for displacement of her NR had been decided on by the county court for the purposes of making a guardianship order.

The High Court refused to make any of those declarations. But, on appeal by the applicant, the Court of Appeal made two declarations, namely: (a) s.2, MHA 1983 was incompatible with Art.5(4), ECHR 1950 as the section had no adequate provision for referring to a court the case of a patient detained thereunder in circumstances where a patient with the right to apply to a Tribunal has no capacity to do so on her own; and (b) s.29(4), MHA 1983 was incompatible with Art.5(4), ECHR 1950 because it had no provision for referring to a court the case of a patient detained under section 2 but whose period of detention has been prolonged by virtue of an application for displacement of their nearest relative. Thereupon the Secretary of State appealed to the House of Lords, which set aside the two declarations made by the Court of Appeal, and also decided that neither section 2 nor section 29(4) was incompatible with Article 5(4) of the ECHR 1950.

When MH applied to the European Court of Human Rights, the European Court held, *inter alia*,[18] that section 2 was incompatible with Article 5(4) in the exact circumstances of MH for the following reason: although the MHA had a mechanism for challenging the legality of compulsory detention under section 2 (in this case) via application to the Tribunal, an incapacitated patient like MH could not have made that application (under s.66(2)(a), MHA 1983). Her nearest relative exercised her right to discharge her from hospital, but that was prevented by a barring order issued under s.25(1), MHA 1983; and that had the effect of stopping her from discharging MH for six months. At that point in time MH, who still lacked legal capacity, could not have been expected at once to instruct her solicitors or mother to request the Secretary of State to refer her case to the Tribunal. Accordingly, an incompetent patient like MH did not have the benefit of taking proceedings, as guaranteed to every person by Article 5(4), to challenge the lawfulness of her detention for

[18] The other parts of the decision are outside the focus of this article, so they are not included here.

assessment. So in her case, her initial detention (in the first 27 days) under section 2 had violated Article 5(4) of the European Convention.[19]

It is recommended by the present author, therefore, that, where there is an incapacitated patient like MH, there ought to be an automatic referral of the case by the Secretary of State for Health to the First-tier Tribunal.

Comment

The conduct of the nearest relative in this case (*MH v UK*) is quite admirable because, despite the various blocks that she had to face in the domestic courts (the House of Lords, in particular), she did not give up. What she and MH achieved in the end in the European Court was worth pursuing. The case also shows that, even though certain nearest relatives may seem to be cantankerous or overly litigious, other nearest relatives actually have a worthwhile case (as, for example, *S v G*[20] illustrates). This may be challenged by pointing out that section 29 proceedings were commenced against MH's nearest relative because of her unreasonable objection to the application for guardianship of MH. However, it may be stated in her defence that her objection to the said guardianship application was only a small part of MH's saga.

3. The present definition of '14 days' for a section 2 patient to apply to the MHRT

This issue, as regards applications by section 2 patients to the Tribunal, arose in *R (Modaresi) v Secretary of State for Health and others*.[21] In that case the applicant, suffering from schizophrenia, was admitted to hospital under s.2, MHA 1983. So, she had a right under s.66(1)(a), MHA 1983 to apply, within 14 days of her admission, to the First-tier Tribunal to renew her detention. Eleven days after her admission (that is, on 31 Dcember 2010) she completed an application form for a review of her detention and gave the form to one of the members of staff on her ward. That staff member faxed the form to the correct office of the hospital trust. However,

[19] The Court referred to *Winterwerp v The Netherlands* ((1972) 2 EHRR 387), where it had been held, *inter alia*, that, regarding the Article 5(4) right, special safeguards might be required to protect the interests of persons not fully capable of acting for themselves owing to their mental disabilities.
[20] [1981] *JSWL* 174. See also *H v Essex County Council*, *Legal Action*, September 1997, p.24 (Southend County Court).
[21] [2013] UKSC 53; [2013] PTSR 1031. The Court of Appeal's decision on the matter concerning the '14 days' is reported at [2011] EWCA Civ. 1359; [2011] WLR (D) 340.

it was not until 4 January 2011, when the trust's office opened after the New Year Bank Holiday, that the trust faxed the form to the Tribunal. The claimant was notified by the Tribunal that her application was invalid because it was received outside the 14 days prescribed by s.66(1)(a), MHA 1983. Therefore, she started judicial review proceedings against the Tribunal and others,[22] arguing, *inter alia*, that, because the time limit for applying to the Tribunal had expired on a non-working day, her application was not out of time when the Tribunal received it on the following working day. The judge dismissed her claim but the Court of Appeal allowed that appeal concerning the decision of the Tribunal and held that her application was in fact made in time since '14 days' ought to be taken to mean '14 working days'.

In her leading judgement (in the Court of Appeal), which allowed the appeal against the judge's dismissal of the applicant's judicial review claim against the Tribunal, Black LJ, with whom Richards LJ and Mumery LJ agreed, quoted and approved Lord Neuberger's statement in *Mucelli v Government of Albania*:[23]

> 83. Another point which arises is what happens if it is impossible to give notice on, or during the final part of, the last day. For instance, in relation to filing, the Court Office may be closed on the last day because it is Christmas Day or another Bank Holiday, and the Court Office will be closed at some point in the late afternoon on the last day. Equally, the respondent's office may be closed for the same reasons.
>
> 84. Where the requisite recipient's office is closed during the whole of the last day, I consider that the notice will be validly filed or served if it is given at any time during the first succeeding day on which the office is open (i.e. the next business day). So if the final day for giving a notice of appeal would otherwise be Christmas Day, filing or service can validly be effected on the 27th December (unless it is a weekend, in which case it would be the following Monday). This conclusion accords with that reached in *Pritam Kaur v S Russell & Sons*

[22] The arguments, etc., regarding the judicial review proceedings against the others (namely, the Secretary of State for Health and the Trust) are not directly relevant to the point being discussed here, so they have been left out. For the same reason, details of the applicant's appeal to the House of Lords have also been left out.

[23] [2009] UKHL 2; [2009] 1 WLR 276, paras 83 and 84. One point in issue in this case, an extradition case, was how to calculate the time allowed for a notice of appeal to be given to the High Court against a district judge's order and, especially, what is to be done if the office that must receive the notice is closed at the end of the period for serving the notice.

> *Ltd* [1973] 1 QB 336. As Lord Denning MR said at 349E, 'when a time is prescribed by statute for doing any act, and that act can only be done if the Court Office is open on the day when time expires, then, if it turns out ... that the day is a Sunday or other *dies non*, the time is extended until the next day on which the court office is open'. I agree, and I can see no reason not to apply the same principle to service on a respondent in relation to the respondent's office.

The appellant's appeal against the Court of Appeal's ruling was rejected by the Supreme Court, which agreed with the Court of Appeal's reasoning.

Therefore, the current definition is only judicial. However, this may not be known by all patients and their nearest relatives. Accordingly, in the interests of clarity, a statutory definition would be very much desirable. The definition should be given in an amendment of s.66(1)(a) MHA 1983 to provide that the period of '14 days' means '14 working days', and so excludes public holidays and weekends. The Department of Health can then publicise the matter by instructing all hospitals up and down the country to inform their compulsory patients about it and to include it in their various official publications.

V. Conclusion

The two types of involuntary admission to hospital for assessment (namely, admission for ordinary assessment and admission for assessment in an emergency) have, so far, been analysed in this paper. The paper has traced the evolution of admission for assessment back to the Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954–1957 (the Percy Commission), the recommendations of which were embodied in the Mental Health Act 1959. It was paragraph 42 of the Commission's Report that contained the Commission's recommendation for compulsory admission to hospital for observation for up to 28 days, for which two medical recommendations were required, and admission for observation in an emergency, for which only one medical recommendation was required. The present law covering admission for assessment has also been looked at (and certain matters relating to it noted). Next, various similarities and differences between sections 2 and 4 have been pointed out. That apart, the paper has also spotted and discussed three problems with s.2, MHA 1983, and gone on to offer proposals to address them.

The first of those proposals concerns the s.29, MHA 1983 procedure. As the conversion of a section 2 admission to a section 3 admission (where there are proceedings for the displacement of a nearest relative under s.29, MHA 1983, which suspends the 28-day period under s.2, MHA 1983) can be a long process, as happened in *MH v UK*, it is proposed that there should be a new statutory provision for a speedy section 29 procedure.

The second proposal is to amend the law to be in line with ECHR's ruling in *MH v UK*, because at the moment s.2, MHA 1983 is incompatible with Article 5(4) of the ECHR. The provisions of the MHA 1983 relating to section 2 ought to be amended to the effect that, as regards incapacitated section 2 patients like MH, there ought to be an automatic referral of their cases by the Secretary of State for Health to the First-tier Tribunal.

The last proposal concerns the period of time within which a section 2 patient may apply to the Tribunal – the 14 days prescribed by s.66(1)(a), MHA 1983 ought to be amended to '14 working days', so as to exclude public holidays and weekends. That would really make the position clearer to everyone, patients and non-patients alike.

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Human Rights in the Time of HIV/AIDS

Dr Rebecca Maina

Abstract

Over the last decade or so, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has reported a marked decline in AIDS-related deaths and new HIV infections. Yet people living with HIV/AIDS (PLWHAs), especially those in the most affected, less industrialized regions of the global south, continue to face problems associated with the illness, among them stigma, discrimination and limited access to healthcare needs such as life-prolonging antiretroviral drugs (ARVs, also referred to as antiretroviral therapy (ART)). PLWHA and HIV/AIDS advocacy groups have long employed human rights as a weapon in the struggle to raise awareness about HIV/AIDS and the suffering of PLWHAs, and to attain and secure better conditions and health provisions for the infected and the affected. This article, based on research conducted in Kenya at the height of the AIDS crisis in the early to mid 2000s, examines PLWHAs' awareness of human rights, the sources that they cite for such information, and any perceived links that they identify between their illness and the subject of human rights. In doing so, it approaches the rights discussion from the less familiar perspective of the PLWHAs themselves, seeking to gain an insight into how this group encounters, internalises and articulates – or not – the language and norms of human rights, and what this may tell us about the role of HIV/AIDS in shaping their subjectivities.

Key words: HIV/AIDS; PLWHAs; human rights; stigma; discrimination

Introduction

In the early to mid 2000s, when the doctoral research from which this article is drawn was first contemplated and then conducted, Kenya was

just waking up to the magnitude of its HIV/AIDS problem.[1] Questions were beginning to be asked about how a culturally and religiously conservative country had ended up with a significant portion of its population, the majority of them at their most (economically) productive,[2] living with a largely sexually transmitted illness;[3] how its people living with HIV/AIDS (PLWHAs), most of whom were women,[4] should be treated by society; what duty, if any, the state had to take care of them; what rights, if any, PLWHAs were due; and how the state should address the wider public health emergency. It was, to say the least, an interesting time to be asking these questions, for parallel dialogues were taking place on the political plane about the nature and role of the postcolonial state in the multi-(political)party era; its duty to its citizens; the nature and scope of their human rights; the citizens' complex dual-membership of both a national as well as an ethnic public; the place of the rule of law in this changing political landscape; and the role of overseas governments and civil society organisations (CSOs) which were increasingly mediating the state–citizen relationship.

In an apparent reaffirmation of the perception of law as the predominant source of rights in the modern age, and of the text as the favoured receptacle that not only carries rights to the individual but also grounds them in reality, in August 2010 Kenya adopted a new constitution. Among its innovations was an enforceable Bill of Rights that explicitly provided for individual health-related rights; or, more precisely, the right to 'the highest attainable standard of health, which includes the right to

[1] According to UNAIDS, in 2005 there were an estimated 91,000 new HIV infections in Kenya (an incidence of 2.87 per 1,000 persons), 130,000 AIDS-related deaths, and around 1.6 million PLWHAs. The national HIV prevalence rate in 2006 was 5 per cent; estimates from the mid 1990s put it at 14 per cent. (UNAIDS, *UNAIDS Data 2017* (2017), 31 <http://www.unaids.org/en/regionscountries/countries/kenya/> accessed 03 May 2018.)

[2] The HIV prevalence rate among 15–49 year-olds in 2001 was 8.4 per cent. (2001 statistics previously accessed from a UNAIDS webpage no longer available: *Global Report: UNAIDS Report on the Global AIDS Epidemic, 2010* (2010), 28 <http://www.unaids.org/documents/20101123_GlobalReport_em.pdf> accessed 12 March 2012.)

[3] Among adults, the HIV virus is primarily 'transmitted through sexual contact between an infected partner and an uninfected partner'. (Kenya National Bureau of Statistics, et al., *Kenya Demographic and Health Survey 2014* (December 2015), 210 < https://dhsprogram.com/pubs/pdf/FR308/FR308.pdf> accessed 03 May 2018.)

[4] In Kenya, as in other parts of sub-Saharan Africa, women and girls have borne the brunt of HIV infection. The most recent figures from UNAIDS estimate that they account for more than half (59 per cent) of the total number of PLWHAs in eastern and southern Africa. (UNAIDS, Factsheet, World AIDS Day 2017 (2017), 2 <http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf> accessed 03 May 2018.) This figure mirrors Kenyan statistics at the end of the first decade of the new millennium, when Kenyan women accounted for 59.1 per cent of adults with HIV, and among 15–49 year-olds, HIV prevalence among women and girls was 8 per cent and nearly half that (4.3 per cent) among men. (National AIDS Control Council (NACC) and National AIDS and STI Control Programme (NASCOP), *The Kenya AIDS Epidemic Update 2011*, (Nairobi, Kenya: 2012), 6 <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_KE_Narrative_Report.pdf> accessed 12 December 2013.)

health care services, including reproductive health care'.[5] This provision was buttressed by various legal assurances from the state, such as equality and non-discrimination,[6] and the adoption of measures, within the boundaries of resource availability,[7] to ensure the progressive realisation of this right.[8] This introduced the prospect – for the first time in Kenya – of legal challenges against the state by individuals alleging that it had failed to meet its healthcare obligations. This was precisely the charge made by many of the PLWHAs interviewed for the research that I had conducted years earlier. In so doing, Kenya had taken its place alongside nearly all the other countries of the world in '[constitutionalizing] the ideology of human rights'.[9]

This drama was played out in a world where rights, and human rights in particular, have acquired incredible currency. As Costas Douzinas asserted:

> … [h]uman rights have become the *raison d'être* of the state system as its main constituents are challenged by economic, social and cultural trends. It is no coincidence that human rights 'triumphed' at the point of maximum angst about life chances and malaise about the collapse of moral certitudes and political blueprints.[10]

The international human rights regime, in the sense of the global movement for the protection, promotion and assertion of international

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[5] Art. 43(1)(a). Republic of Kenya, *Laws of Kenya: The Constitution of Kenya, 2010* (2010) <http://www.kenyalaw.org/lex//actview.xql?actid=Const2010#KE/CON/Const2010/chap_4> accessed 10 May 2018.

[6] The first four subsections of Article 27 state that: '(1) Every person is equal before the law and has the right to equal protection and equal benefit of the law; (2) Equality includes the full and equal enjoyment of all rights and fundamental freedoms; (3) Women and men have the right to equal treatment, including the right to equal opportunities in political, economic, cultural and social spheres; and (4) The State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth ...' (*Ibid.*, at 24.)

[7] Section 19(2) ('Access to Healthcare Services') of the 2006 HIV and AIDS Prevention and Control Act anticipated the state's responsibilities in relation to PLWHAs' health needs: 'The Government shall, to the maximum of its available resources, take the steps necessary to ensure the access to essential healthcare services, including the access to essential medicines at affordable prices by persons with HIV or AIDS and those exposed to the risk of HIV infection.' (Kenya Law Reports, 'Laws of Kenya' <http://www.kenyalaw.org/lex//actview.xql?actid=No.%2014%20of%202006#part_II> accessed 03 May 2018.)

[8] Specifically, the new constitution requires the state to 'take legislative, policy and other measures, including the setting of standards, to achieve the progressive realisation of the [socio-economic] rights guaranteed under Article 43'. (Art. 21(2). *Ibid.*, at 20).

[9] Loius Henkin, 'Human Rights: Ideology and Aspiration, Reality and Prospect', in Samantha Power and Graham Allison (eds), *Realizing Human Rights: Moving from Inspiration to Impact* (New York, NY: St Martin's Press, 2000), 25.

[10] Costas Douzinas, *The End of Human Rights: Critical Thought at the Turn of the Century* (Oxford: Hart, 2000), 374.

responsibility for human rights at the national level,[11] thus underwrites the role of the state despite its diminution in the face of globalisation. Further, the international law of human rights, in largely allocating no legal role for CSOs despite their growth in influence,[12] arguably suppresses their status. The state remains the pivotal framework for political, social and economic interaction.[13]

And the instruments by which the system of human rights law cements the state–individual dynamic are important to our understanding of rights today: Douzinas writes of the decline of the concept of nature as the source of rights; unless they are recognised in domestic and international law, rights cannot be called upon for the protection of individuals.[14] In other words, the Bill of Rights in Kenya's constitution is a triumph of legal positivism and its proponents,[15] locating Kenya in the modern, rational age of law. As Ronald Dworkin asserted: 'If the Government does not take rights seriously, then it doesn't take law seriously either.'[16] For the many who increasingly turn to the law when articulating their claims to entitlements, the law is confirmation of a political commitment to the moral principles on which those claimants base their demands.[17]

Yet one of law's ingrained conceits is its presupposition of subjects 'who can identify and use it'.[18] Stephen Hicks persuasively identifies a problem of perspective: the tendency in legal theory to accentuate the aspect of law that is external to the human being – law as a system of rules and norms – and to de-emphasise its subjective aspect, thus dehumanising it.[19] He contends that law, like religion and morality, embodies the human being's attempt to organise the conceptual space that she shares with others and is a manifestation of how she negotiates and regulates her relationship with them.[20] And it is in this internalised sense that we first

[11] Henkin, *op. cit.*, 8.
[12] Abdullahi Ahmed An-Na'im, 'Introduction: Expanding Legal Protection of Human Rights in African Contexts', in Abdullahi Ahmed An-Na'im (ed.), *Human Rights Under African Constitutions: Realizing the Promise for Ourselves* (Philadelphia, PA: University of Pennsylvania Press, 2003), 4–5.
[13] *Ibid.*, 4.
[14] Douzinas, *op. cit.*, 10–11.
[15] See William A. Edmundson, *An Introduction to Rights* (Cambridge: Cambridge University Press, 2004), 62–3.
[16] Ronald Dworkin, *Taking Rights Seriously* (London: Duckworth, 1977), 205.
[17] Colin Harvey, 'Talking About Human Rights', *European Human Rights Law Review*, No. 5 (2004), 500–516, 500.
[18] Stephen Hicks, 'Law and Being in Law as Way of Being', in S. Panou, G. Bozonis, D. Georgas and P. Trappe (eds), *Human Being and the Cultural Values: 12th World Congress, Athens, 1985* (Weisbaden: F. Steiner Verlag, 1988), 41.
[19] *Ibid*., 43.
[20] *Ibid*., 41–2.

experience law, 'before we experience law as citizens, in law suits or otherwise as conventionally understood'.[21]

This interface between the internal aspect of the law and the external element is interesting, then, for here we might glimpse the real subject of law, one who, in psychoanalytical terms, has no 'inside' and 'outside' but who is constituted of all elements, from her psyche to her identity, language, society, law.[22] How do they aggregate in a PLWHA to mould her awareness and understanding of her rights, and what role does her sero-positivity play in all this? Such a discussion surely precedes or occurs contemporaneously with the one about the structural framework which facilitates and/or hinders an individual's realisation of her right to health. This underlines the importance of studies such as the in-depth, semi-structured, qualitative interviews with 49 PLWHAs conducted in the original research from which this article is drawn, although only a tiny fraction of these responses are extracted for this article.

Briefly, the interviews broadly inquired about respondents' healthcare needs and human rights. They were conducted in the English and/or Kiswahili languages by the author, primarily at Mbagathi District Hospital in Nairobi, Kenya, and at PLWHAs' support organisation, Women Fighting AIDS in Kenya (WOFAK).[23] A range of questions relating to interviewees' healthcare needs and human rights were asked, although this article focuses on just a few: whether the interviewees had heard of the phrase 'human rights'; what they thought it meant; examples of human rights that they were aware of; and the source of this information. The views expressed by PLWHAs in the interviews were not aimed at making generalisations which could be extrapolated to other Kenyan PLWHAs, let alone the wider population. For such analyses, the research relied on data from more extensive quantitative and qualitative surveys, from sources such as the Haki Index – a countrywide human rights perception survey published in 2006 – UNAIDS, and the Kenya Demographic and Health Surveys (KDHS). Instead, the interviews' rich qualitative data was intended to provide insights into how PLWHAs conceptualise and articulate health entitlements and rights, and the role that HIV/AIDS plays in how they construct their subjectivity, and, consequently, their imagination of these entitlements and rights. What the

[21] *Ibid*., 42.
[22] David S. Caudill, *Lacan and the Subject of Law: Toward a Psychoanalytic Critical Legal Theory* (Atlantic Highlands, NJ: Humanities Press, 1997).
[23] The research was carried out with the collaboration of Mbagathi District Hospital, Nairobi, Kenya, and Women Fighting AIDS in Kenya (WOFAK), and with the kind permission of the Ministry of Health, Kenya.

interviews illuminate about the public discourse on HIV/AIDS and human rights in Kenya in the mid 2000s transcends that particular timeframe: the social, economic and political dynamics remain broadly intact;[24] HIV/AIDS is still a major public health concern in Kenya.[25] Moreover, the interviews feature a special group of respondents, the complexity of whose particular health concerns arguably gives them a very distinct perspective on human rights issues.[26] Thus, they provide an empirical context within which to highlight the importance of subjectivity in legal research. They help rationalise and validate the assertions of theorists like Jacques Lacan of the seamless continuity between inner aspects, such as identity and desire, and outer ones, such as society and law, in the construction of the legal subject.

1. Human rights awareness

The comparative examination of PLWHAs' knowledge of rights was greatly aided by the Haki Index.[27] This author's own primary research avoided making presumptions about interviewees' knowledge, and started by asking the basic question: had respondents heard of the phrase 'human rights' or its Kiswahili equivalent, *haki za ki-binadamu*. Indeed, the vast majority of respondents said that they had. An attempt was made to find any common characteristics among the five who had not, which may be significant to rights awareness. A Zimbabwean human rights awareness study from the early 1990s, for instance, indicated that 'professionals' knew more about rights than any other groups in the survey; however, it

[24] A major change relates to a new system of government established by the 2010 Constitution (for a summary, see Library of Congress, 'National Parliaments: Kenya' <https://www.loc.gov/law/help/national-parliaments/kenya.php> accessed 03 June 2018). However, even this constitutional change appears to articulate and cement the postcolonial bifurcated-state experience of many Africans, which is described, for instance, by Mahmood Mamdani (see Mahmood Mamdani, *Citizen and Subject: Contemporary Africa and the Legacy of Late Colonialism* (Princeton, NJ: Princeton University Press, 1996)), and which frames many of the discussions on socio-political identity and subjectivity in the broader PhD research from which this article is drawn.

[25] UNAIDS estimates that, in 2018, 1.6 million Kenyans live with HIV/AIDS. HIV incidence, 'the number of new HIV infections among a susceptible population during a certain time among all people of all ages was 1.02%'. Meanwhile, among adults (categorised as those aged between 15 and 49 years of age), HIV prevalence stood at 4.7 per cent. Further, 46,000 people became newly infected with HIV, and 25,000 lost their lives to an AIDS-related disease. (UNAIDS, UNAIDS Country Overview (2018), 31 <http://www.unaids.org/en/regionscountries/countries/kenya/> accessed 02 November 2019.)

[26] It is not possible within this relatively short article to lay out in detail the social, cultural, economic and political context which underpins the matrices of entitlements, rights, responsibilities and duties which shape the subjectivities of modern Kenyan PLWHAs. Nor can the article delve into the extensive postcolonial analysis undertaken in the original doctoral thesis, which framed an inquiry into the intricate power dynamics and systems of privileges and obligations that locate Kenyan PLWHAs within their wider social networks.

[27] Kenya Human Rights Commission (KHRC), *The 2006 Haki Index: Measuring Public Perceptions on the State of Human Rights in Kenya and the Case of the Devolved Public Funds*, KHRC, 2006 <http://www.khrc.or.ke/documents/2006%20Haki%20Index.pdf> accessed 20 May 2009.

suggested that 'lack of human rights knowledge [seemed] mainly to be caused by lack of education than a total absence of education'.[28] Among the five, interviewees 23 and 12 had not attained secondary-level education, with the former, a driver before his illness, leaving primary school after about seven years, while the latter only had three years of school before she was forced to drop out in 1967 when an illness in the family left her in charge of the household. Interviewee 19 completed two years of high school and was unemployed at the time of the interview; interviewee 38 completed four years of high school and was working as a teacher in a kindergarten; interviewee 49 had one year of high school education and at the time of the interviews sold second-hand clothes. The information given, therefore, did not suggest any obvious commonalities crucial to human rights awareness.

The Haki Index survey did not break down its findings according to these two important factors, considering instead the gender and living standards of its respondents. In the absence of any obvious patterns, one may speculate about why the five respondents had not heard of the phrase 'human rights'. The issue of the language in which interviews were conducted is important: some Kiswahili language interviewees appeared better acquainted with the English phrase 'human rights' than its Kiswahili equivalent. English is Kenya's official language and the one by which local and foreign rights experts are most likely to communicate. The language that such professionals choose to express and disperse what William Conklin calls 'magic terms', known only to human rights experts,[29] is vital. The apparently greater currency of the English phrase suggests their partiality to this tongue, and the exclusivity already inherent in this choice may further substantiate the charge of commentators like Nigerian human rights lawyer, Chidi Odinkalu, who argued, in 1999, that '[i]n the absence of a membership base there is no constituency-driven obligation or framework for popularizing the language or objectives of the group beyond the community of inward-looking professionals or careerists

[28] Marina d'Engelbronner-Kolff, *The Provision of Non-formal Education for Human Rights in Zimbabwe* (Harare: Southern Africa Printing & Publishing House/SAPES Trust, 1998), 8. The study involved over 800 interviewees, grouped as school pupils, students at institutions of higher learning, professionals ('lawyers, magistrates, teachers, lecturers, doctors, police officers and other government officials') and adults ('women and men, workers, consumers, religious groups'). They were carefully selected in order to be as representative of the Zimbabwean population as possible.

[29] William E. Conklin, 'Human Rights, Language and Law: A Survey of Semiotics and Phenomenology', *Ottawa Law Review*, Vol. 27, No. 1 (1995–1996), 129–74, 134–5 and 145.

who run it.'[30] In his view, they fail to maximise on the power of the language of rights and the ideas that it brings to life.[31]

Further, many ethnic African languages – Kenya has dozens – have no equivalent of the phrase 'human rights'.[32] These terms have been useful for PLWHAs seeking to positively redefine their lived experiences and actively, rather than passively, engage in the (re)construction of their identities and subjectivities, and the narratives of their illness. Arguably, the suggestion of the limited permeation of rights language stands despite the high number of respondents in the Haki Index (77 per cent)[33] who showed a spontaneous awareness of rights, that is, mentioned without prompting some 'aspect of human rights'.[34] This is because the survey's inherent presumption of prior knowledge may have made it harder for respondents to correct such a presumption, whether out of embarrassment or deference to the interviewer.

As might be expected, lack of familiarity with the precise vocabulary of human rights, or the existence of vernacular equivalents, did not appear to preclude respondents in this research holding or articulating ideas about obligations and entitlements, which will be familiar to human rights scholars. As William A. Edmundson notes: '[t]he presence or absence of a word or concise phrase or locution in another language, with which to translate a word we use is hardly conclusive as to the availability of an idea to speakers of another language.'[35] The high numbers of interviewees who claimed to have heard of the phrase 'human rights' bore out the Haki Index survey findings. Further, the widespread use, without the interviewer's prompting, of terms like 'stigma', 'discrimination' and 'equality' – the first of which, especially, is a key plank of the PLWHA rights advocacy and discourse, and which distinguish HIV/AIDS from any other modern pandemic – suggests that the respondents' identity as PLWHAs may have further contributed to the high rates of rights awareness. Stigma is central to understanding how the psychosocial aspects of HIV/AIDS, the construction of subjectivities and the

[30] Chidi Anselm Odinkalu, 'Why More Africans Don't Use Human Rights Language', *Human Rights Dialogue*, Series 2, No. 1 (1999), Carnegie Council on Ethics and International Affairs <http://www.cceia.org/resources/publications/dialogue/2_01/articles/602.html> accessed 20 May 2009.
[31] See Michael Kirby, 'The Rights to Health Fifty Years On: Still Sceptical?', *Health and Human Rights: An International Journal*, Vol. 4, No. 1 (1999), 6–25. He writes about the power of the Universal Declaration of Human Rights and its ideals, which have spawned a multitude of NGOs and CSOs dedicated to actualising these ideals around the world (at 15).
[32] Odinkalu, *op. cit.*
[33] KHRC, *op. cit*., 20.
[34] *Ibid*., 129.
[35] Edmundson, *op. cit*., 5.

development of notions of entitlements intersect. Susan Sontag explored this theme, asserting that 'the unsafe behaviour that produces AIDS is judged to be more than just weakness. It is indulgence, delinquency …'[36] An individual's HIV status, real or imagined, may lead to unfair treatment, and thus stigma leads to discrimination and unequal treatment.

Arguably, then, being personally affected by HIV/AIDS might not only increase the likelihood of a PLWHA's contact with human rights-related information on these issues, through the media, support groups or advocacy organisations (as will be seen shortly), but it might also make PLWHAs more attuned to (particular) rights-related matters. This might explain why interviewee 23, who said that he had only discovered that he was HIV positive two weeks prior to the interview, may not have heard of the term. He also said that he had not initially heard of the government ARV cost-sharing scheme that had been announced about six months before,[37] explaining tellingly that:

> ... my mind was not focussed on issues about HIV. I used to hear that this thing exists but I had never taken a test and been found out to have it. So now is the time that I am listening and paying attention to news about HIV so that I can know what is happening.

It is a view reiterated by another respondent, interviewee 40: although she later conceded that she could not name any specific examples of human rights, she said:

> When I got this problem with this illness, I started to hear things about rights from the radio and also from the support groups here [at Mbagathi District Hospital]. Like, I met a woman here who then told me about WOFAK so I went there. But I have never been to any human rights organizations to seek help.

The Haki Index appeared further to corroborate the linkage between rights awareness and marginality, especially, perhaps a respondent's particular

[36] Susan Sontag, *AIDS and Its Metaphors* (Harmondsworth: Penguin, 1990), 25.

[37] In September 2003, the Kenyan government announced that ARVs would be available at all district hospitals by the end of September 2003. It was added that patients would have to pay for the drugs, although the cost would be reduced. *The Daily Nation* reported: 'On Monday, Health assistant minister Gideon Konchellah said although all district hospitals would be stocked with anti-retrovirals by the end of the month, patients would have to pay for treatment under the cost-sharing system. Currently, the cheapest anti-retroviral treatment costs Sh3,000 a month. Mr Konchellah clarified that only a selected number would get free anti-retroviral treatment under the Prevention of Mother to Child Transmission programme. The others would have to pay for their treatment though the cost would be reduced, the assistant minister added.' ('State Accused of Betrayal on Aids Medicines', *The Daily Nation*, 17 September 2003.)

species of marginality.[38] This may seem to suggest that voluntary counselling and testing (VCT) sites and medical centres where HIV testing and diagnosis are conducted may be ideally positioned to provide information on, and promote rights related to, HIV/AIDS. At the time of the research on which this article is based, national guidelines for HIV testing in Kenya stated that part of the minimum services expected in a pre-HIV test session was information on the requirement of consent for HIV tests. Additionally, information on 'referral to support, care and treatment' and on the 'importance of disclosure to partners and other family members' may be offered.[39] While these issues are linked to rights and the document stressed respect for the relevant rights, there was no apparent explicit mandate to discuss the client's rights.

A possible reason may be that healthcare officials conducting the test might themselves be unfamiliar with the human rights involved.[40] Further, it may be inappropriate to address such issues at this precise, delicate stage, particularly if a patient has just received a positive test result; the immediate medical needs – referral and follow-up care – are likely to be the paramount concern. However, it might be worth making available written information (such as pamphlets and posters) to people undergoing tests, or directing them to relevant organisations as part of the support available (although some interviewees rightly questioned the benefits of knowledge about rights which cannot be realised). Indeed, as Leslie London argued, healthcare officials must ensure that they do not become tools of the state's violation of its health rights obligations, suggesting that informing patients of the government's legislative, financial and administrative failures in providing adequate treatment and preventive services 'may help to spur a patient rights advocacy movement'.[41]

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[38] The Haki Index recorded a higher rate of spontaneous awareness of a number of rights among people in Kenya's North-Eastern Province (NEP) in comparison to other provinces. 'This,' it was suggested, 'could be because they are more likely to face violations of them. For example, 90% of the sample in NEP was able to mention, spontaneously, the right to education. The right to nationality or citizenship also stood out in NEP. This could be attributed to the geographical location of the area: it borders Somalia and Ethiopia, and a significant proportion of the population in this province are "perceived" not to belong to Kenya, rather being seen as refugees from the bordering countries.' (KHRC, *op. cit*., 22.)

[39] National AIDS and STI Control Programme (NASCOP) and Ministry of Health and Sanitation (MoHS), Kenya, *National Guidelines for HIV Testing and Counselling in Kenya* (Nairobi: NASCOP, 2008) <http://www.who.int/hiv/topics/vct/policy/KenyaGuidelines_Final2009.pdf> accessed 20 May 2009, 16.

[40] Lawrence Gostin and Jonathan Mann, 'Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Health Policies', *Health and Human Rights: An International Journal*, Vol. 1, No. 1 (1994), 59–81, at 59.

[41] Leslie London, 'What Is a Human Rights-Based Approach to Health and Does It Matter?', *Health and Human Rights: An International Journal*, Vol. 10, No. 1 (2008), 65–80, at 69. Laura Turiano and Lanny Smith provide examples of just such an approach by health rights advocates participating in the 'Tents of Life' campaign in Paraguay. They report that '[i]nside the tents, health facility users are presented with information on the services that should be available by law. Paraguay's constitution guarantees the right to health and health care, but

However, she points out the systemic problems that may obstruct the provision of adequate healthcare to patients and warns against situations which foment 'fruitless antagonism between the aggrieved rights holder and the disempowered duty bearer without recognizing the structural constraints imposed by a health system poorly geared to respond to a human rights demand'.[42] Nevertheless, she argues that rights language can provide a platform on which both parties can build a consensus and challenge the state to be accountable for its obligations to provide adequate healthcare.[43]

2. Defining 'human rights'

The interviewees who claimed to have heard the phrase 'human rights' were also asked to explain what they thought that it meant. None gave what might be regarded as a 'textbook' definition, which may be unsurprising and perhaps even inevitable. No specific parameters were set for this research regarding a meaning, and respondents' definitions sometimes even exceeded the anticipation of the interviewer. The Haki Index, however, while noting correctly that there is no hard and fast definition, nor that there were any right or wrong answers,[44] provided a working one for its survey, noting those responses which could be considered to fall outside it. This characterised human rights as 'entitlements which are due to every human being by virtue simply of their being human and are founded on the notion of respect for the inherent dignity of the human person'.[45]

The Haki Index observed a generally substantial awareness of the definition of human rights among Kenyans, with only 4 per cent of those responses given falling outside the survey's operational definition; but nearly a quarter of the survey respondents failed to provide any definition of the term.[46] Among the PLWHAs interviewed for this research, many indicated familiarity with the phrase, even without quite being able to define it: interviewee 30 said that he had heard of the phrase 'but I have never understood what it means'. Interviewee 18 said that she had heard

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facilities often lack equipment, fail to provide key services, and are not clean. Furthermore, basic services are supposed to be free, but charges are frequently levied that prevent access.' (Laura Turiano and Lanny Smith, 'The Catalytic Synergy of Health and Human Rights: The People's Health Movement and the Rights to Health and Health Care Campaign', *Health and Human Rights: An International Journal,* Vol. 10, No. 1 (2008), 137–47, at 140.)

[42] London, *op. cit.*, 72.

[43] *Ibid*., 73.

[44] KHRC, *op. cit*., 124.

[45] *Ibid*., 19.

[46] *Ibid*., 10.

'about [human rights] but I don't know what it means'. Interviewee 22 had also heard of it, but as to its meaning, he had not 'taken much notice'. Interviewee 45 said: 'It is difficult to explain although I feel I know the meaning'; and interviewee 35 noted: 'I think it means … I don't think I can explain very well … it's like … I can't explain!' But even some vague responses, such as the one by interviewee 15 who defined rights as 'talking about my rights', may nevertheless point to useful ideas: this one, for instance, might suggest that the respondent associated rights with debate or public discussion, may perhaps even be articulating a claim to that space, dominated by professionals, where the exercise of 'rights-talk' or 'discursivity' takes place.[47] In so doing, she seemed to anticipate Marie-Bénédicte Dembour's assertion that 'human rights exist only because they are talked about.'[48] This may reflect the idea that acknowledging an individual's rights admits her into the public arena. This has sometimes been a challenging proposition for PLWHAs – as some interviews revealed – often denied a voice because they may not be deemed exemplars of society's highest ideals or the ideal subjects of human rights.

Interestingly, those interviewees unable to offer a definition of rights that they considered correct or acceptable were often noticeably uneasy or embarrassed. Interviewee 2, for example, unable to name some examples of the human rights she had heard of or knew of, said falteringly: 'Maybe you'll help me there …' Interviewee 16, who admitted to political ambitions, said when she could not offer a definition of rights: 'That's a major question – and I'm aspiring to be an MP and I don't know that one!' Such discomfort is perhaps inherent in the interviewing process, which arguably instils in a respondent the belief that her selection carries an expectation of knowledge. The notion of rights as an issue of great contemporary importance arguably has a generational aspect. This may be illustrated by the process of interview 33: in what may be called vicarious embarrassment at a perceived lack of human rights awareness, the respondent's daughter, who voluntarily acted as her interpreter, was forced

[47] Baxi's concept of 'discursivity' encompasses 'both erudite and ordinary practices or "rights-talk"'. He continues: 'Rights-talk (or discursive practice) occurs within traditions (discursive formations). Traditions, themselves codes for power and hierarchy, allocate competences (who may speak), construct forms (how one may speak, what forms of discourse are proper), determine boundaries (what may not be named or conversed about), and structure exclusion (denial of voice). What I call "modern" human rights offers powerful examples of the power of the rights-talk tradition.' (Upendra Baxi, 'Voices of Suffering and the Future of Human Rights', *Transnational Law and Contemporary Problems*, Vol. 8, No. 2 (1998), 125–69, at 129.)

[48] Marie-Bénédicte Dembour, 'Human Rights Talk and Anthropological Ambivalence: The Particular Contexts of Universal Claims', in Olivia Harris (ed.), *Inside and Outside the Law* (London: Routledge, 1996), 18.

to concede that, despite much coaxing, her mother did not know any examples of human rights.[49]

In the last decade, there has been a rise in the public's interest in – and arguably knowledge of[50] – human rights issues in Kenya, with concerted efforts to draw it into the wider debate. A huge nationwide civic education drive on the eve of the December 2002 national elections – about 18 months prior to the interviews for this research – helped raise grassroots political awareness and assertiveness about rights.[51] Similarly, there were public consultations and debates in the run-up to the constitutional referendums in November 2005 and August 2010, which will have drawn renewed attention to issues of rights and the entitlements of citizens from their government. These referendums sandwiched the post-election violence of 2007/8, which provided a fresh impetus for the latter referendum and spotlighted concerns about state abuse of power, persistent socio-economic inequalities and the unresolved multiple allegiances that many individuals experience to the state and ethnic collective.

These political changes have compelled CSOs – so crucial in animating human rights issues in Kenya – to address concerns about lack of inclusion and local participation and ownership of output, as Celestine Nyamu-Musembi and Samuel Musyoki illustrated in a 2004 study, which also provides a critique of civil society practice and human rights in action.[52] They highlighted positive changes in approach by human rights groups like the Kenya Human Rights Organization (KHRC), aimed at grounding rights in the community. These included a shift in emphasis from fixed-term to more long-term, responsive programming, and greater willingness to traverse both its usual urban (Nairobi) base and civil and political rights agenda.[53] KHRC's co-founder and former head, Maina

[49] Apparently incredulous and rather impatient at her mother's lack of knowledge of what she seemed to regard as a crucial issue, she added at the end of the question: 'It's hard for her to give examples but for instance children's rights, I am sure she must have heard of those.'

[50] Although it does not offer a baseline for its survey, the Haki Index reveals an impressive level of spontaneous awareness of human rights.

[51] Celestine Nyamu-Musembi and Samuel Musyoki, 'Kenyan Civil Society Perspectives on Rights, Rights-Based Approaches to Development, and Participation', *IDS Working Paper 236* (Brighton, Sussex: Institute of Development Studies (IDS), December 2004), 1.

[52] *Ibid*.

[53] *Ibid*., 17–18. Other organisations involved in human rights education which Nyamu-Musembi and Musyoki looked at included the Centre for Law and Research International, CLARION – a research and advocacy organisation involved in civic education and anti-corruption work – and the Centre for Governance Development (CGD). Both were using methods such as theatre, featuring community residents, to communicate key messages. Such was the emphasis on local grounding that CLARION, for instance, as part of its selection criteria for trainees included: 'residency, local language, knowledge of local geography and history, a certain aptitude level and political awareness. These criteria eliminate the transient category of recent school leavers

Kiai, accepted that human rights organisations like his had neglected socio-economic rights to a degree, but pointed to projects that the KHRC had undertaken with overlapping civil, political and socio-economic elements, and cited general capacity problems in dealing with the latter concerns.[54]

Reiterating Odinkalu's earlier-cited criticism, Upendra Baxi stresses that grassroots movements must be nurtured if human rights are to be institutionalised around the world, and denounces attempts to locate the source of human rights exclusively in the West as:

> … sensible only within a meta-narrative tradition that in the past served the domineering ends of colonial/imperial power formations and that now serve these ends for the Euro-Atlantic community or the 'triadic states' (the USA, the EC and Japan).[55]

Advancing the adoption and protection of rights at local level not only plays a crucial role in shaping subjectivities but is also an effective organising tool.[56] Nyamu-Musembi and Musyoki's findings in Kenya five years later seem to support aspects of Odinkalu's criticisms: their interviews with officials from key development agencies about the impact of rights-based approaches (RBAs) on their policies and operations highlighted concerns about the exclusionary 'working methods that have characterised the professionalised elitist practice of rights advocacy', with one official owning that the human rights debate had not yet become 'a people's debate'.[57] This observation recalls a comment by an official at the Kenyan AIDS non-governmental organisation (NGO) Women Fighting AIDS in Kenya (WOFAK), where the first interviews for this research were conducted. Asked by this author to characterise the knowledge of rights among his clients, he commented that human rights 'are not like the Bible; [they are] not something you're brought up on from a very early age'.[58] Moreover, Nyamu-Musembi and Musyoki noted perceptions of official aloofness, dismissiveness of locals and their concerns, and mistrust of locals in the management of finances, which were cited by some grassroots communities and which further hampered the former's capacity

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who would only be looking for something temporary to do and who are unlikely to remain in the community.' (18).

[54] Interview with Maina Kiai, 26 May 2004.

[55] Baxi, *op. cit*., 148.

[56] Kenneth Roth, 'Defending Economic, Social and Cultural Rights: Practical Issues Faced by an International Human Rights Organization', *Human Rights Quarterly*, Vol. 26, No. 1 (2004), 63–73, at 65.

[57] Nyamu-Musembi and Musyoki, *op. cit*., 6.

[58] Informal exploratory discussion with WOFAK Program Officer, 22 March 2004.

to cultivate mass movements and make rights advocacy and practice more participatory.[59]

And yet the intervening years since Odinkalu's observations have also seen increased steps to propagate such movements in Kenya. This is evinced by the periodic emphasis on mass civic education described earlier by Musyoki et al., but can also be detected at the beginning of the decade in the efforts of human rights organisations to transform themselves into membership organisations.[60] The other compelling reason for qualifying Odinkalu's thesis today, of course, is the documented success of grassroots movements dealing with specific human rights issues, particularly those on the health entitlements of PLWHAs.[61]

3. Sources of human rights information

The media – radio, television, newspapers or magazines – emerged as the main source of information on human rights cited by PLWHAs interviewed for this research. Therefore, the research for this article took place before the mass availability of digital/mobile technology in Kenya, which would undoubtedly alter this element of the findings today.[62] *The Daily Nation* quoted polls conducted prior to the August 2010 constitution referendum that identified the media as 'the most trusted and reliable source of information on the new constitution',[63] a significant aspect of which, of course, concerned citizens' rights. The Haki Index surveyed its respondents' access to media in the seven days prior to interview: radio access was highest (89 per cent), then television (47 per cent), telephone (40 per cent), newspapers (38 per cent), magazines (15 per cent) and the internet (5 per cent).[64] Again, the last of these would likely rank much higher today.

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[59] Nyamu-Musembi and Musyoki, op cit., 15–16.

[60] Sammy Musyoki, Celestine Nyamu-Musembi, Mwambi Mwasaru and Patrick Mtsami, *Linking Rights and Participation: Kenya Country Study* (Washington, DC: Just Associates; Brighton, Sussex: Institute of Development Studies (IDS), November 2004) <http://www.afrimap.org/english/images/documents/file438edb948d7ed.pdf>, 26–7.

[61] See also Alicia Ely Yamin, 'Will We Take Suffering Seriously? Reflections on What Applying a Human Rights Framework to Health Means and Why We Should Care', *Health and Human Rights: An International Journal*, Vol. 10, No. 1 (2008), 45–63, at 50. See also London, *op. cit.*, 70–73.

[62] See, for instance, Amanda Lawrence-Brown and Minja Nieminen, 'How Kenyans Are Embracing Mobile Technology to Access Healthcare', *The Guardian* <https://www.theguardian.com/sustainable-business/2016/may/10/how-kenyans-are-embracing-mobile-technology-to-access-healthcare> 02 November 2019.

[63] 'Survey Faults Media Over Referendum Coverage', *The Daily Nation*, 24 August 2010.

[64] KHRC, *op. cit.*, 117. However, the usage and social, economic and political significance of some of these media, particularly telephones and the internet, is likely to have risen since the survey, not least due to the increase in mobile phone subscriptions. See, for instance, 'How a Luxury Item Became a Tool of Global

The then-Vice-President lauded the media's role in enabling the public debate over constitutional reform over the years – culminating in the August 2010 referendum – urging them to 'moderate the peoples' thinking' during the transitional period.[65] However, the media was also criticised for, among other things, biased and/or sensationalist reporting, misinformation, lack of professionalism and susceptibility to 'the political propaganda campaigns peddled by politicians',[66] suggesting that some of the issues cited in 2004 by Kiai, then-head of the Kenya National Commission on Human Rights (KNCHR), have not been addressed. He firmly asserted that media legitimacy in these matters had declined over the years due to their preoccupation with political personalities rather than issues of substance.[67]

The media's influence in cultivating human rights consciousness is well illustrated by the example of domestic violence cited by respondents for this research, such as interviewee 5 who, when asked for a sample of a human right that she knew, laughed and said: 'The famous wife-beating!', citing the media as her source of information. Similarly, in a response in which the interviewee almost appeared to perceive human rights as animate rather than inanimate things (discussed shortly), interviewee 42 said:

> [I heard about human rights] from the TV, where someone has been caught and punished for nothing so human rights intervene. Sometimes a wife is beaten by her husband and there's a tussle for the children. Again, here the human rights come in.

These responses may be explained by the much-publicised coverage in the local media at the end of 2003 of domestic violence issues and wives' rights within marriage, which followed allegations of assault by an MP's spouse. The wife then sought the help of a women's rights organisation, Federation of Women Lawyers of Kenya (Fida Kenya).[68] This was part of a wider debate covered by papers like the popular *Daily Nation*.[69] Some of

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Development', *The Economist*, 24 September 2009; Sarah McGregor, 'Safaricom of Kenya Money-Transfer Users Rise to 61% in July from a Year Ago', *Bloomberg News*, 13 August 2010 <http://www.bloomberg.com/news/2010-08-13/safaricom-of-kenya-money-transfer-users-rise-to-61-in-july-from-year-ago.html> accessed 30 August 2010.

[65] 'VP Lauds Media Role in Constitution Making', *The Daily Nation*, 25 August 2010.

[66] 'Survey Faults Media Over Referendum Coverage', *op. cit.*

[67] Kiai, *op. cit.*

[68] See 'Of Fred Gumo and His Stone Axe', *The Daily Nation*, 6 November 2003.

[69] The Haki Index indicates that '[a]lthough newspaper reading is substantially lower than radio listening and television viewing, a majority of readers (89%) had read *The Nation* in the past seven days.' (KHRC, *op. cit.*,

the coverage accused the MP of being 'primitive';[70] some female MPs called upon his supporter and fellow MP, Mr Gumo, to resign;[71] others alleged that Fida Kenya itself discriminated against male victims of domestic violence;[72] while others lauded its efforts and decried the lack of support for victims.[73] Interviewee 47, asked about her source on rights information, said: 'I've only heard about when these women go on hunger-strikes!' Although unable to find any media reports of such an event in the 12 months preceding this interview, such strategies by human rights activists are not unknown in Kenya's recent political history; it is noteworthy, therefore, that this respondent associated such public acts of protest or defiance with human rights.

Further, as these actions are often widely reported in the press, it underlines the importance of media coverage of protests or demonstrations which are explicitly linked to human rights in engendering and crystallising a national consciousness about the kind of issues with which human rights are concerned. This demonstrates the potency of judicial action coupled with an effective media campaign, which would aid the kind of social mobilisation required for a greater and lasting impact. Another respondent, interviewee 48, went on to give this answer when asked to list examples of rights that she had heard about:

> I keep hearing about them, especially when the story of torture at Nyayo House came out and then also there's something that happened recently that they had gone to intervene. You remember when [the opposition political party] KANU MPs were stopped from attending a meeting recently … so I have been hearing about it but I haven't been keen. So mainly through the media.

Indeed, in the previous month a local newspaper had carried an article stating:

> Nyayo House torture survivors … urged local well-wishers and the international community to steer clear of (retired) President Moi's peace institute ... [T]he torture survivors said it was an

118.)
[70] Gathoni Oywaya, 'Violence Primitive', *The Daily Nation*, 7 November 2003.
[71] 'Women MPs Demand Gumo's Resignation', *The Daily Nation*, 8 November 2003.
[72] Joseph Mutua, 'Fida Should Say Why It Didn't Help Battered Man', *The Daily Nation*, 11 November 2003.
[73] Lucy Oriang, 'Fida Lawyers Not To Blame, Gumo', *The Daily Nation*, 7 November 2003.

> ‘open lie’ for the former president to claim that he never knew of torture at the infamous Nyayo chambers.[74]

Educational institutions such as universities were another source of human rights information for PLWHAs. Indeed, one interviewee appeared to rank rights awareness alongside formal education as a signifier of advancement:

> I heard about it through education. Like me, I am educated. You have to know your human rights although we’re not being taught. Through counselling, for example, about ARVs, you can know your human rights.[75]

Having recognised the importance of schools as an avenue for transmitting human rights information, the KHRC established a schools outreach programme in 2001.[76] In 2002, human rights were introduced into the Kenyan school curriculum, with the KHRC working with teachers – the so-called ‘Friends of KHRC’ – to develop the relevant materials.[77]

Another important source of human rights information for PLWHAs was conferences and seminars, or contact with/membership of AIDS support groups. Interviewee 11, asked if she had heard about links between the issues of human rights and HIV/AIDS, said:

> I really don’t know what I’ve heard but there was a time there was a meeting at Kasarani for women and they were talking about that. But I didn’t really follow it up – I was really ill.

She was referring to a conference, also mentioned by other interviewees, on women and HIV/AIDS held in early 2004, which was later cited as an example of government resource wastage after it closed abruptly a day earlier than advertised, at a cost of Ksh. 30 million (approx. GBP 230,000) to the taxpayer.[78] Interviewee 41, who received her free ARVs in the MSF programme at MDH, also said that she had heard about human rights from that organisation. In fact, some PLWHAs appeared to define human rights

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[74] ‘Snub Moi Foundation, Say Activists’, *The Daily Nation*, 1 April 2004. Further, the interviewee may also be referring to the fundraising meeting by MPs of the opposition KANU political party, disbanded by police on 14 May 2004 amidst protests by the local area MP that he had the right to address his constituents. (See ‘Police Break Up Kenyatta Meeting’, *The Daily Nation*, 15 May 2004.)

[75] Interviewee 8, who was attending a computer college at the time.

[76] See the KHRC website <http://www.khrc.or.ke/subsubsection.asp?ID=11> accessed 20 May 2009.

[77] Nyamu-Musembi and Musyoki, *op. cit.*, 16.

[78] On informing her about the reported amount spent at the meeting, she said: ‘I wish they had bought the ARVs instead.’ On the Kasarani debacle, see ‘Abrupt End to Aids Meeting’, *The Daily Nation*, 23 February 2004. See also ‘Uproar Over Kibaki Role at Aids Meet’, *The Daily Nation*, 23 February 2004. In his article, Muriithi Muriuki reported: ‘An MP caused an uproar when he sought to know why President Kibaki was allowed to preside over a conference in which Ksh. 30 million of the taxpayers’ money was spent in questionable manner. Mr Raphael Wanjala (Budalangi, Narc) said the conference was aimed at enriching some individuals.’

synonymously with the organisations or groups that advocated for them, perhaps finding this a more concrete way of capturing a seemingly intangible concept. For instance, in outlining why she thought that HIV/AIDS and human rights interconnected, and disparaging the perceived ineffectualness of such organisations, interviewee 48 said:

> But what are they doing for us? I have not heard them speaking out on our behalf … *The human rights* [emphasis added] are supposed to stand [up] for PLWHAs where people are being discriminated against, denied jobs, where people can't even get drugs, or get shelter, the very basic things. So I think that's the connection.

The work of the International Reproductive Rights Research Action Group (IRRRAG) on reproductive rights illustrates the transformative effects of contact between affected communities and local NGOs. Rosalind Petchesky observes that in many of the countries where IRRRAG ran its project, respondents' connections with local organisations, unions or community groups 'seemed to make the difference between an implicit sense of entitlement, expressed mainly through actions, and one that is expressly articulated in terms of rights'.[79] Interviewee 48, for example, who spontaneously used advocacy terminology such as 'access' when talking about her health needs and those of other PLWHAs, may well have first acquired them from her regular contact with such groups. She described her role thus: 'I'm a volunteer ... I'm a public educator, I go for seminars, I educate people and I'm paid.' Reiterating the inadequacy with which she felt PLWHAs' needs were being catered for, she said:

> There's also lack of information in Kenya. I keep saying that knowledge is power because if people knew their rights, they would not be taken for a ride. You heard what is happening at Nyumbani Children's Home, kids being tested without their consent and the tests being taken to other countries.[80]

That organisations themselves might come to embody human rights for such an interviewee is therefore perhaps unsurprising: after identifying the

[79] Rosalind Petchesky, 'Cross-country Comparisons and Political Visions', in Rosalind Petchesky and Karen Judd (eds), *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures* (London: Zed Books, 1998), 309.

[80] However, she appears to be mistaken as to the children's right of consent; she assumes that they would automatically have it, which is unlikely to be the case, especially if they are minors; issues regarding permissions and ethical checks would appear to be a matter for the government and the children's home's board of directors, the latter of whom claimed (in the second of the reports above) not to have 'consented to any Aids research on children under its care'.

right to inheritance as an example of human rights, interviewee 25 was asked how she had heard of it: 'I even know their offices! I know Catherine Mumma, I know Maina Kiai.[81] It's the NSSF Building, 9th floor.' Further, she revealed that she had sought and received their help following a dispute related to her HIV status, with the response underlining the role of the media in raising awareness about the work of human rights organisations:

> *Interviewer:* How do you know about them, or is it just a personal interest?
>
> *Interviewee 25:* No. I had a problem with my in-laws and they were stigmatising me and trying to disinherit me after my husband died. So someone directed me to Human Rights – I went to a lawyer who told me first I should go to them. I went and met Catherine and we really talked. I wanted to know more about my rights.
>
> *Interviewer:* Was it your first contact with a human rights organisation?
>
> *Interviewee 25:* No. I had been reading about them in the papers. I've been so eager to read about them because I really wanted to … especially after I went public [about my HIV-positive status] and I had been attending seminars. I'd been meeting Catherine in seminars – she'd always been invited in seminars for PLWHAs to talk to us about our rights.

Another instance of identifying organisations with the definition of rights can be seen from interviewee 5, who, it will be recalled, mentioned wife-beating as a human rights issue, and thus may well have had the organisation Fida Kenya in mind when she described human rights thus:

> These are people who give us a green-light on what our rights as human beings in Africa are. You see, there are people who are very inhuman to others – they do funny things and you don't know that if this guy did this to me, that is inhuman. So, at least, they have been giving us a green-light on our rights as human beings.

[81] Both Catherine Mumma and Maina Kiai worked at the Kenya National Commission on Human Rights at the time, with Kiai serving as director.

Interviewee 6 was even more explicit in his association of rights with the organisations that champion them. He declared:

> I've heard about human rights, when they are making noise to the police. So I know if I were to be arrested, I will call the human rights! If there is any other job they have to do, I'm sorry but that I do not know.

I asked him a further question for clarification:

> *Interviewer:* So when you think about human rights, what is the first idea that comes to your mind?
>
> *Interviewee 6:* It is like I've said – that when I am arrested without fault and taken to a police station, I have to call the human rights people. Because that is the area where I've been hearing them making noise and assisting.

In retrospect, of course, the very fact that his definition was linked to a rights organisation was telling, as is argued here. Interviewee 40, asked to mention examples of human rights, said: 'Like WOFAK, aren't they like human rights? I don't know.' Interviewee 48, discussed above, also defined human rights by saying: 'They are supposed to fight for our rights.' When asked to explain who 'they' were, she said: 'The human rights people.' Here, again, it seems that media publicity helps cement these organisations' identity in the mind of some respondents as human rights made flesh.

It may be that meanings of human rights have become fused with the groups and people that are seen to represent them, and Baxi points out that: 'more often than not, we think of human rights praxis in terms of social movements.'[82] The respondents' comments above may be a further reflection of the dominance of human rights organisations and professionals in the public debate about rights, so that its concepts and ideas become associated with those who are perceived to own the discourse. As such, once again, they might be seen as the outcome of a failure to fully inculcate a more participatory approach to human rights advocacy that focuses on capacity-building for communities, to enable them to conduct these functions themselves. And, as noted by one official for the Centre for Governance and Development (CDG) organisation, interviewed by Nyamu-Musembi and Musyoki for their study on RBAs,

[82] Baxi, *op. cit*., 155.

this amplifies the potential for creating dependency on these organisations.[83]

4. Examples of human rights

When asked to provide examples of rights, most interviewees revealed an awareness of what human rights text books broadly define as civil and political rights, the so-called 'negative' or 'first generation or "blue" rights',[84] which at the inception of the rights movement were imagined to require only the state's restraint from interfering with the rights of its citizens,[85] and were linked with the liberal ideals of individual freedom.[86] These rights were considered '"absolute" and "immediate"',[87] whereas economic, social and cultural (ESC), 'second generation or "red"' rights[88] were 'programmatic, to be realized gradually, and therefore not a matter of rights'.[89] As noted elsewhere, the examples cited by PLWHAs were particularly concerned with issues of stigma, discrimination and equality. Non-discrimination is central to the health rights laid out in the WHO Constitution and is re-emphasised in numerous human rights instruments, including the Convention on the Elimination of All Forms of Racial Discrimination (CERD, Article 5(e)(iv)), and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, Article 11(1)(f)).[90] Interviewee 18, for instance, felt that it was 'the right of every human being to be treated equally', and said that she had heard it from the Kenyan president. The Haki Index reinforced the view that respondents' identity as PLWHAs influenced awareness of certain rights: it noted with dismay the low ranking accorded to the 'right against discrimination for people living with HIV/AIDS regardless of the campaigns that have been carried out in the country on this issue'.[91] When they are asked to rank the list of rights provided, only 1 per cent of the

[83] Nyamu-Musembi and Musyoki, *op. cit*., 15.
[84] Douzinas, *op. cit*., 115.
[85] Henry J. Steiner and Philip Alston, *International Human Rights in Context: Law, Politics, Morals*, 2nd edition (Oxford: Oxford University Press, 2000), 181.
[86] Douzinas, *op. cit*., 115.
[87] Asbjørn Eide, 'Economic, Social and Cultural Rights as Human Rights', in Asbjørn Eide, Catarina Krause and Allan Rosas (eds), *Economic, Social, and Cultural Rights: A Textbook*, 2nd revised edition (Dordrecht: Martinus Nijhoff Publishers, 2001), 10.
[88] Douzinas, *op. cit*., 115.
[89] Eide, *op. cit*., 10. For a summary of the history of ESC rights and the right to health in particular, see Kirby, *op. cit*.
[90] Virginia Leary, 'The Right to Health in International Human Rights Law', *Health and Human Rights: An International Journal*, Vol. 1, No. 1, 24–56, at 33.
[91] KHRC, *op. cit*., 25.

Haki Index respondents thought this right as the first, second or third most important.[92]

There were other examples of human rights from the respondents of this research: some linked them with 'torture, when people are arrested, such basic things'.[93] Indeed, protection from torture was mentioned spontaneously by 7 per cent of the Haki Index respondents. Allegations of this violation were widely reported in the media – to be sure, interviewee 39 above explicitly cited it as his source – particularly during the latter days and aftermath of the Moi regime.[94] Interviewee 11, meanwhile, associated rights with issues around child abuse and women's rights.

Some respondents' catalogue of rights consisted almost entirely of ESC rights: 'The right to education, right to healthcare, right to clothing, right to eat!'[95] Others included a right to inheritance,[96] free medication,[97] and rights for the disabled.[98] Interviewee 29 stressed that she had rights pertaining to sexual interactions with her husband:

> For example, it is a woman's right to insist that her husband uses a condom. If he doesn't want to, then he should leave me alone. Some of them refuse and threaten to beat up their wives or chase them away from the home. A lot of women I speak to complain about this. This is not right and there should be a law to stop this so that women can be protected.

Interviewee 41, meanwhile, had heard of 'the right to get treatment' after attending a human rights workshop. Her response, and that of interviewee 13, are particularly interesting: rarely did interviewees spontaneously mention an actual right to health or healthcare on their list of examples, although when questioned about the links between health and rights, nearly half would later claim to have heard of such a right.

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[92] *Ibid*., 24.

[93] Interviewee 39.

[94] See, for instance, proceedings brought by victims of the Moi regime demanding compensation for alleged torture. ('Date Set for Ruling in Nyayo Torture Case', *The Daily Nation*, 5 November 2009.)

[95] Interviewee 13; see also interviewee 16, mentioned elsewhere. Interviewee 34's list is near-identical and concerns 'free education, free medication, people without food'.

[96] Interviewee 2.

[97] Interviewee 9.

[98] Interviewee 10 linked rights to the needs of the disabled: '…The other day I heard that handicapped people also wanted the government to look upon them and enlighten them on this HIV problem.' She may have been referring to reports in the news on lobbying by organisations for audio and visually impaired for services that cater to their special needs. (See, for example, 'Inside a VCT Centre for the Deaf', *The Daily Nation*, 7 April 2004.)

ESC rights were widely regarded as 'positive' rights obliging affirmative action from the state.[99] It is perhaps unhelpful to sustain the Cold War-inspired dichotomy of civil and political versus ESC rights,[100] especially given the emphasis on the indivisibility of rights.[101] Many commentators acknowledge the dominance of this classification but denounce such categories as superficial and indiscrete.[102] Indeed, health is one of the areas where both these species of rights heavily intersect.[103] The interviewees were either unaware or made no such distinctions, listing a range of needs and requirements such as water, sanitation and shelter, all health determinants that straddle these categories. Nevertheless, this dichotomy serves a purpose in the analysis of interviewees' responses, because it suggests that issues often associated with the first category receive wider media coverage – the interviewees' primary source of rights information – and perhaps as a result of this, they attract the most attention from campaigners and activists. Indeed, Kiai suggested that lack of understanding about ECS rights by local and international media may have led them to overlook or underplay this dimension during their reporting of certain events and campaigns, thus denying these rights much-needed publicity.[104]

In Kenya the imbalance may also be a consequence of the much publicised political turmoil of the early 1990s.[105] Yet the fact that these

[99] Steiner and Alston, *op. cit.*, 181.
[100] Rosalind P. Petchesky, 'Rights and Needs: Rethinking the Connections in Debates over Reproductive and Sexual Rights', *Health and Human Rights: An International Journal*, Vol. 4, No. 2 (2000), 17–29, at 20.
[101] See, for instance, Office of the United Nations High Commissioner for Human Rights (OHCHR), *Vienna Declaration and Programme of Action*, Adopted by the World Conference on Human Rights in Vienna on 25th June 1993 <http://www2.ohchr.org/english/law/pdf/vienna.pdf> accessed 14 March 2009, Art. 5.
[102] Steiner and Alston, *op. cit.*, 136. See also Mark Heywood and Dennis Altman, 'Confronting AIDS: Human Rights, Law, and Social Transformation', *Health and Human Rights: An International Journal*, Vol. 5, No. 1 (2000), 149–79, at 69; Monica Feria Tinta, 'Justiciability of Economic, Social and Cultural Rights in the Inter-American System of Protection of Human Rights: Beyond Traditional Paradigms and Notions', *Human Rights Quarterly*, Vol. 29, No. 2 (2007), 431–59; James Nickel, 'Rethinking Indivisibility: Towards a Theory of Supporting Relations Between Human Rights', *Human Rights Quarterly*, Vol. 30, No. 4 (2008), 984–1001.
[103] Marvellous Mhloyi, 'Health and Human Rights: An International Crusade', *Health and Human Rights: An International Journal*, Vol. 1, No. 2 (1995), 125–7, at 125. However, commentators like Halabi have been keen to warn against the oversimplification of such a notion, pointing out – in relation to the link between the right to participation as a political right and as an aspect of the right to health – an example from Indonesia: here the decentralisation of political authority as a means for boosting political participation has not resulted in improved health outcomes, or indeed the political participation of the marginalised. (See Sam Foster Halabi, 'Participation and the Right to Health: Lessons From Indonesia', *Health and Human Rights: An International Journal*, Vol. 11, No. 1 (2009), 49–59.)
[104] Kiai, *op. cit.*
[105] Later, the debate about possible war crimes committed during the post-election violence of 2007/8 and the role of the International Criminal Court is likely to have been similarly influential in further informing people about these issues, as they received wide coverage in a range of media, including electronic. See reports from *The Daily Nation* such as: 'Kenya Post-Poll Case Set for ICC', 5 November 2009, the online version of which gives readers an opportunity to comment publicly on the articles and the news.

events occurred against the background of a long and unbroken history of socio-economic problems has arguably failed to promote ESC rights awareness in the same way, although the Haki Index suggested things may be changing.[106] In his interview with this author, Kiai, who co-founded and headed the KHRC during the turbulent early 1990s, argued that it was unfair to categorise the organisation's work as purely focused on civil and political rights, and insisted that the organisation could gain little legitimacy by adopting such an approach. He noted the cross-cutting elements of its early programme, citing its campaigns on land rights for those disenfranchised by the ethnic clashes of that period, and famine relief (in association with the Catholic Church) in drought-stricken northern Kenya. But he also admitted that at its inception the organisation, inevitably, tended to 'do what they [knew] best'.[107]

It should indeed be a cause for concern for human rights organisations that, despite clearly articulating many ESC-related needs, few respondents were aware that most are covered by rights guaranteed under international law.[108] Few national human rights institutions, for instance, are involved in ESC rights work, even fewer on health,[109] and CSOs have generally been accused of a reluctance to develop strategies to promote ESC rights.[110] One reason for this may be that the most influential human rights organisations which might spearhead the fight are based in, and rely on funding from, the wealthier global north,[111] where the agenda may prioritise civil and political over ESC rights.[112] Some commentators highlight a geopolitical divide in the emphasis and promotion of ESC rights, with a northern emphasis on civil and political rights while the

[106] The 2006 survey revealed that there was a lower spontaneous awareness of all civil and political rights, bar freedom of worship, than in the previous year. By contrast, there was a generally higher number of spontaneous awareness amongst respondents of socio-economic rights in 2006 than in the previous year. When the survey respondents were asked to prioritise a number of rights read out to them, at least three of the top five may be strictly classified as socio-economic ones, with the right to life topping the list, then education, food, security and 'good health'. (KHRC, *op. cit.*, 25.)

[107] Kiai, *op. cit.*

[108] This does not mean that PLWHAs do not want civil and political rights, but suggests that their most immediate needs are of a socio-economic nature. Paul Farmer makes a similar observation, citing his work over a decade ago with a group called Partners in Health which motivated a rethink in approach: '… [A]lthough those we served ardently desired civil and political rights, they spoke more often of social and economic rights.' (Paul Farmer, 'Challenging Orthodoxies: The Road Ahead for Health and Human Rights', *Health and Human Rights: An International Journal*, Vol. 10, No. 1 (2008), 5–19, at 5.)

[109] Alicia Ely Yamin, 'Beyond Compassion: The Central Role of Accountability in Applying a Human Rights Framework to Health', *Health and Human Rights: An International Journal*, Vol. 10, No. 2 (2008), 1–20, at 5.

[110] Heywood and Altman, *op. cit.*, 168.

[111] Odinkalu, *op. cit.*

[112] Paul Farmer accuses a wide range of stakeholders of shying away from the difficult topic of resource redistribution which is a crucial component in addressing socio-economic problems, from NGOs to human rights organisations and university researchers. (Farmer, *op. cit.*, 10.)

poorer south stresses the importance of ESC ones.[113] Per this critique, the globalisation of the human rights enterprise and CSO activism on its behalf has not translated to a similarly geopolitically transcendent agenda. Further, the integration of ESC rights has been criticised by some as diluting the Universal Declaration of Human Rights (UDHR) and 'considerably [reducing] the impact of Western ideals by securing approval for some fundamental postulates of the Marxist ideology', and condemned as 'a letter to Santa Claus'.[114] But the idea that developed countries denigrate ESC rights has been dismissed elsewhere as a myth.[115] It is pointed out that the original drafters from these countries recognised that the UDHR needed to address the socio-economic deprivations which had significantly contributed to the rise of totalitarian regimes in the interwar period.[116] Nevertheless, the philosophical debates persist about the validity of ESC and other categories of rights,[117] namely, the 'third generation or "green" rights' that guarantee self-determination, group and (recently) environmental rights,[118] leading to questions about the slippage from needs to rights characteristic of the postwar period and the possible 'overproduction' of rights.[119] The right to development, too, has proved contentious,[120] even as others argue that it might provide the appropriate framework within which to address the multiple aspects of health.[121] Kenneth Roth sidestepped the philosophical quandaries about whether ESC rights are rights at all, and hung the legitimacy of his (Human Rights Watch) and similar organisations' work on the hook of positive law.[122] And, as Steiner and Alston underline, rights are dynamic, their content

[113] See, for instance, Douzinas, *op. cit*., 124. See also Celestine Nyamu-Musembi and Andrea Cornwall, 'What Is the "Rights-Based Approach" All About? Perspectives from International Development Agencies', *IDS Working Paper 234* (Brighton, Sussex: Institute of Development Studies (IDS), November 2004), 9.

[114] The first description is Antonio Cassese's; the second is by the (former US president Ronald) Reagan administration's representative to the UN. Both are quoted in Douzinas, *op. cit*., 123.

[115] See Daniel J. Whelan and Jack Donnelly, 'The West, Economic and Social Rights and the Global Human Rights Regime: Setting the Record Straight', *Human Rights Quarterly*, Vol. 29, No. 4 (2007), 908–49.

[116] Eide, *op. cit*., 16.

[117] See Odinkalu's rejection of this position in Chidi Anselm Odinkalu, 'Implementing Economic, Social and Cultural Rights Under the African Charter on Human and Peoples' Rights', in Malcolm Evans and Rachel Murray (eds), *The African Charter on Human and Peoples' Rights: The System in Practice, 1986–2000* (Cambridge: Cambridge University Press, 2002), 181–2.

[118] Douzinas, *op. cit*., 115.

[119] See, for instance, Baxi, *op. cit*., 139–41.

[120] See Noam Chomsky's quote (reproduced in Douzinas, *op. cit*., 115) of US Ambassador Morris Abrams in his address to the UN Commission on Human Rights, who referred to this right as 'a dangerous incitement' and 'little more than an empty vessel into which vague hopes and inchoate expectations can be poured'. See also Nyamu-Musembi and Cornwall, *op. cit*., 8–9.

[121] Benjamin Mason Meier and Ashley M. Fox, 'Development as Health: Employing the Collective Right to Development to Achieve the Goals of the Individual Right to Health', *Human Rights Quarterly*, Vol. 30, No. 2 (2008), 259–355.

[122] Roth, *op. cit*., 64.

expanding or contracting over time.[123] This is reflected in the increased advocacy that ESC rights now attract from organisations such as Amnesty International, whose work has previously focused on the promotion of civil and political rights.[124] Leonard S. Rubenstein argues that at a minimum such groups should use their credibility to find innovative ways to promote the acceptance of ESC issues such as healthcare as matters of right.[125]

Conclusion

HIV/AIDS has profound health implications for PLWHAs. But arguably it also impacts on their subjectivities, and, ultimately, their awareness and perceptions about their entitlements and rights. Understanding this can illuminate the often unseen hinterland in which the individual, per Hicks, first encounters the law. And only by adding flesh to the individual 'human' of human rights and understanding how she synthesizes her lived experiences with its norms can one hope to understand how she imagines her entitlements and human rights. Interviewees' responses suggested that HIV/AIDS can not only influence their chances of human rights awareness, but that it may also draw them towards knowledge of particular areas of rights that others within the general public may not focus on. The terminologies and ideas that they encounter in their interactions with PLWHA advocacy and support groups also shape their internalisation of human rights norms, and, even more fundamentally, often inspire them to reimagine their sense of self within the marginality of a stigmatising illness.

Human rights advocates would do well to acknowledge these personal, internal encounters with human rights language and norms. For although the human rights paradigm has been increasingly mainstreamed since the latter half of the 20th century, there is often a disconnect between the way that human rights experts and lay people conceptualise and articulate claims to entitlements. This challenges the efficacy of the human rights framework itself to address these concerns. Indeed, Conklin has highlighted the counterproductive effect of using a medium that is hidden from, or unknown to, those in whose aid it is apparently deployed,

[123] Steiner and Alston, *op. cit*., 181.
[124] Leonard S. Rubenstein, 'How International Human Rights Organizations Can Advance Economic, Social, and Cultural Rights: A Response to Kenneth Roth', *Human Rights Quarterly*, Vol. 26, No. 4 (2004), 845–65, at 846. See also Ely Yamin, *op. cit*., 52.
[125] Rubenstein, *op. cit*., 847.

decrying the fate of 'the pained individual ... overwhelmed by the distant language of experts'.[126] Yet the interviews with PLWHAs glimpsed in this article point to the opportunities and possibilities for popularising the human rights project and promoting its framework by taking a more intimate and grounded approach.

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[126] Conklin, *op. cit.*, 137.

Legalising Euthanasia: A Slippery Slope to Wanton Killing?

Amy Edgson

Abstract

It is argued in this paper that legalising any form of euthanasia (whether physician-assisted suicide or voluntary active euthanasia) without adequate safeguards will create a set of circumstances which will naturally result in a slide to the practice of involuntary euthanasia. The impossibility of drafting precise and clear criteria and implementing adequate safeguards means that, at present, the slippery slope is unavoidable. Therefore, any law permitting a form of euthanasia will inevitably result in a slide to involuntary and irrational killings. In many cases euthanasia may appear to be the fair outcome, when the case involves a person who is terminally ill or suffering unbearably, and has a genuine wish to die. Although there are some people who should rightfully be allowed to end their life with the help of another, there are a greater number of people who would face an undesired death as a result of the pressure that would be put on them if euthanasia were an option. This paper demonstrates that, on the exceedingly controversial issue, much remains unresolved with regard to how such practices could be lawfully carried out without putting a number of people at risk of an unwanted or unrequested death. Therefore, legalising euthanasia at present would result in an unpreventable slippery slope to outrageous killings of vulnerable individuals.

Keywords: euthanasia; assisted suicide; right to life; right to die; Suicide Act 1961; sanctity of life; doctrine of double effect; autonomy; mental capacity

Introduction

This paper seeks to establish whether legalising euthanasia will inevitably result in a slippery slope to wanton killing. It investigates the possibility of there being involuntary killings of the vulnerable, and irrational and immoral hastened deaths, as a consequence of legalising voluntary active euthanasia.

The slippery slope argument is the idea that legalising one practice, which people believe to be moral, will inevitably lead to the practice of another, which people believe to be immoral.[1] The slippery slope argument in relation to voluntary euthanasia consists of two individual arguments.[2] The empirical argument is that, even if it is possible to separate in principle practices of voluntary active euthanasia and involuntary active euthanasia, a slide will inevitably occur because the safeguards to prevent it cannot be made effective.[3] The logical argument holds that, even if final guidelines were established which permitted voluntary active euthanasia as a last resort for people suffering unbearably from a terminal illness, logic would demand those guidelines to be relaxed due to the practical difficulties of definition and because the case for euthanasia within those limits is also, logically, a case for euthanasia without them.[4]

First, in part one, the current law on euthanasia and assisted suicide in England and Wales will be examined. There will be a discussion of the scope of the law and whether *Nicklinson*[5] and *Conway*[6] represent the last word on the issue. The effect which euthanasia, being illegal, has on those seeking a hastened death will also be briefly discussed. Part two will look at the difference between lawful and unlawful life-shortening practices. It will examine the clarity of the distinction and whether this distinction is justified and upheld by the courts. *Purdy*[7]and its impact on the prosecution of family members who assist individuals in their end-of-life decision will be discussed as well.

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[1] John Keown, *Euthanasia, Ethics and Public Policy*, 2nd edition (Cambridge: Cambridge University Press, 2018), 68.
[2] *Ibid*., 71.
[3] *Ibid*., 71.
[4] *Ibid.*, 82.
[5] *Nicklinson v Ministry of Justice* [2012] EWHC 304 (QB), [2012] H.R.L.R. 16.
[6] *Regina (Conway) v Secretary of State for Justice (Humanists UK and others intervening)* [2017] EWHC 2447 (Admin) [2018] 2 W.L.R. 322.
[7] *Regina (Purdy) v Director of Public Prosecutions (Society for the Protection of Unborn Children intervening)* [2009] UKHL 45, [2010] 1 A.C. 345.

Next, the effectiveness of the possible safeguards to protect vulnerable groups in society from involuntary euthanasia will be considered. Part three will explore the sanctity-of-life principle and how it informs the discourse on euthanasia and other socio-legal debates on life and death issues. *Re A*[8] will be discussed to help highlight the complexities of the debate around the sanctity-of-life principle and whether it provides absolute protection to the vulnerable, or fails to protect individuals who it is believed have lives which are no longer worth living. Part four will then consider whether the need for autonomy provides a rationale for how the practice can be safely legalised, holding that only those who make an autonomous choice will receive assistance. The investigation will show the difficulties in determining whether an end-of-life decision is the truly autonomous wish of the patient. The Dutch approach will be briefly evaluated to demonstrate whether a law permitting euthanasia, in which people lawfully make the autonomous choice to die, will result in the deaths of individuals who are not terminally ill or suffering unbearably, as autonomy will be exercised by everyone equally.

Finally, in part five, there will be discussion of whether it is possible to be sure that a person has the mental capacity to make a decision about their own death and the difficulty in determining whether a person is mentally competent. It will consider the conditions which any effective Bill proposing the legalisation of assisted dying should contain, which the House of Lords have continuously failed to include.

By identifying the key fears associated with the practice, investigating potential safeguards and examining the results from the Netherlands, a conclusion can be made as to whether legalising euthanasia will result in the slippery slope fear.

I. The law on euthanasia in England and Wales

This part briefly outlines the current law on euthanasia in England and Wales, and explores the chance of any changes to that law. It also addresses the wider impact of the current legal situation, particularly on neighbouring jurisdictions with a different approach.

Euthanasia is illegal

[8] *In Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam. 147.

In England and Wales all forms of euthanasia are illegal. For this paper it is first necessary to define some of the different forms of euthanasia. Euthanasia occurs when a doctor deliberately acts to kill a patient.[9] Voluntary active euthanasia is euthanasia at the request of the patient or with the patient's consent.[10] Involuntary active euthanasia is euthanasia of a person unable to make a request or against the wishes of a competent person.[11] Assisted suicide refers to a patient who brings about his or her own death with the help of another.[12] When this assistance comes from a doctor, it is known as physician-assisted suicide.[13] The assistance could involve giving a patient lethal drugs or simply advice about methods.[14] Assisted dying is a term used when referring to both voluntary active euthanasia and physician-assisted suicide.

Euthanasia satisfies both the *actus reus* and *mens rea* for the crime of murder.[15] *Actus reus* refers to the conduct element of the offence.[16] It describes what the defendant must be proved to have done or failed to do, in what circumstances and with what consequences in order to be guilty.[17] The *actus reus* of murder is fulfilled when a person unlawfully causes the death of a human being under the Queen's peace.[18] *Mens rea* describes the element of a criminal offence that relates to the defendant's mental state.[19] Different crimes have different *mentes reae*.[20] Some require intention, whereas others can require recklessness, negligence or knowledge.[21] The *mens rea* of murder is intention to kill or an intention to cause grievous bodily harm.[22]

As murder carries a mandatory life sentence, it is irrelevant whether a person acted compassionately with good intentions when hastening another's death or whether the patient was already close to death.[23] In

[9] Emily Jackson, *Medical Law: Text, Cases and Materials*, 4th edition (Oxford: Oxford University Press, 2016), 914.
[10] Keown, *op. cit*., 15.
[11] *Ibid*.
[12] Jackson, *op. cit*., 914.
[13] Keown, *op. cit*., 16.
[14] *Ibid*.
[15] Jackson, *op. cit*., 914.
[16] Jonathan Herring, *Criminal Law: Text, Cases and Materials*, 7th edition (Oxford: Oxford University Press, 2016), 71.
[17] *Ibid*., 71.
[18] Michael J. Allen, *Textbook on Criminal Law*, 13th edition (Oxford: Oxford University Press, 2015), 326.
[19] Herring, *op. cit*., 132.
[20] *Ibid*., 132.
[21] *Ibid*., 132.
[22] Allen, *op. cit*., 327.
[23] Jackson, *op. cit*., 915.

Inglis,[24] a mother killed her severely disabled son by injecting him with heroin as he lay in his hospital bed.[25] She genuinely believed that her actions constituted an act of mercy.[26] The Court of Appeal upheld the conviction of murder, Lord Judge CL stating:

> We must underline that the law of murder does not distinguish between murder committed for malevolent reasons and murder motivated by familial love. Subject to well established partial defences, like provocation or diminished responsibility, mercy killing is murder.[27]

Section 2 of the Suicide Act 1961 states:

> A person (D) commits an offence if (a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and (b) D's act was intended to encourage or assist suicide or an attempt at suicide.[28]

The Act makes it an offence for an individual to assist the suicide of another in every way.

A summary of the current position of the law governing the end of life was provided in *Nicklinson*, in which Lord Sumption stated:

> In law, the state is not entitled to intervene to prevent a person of full capacity who has arrived at a settled decision to take his own life from doing so. However, such a person does not have a right to call on a third party to help him to end his life.[29]

The position of the law is unlikely to change

In 2012, Tony Nicklinson sought several declarations which, if granted, would have had a substantial impact upon the prohibition of euthanasia in the UK.[30] Nicklinson sought a declaration that the common defence of necessity should be available to a charge of murder for voluntary euthanasia, and that the law on murder and assisted suicide was

[24] *Regina v Inglis* [2010] EWCA Crim 2637, [2011] 1 W.L.R. 1110.
[25] *Ibid*.
[26] *Ibid*.
[27] *Ibid*.
[28] Suicide Act 1961.
[29] *Regina (Nicklinson) and another v Ministry of Justice and others (CNK Alliance Ltd and others intervening), Regina (AM) v Director of Public Prosecutions and others (CNK Alliance Ltd and others intervening)* [2012] EWHC 2381 (Admin), [2013] EWCA Civ 961, [2014] UKSC 38, [2015] A.C. 657.
[30] Jackson, *op. cit.*, 917.

incompatible with the right to respect for private life under Article 8 of the European Convention on Human Rights.[31] Several reasons were given by Lord Dyson as to why the common law should not recognise a defence of necessity to apply to cases of euthanasia, one reason being:[32]

> There is no self-evident reason why it should give way to the values of autonomy or dignity and there are cogent reasons why sensible people might properly think that it should not. So the mere fact that there may be rights to autonomy and to be treated with dignity does no more than raise the question whether they should be given priority in circumstances like this; it does not of itself carry the day.[33]

The concept of autonomy is extremely prominent in the euthanasia debate, as this paper will later demonstrate.[34] Proponents of euthanasia believe that euthanasia is warranted out of respect for a patient's right to self-determination.[35] Yet, many opponents, while valuing autonomy, share the same view as Lord Dyson, believing that autonomy does not have primacy in this debate.[36]

More recently, in 2018, the Supreme Court refused to grant permission to Noel Conway to challenge the law on assisted dying.[37] Conway, who was terminally ill suffering from motor neurone disease, wished to have the option of ending his life with the assistance of a medical professional, once he had been given a prognosis of six months or less to live.[38] Conway sought judicial review by way of a declaration of incompatibility under section 4 of the Human Rights Act 1998 in respect of section 2 of the Suicide Act 1961, on the grounds that it was incompatible with the right to respect for private life guaranteed by Article 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms.[39] Conway proposed a scheme in which an adult diagnosed with a terminal illness with a prognosis of six months or less to live could apply

[31] *Regina (Nicklinson), op. cit.*
[32] *Ibid*.
[33] *Ibid*.
[34] Keown, *op. cit.*, 50.
[35] *Ibid*.
[36] *Ibid*., 51.
[37] Fergus Walsh, '"I feel cheated" – right to die campaigner', *BBC News* (8 December 2018) <https://www.bbc.co.uk/news/health-46475083?intlink_from_url=&link_location=live-reporting-correspondent> accessed 23 January 2019.
[38] *Regina (Conway), op. cit.*
[39] *Ibid*.

to a High Court judge for authorisation of assistance to commit suicide.[40] The Court of Appeal refused, holding:

> … the legitimate aims which section 2 of the Suicide Act 1961 sought to pursue encompassed not only protection of the weak and vulnerable but also protection of the sanctity of life and promotion of trust between doctor and patient.[41]

Nicklinson and *Conway* both demonstrate that the law on euthanasia in England and Wales is extremely unlikely to change for the foreseeable future. In both cases the sanctity-of-life principle prevailed over autonomy and quality-of-life issues. The sanctity-of-life principle is supported by opponents of euthanasia, who reject the argument that life can lose its worth so as to make death a benefit.[42] The scope of the sanctity-of-life principle will be examined later in this paper.

A right to life, not a right to die

By virtue of the Human Rights Act 1998, the provisions of the European Convention on Human Rights are directly enforceable in the English legal system.[43] Article 2 states: 'Everyone's right to life shall be protected by law.'[44] This right is in direct conflict with the argument for euthanasia, being that there are circumstances in which people should lawfully be allowed to end the life of another.

Pretty[45] concerned a terminally ill woman who faced an imminent prospect of a distressing death. Diane Pretty claimed that Article 2 protected a right to self-determination, entitling her to commit suicide with assistance. She also claimed that not allowing her to end her life infringed her rights under Articles 3 and 8, and was also a breach of Article 14 as she suffered discrimination, since an able-bodied person might exercise the right to suicide, whereas her incapacities prevented her doing so without assistance.[46] Pretty's appeal was dismissed by the House of Lords which held:

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[40] *Ibid*.
[41] *Ibid*.
[42] Keown, *op. cit*., 37.
[43] Alex Carroll, *Constitutional and Administrative Law*, 8th edition (Harlow: Pearson, 2015), 397.
[44] Human Rights Act 1998, Schedule 1, Part 1, Article 2.
[45] *Regina (Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department intervening)* [2001] UKHL 61, [2002] 1 A.C. 800.
[46] *Ibid*.

> … the language of Article 2 reflected the sanctity of life and expressed protection of the right to life and prevention of the intentional taking of life, save in closely defined circumstances, and that, so framed, it could not be interpreted as conferring a right to self-determination in relation to life and death and assistance in choosing death; and that, although the state had a positive obligation to safeguard the lives of those within its jurisdiction, it had no positive duty to recognise any right to assisted suicide.[47]

The words 'save in closely defined circumstances' illustrate that even the court recognises that the bar to the intentional taking of life is not absolute. However, the House of Lords did make clear that Article 2 cannot be interpreted as conferring the diametrically opposite right, namely a right to die.[48] Neither does the Article create a right to self-determination in the sense of conferring on a person the right to choose death instead of life.[49]

The law is 'exporting the problem'

As the law on euthanasia appears not to be heading towards legalisation in the foreseeable future, the law will continue, in effect, to export the problem of assisted dying. Citizens of the countries in which euthanasia is unlawful are able to, and often do, travel to countries in which the practice is lawful in order to access assisted dying.[50] Dignitas – an association founded in 1998 and based in Switzerland – has, in accordance with its constitution, the objective of ensuring a life and death with dignity.[51] People who travel to Dignitas clinics are almost always from other European countries and are virtually always assisted by family or friends.[52] These individuals who travel to Zurich have to go whilst they are still able to travel.[53] This results in people dying sooner than necessary, as well as away from the comfort of their own home.[54] Dr Anne Turner, who suffered from progressive supranuclear palsy, an incurable brain disease, had very few symptoms of her disease when she ended her life in Zurich

[47] *Ibid*.
[48] 'Article 2: Right to Life' (Justice) <https://justice.org.uk/article-2/> accessed 13 March 2019.
[49] *Ibid*.
[50] Emily Jackson and John Keown, *Debating Euthanasia* (Oxford: Hart, 2012), 33.
[51] 'Who is DIGNITAS' (Dignitas) <http://www.dignitas.ch/index.php?option=com_content&view=article&id=4&Itemid=44&lang=en> accessed 20 March 2019.
[52] Jackson and Keown, *op. cit*., 33.
[53] *Ibid*., 33.
[54] *Ibid*.

with the help of Dignitas.[55] During an interview shortly before her death, Anne told a reporter:

> I think it's dreadful that somebody like myself has to go to Switzerland to do this, which is an awful hassle … I want to go there while I still can, because I have to be able to swallow a solution of barbiturates.[56]

The law on assisted dying in Switzerland contains none of the safeguards which the UK might have found necessary to implement if legalising assisted dying.[57] The Swiss have not specifically taken steps to legalise assisted suicide, rather, according to the Swiss Penal Code, it is only a crime if the motive is 'selfish'.[58] All that needs to be established is that the person who assisted the suicide acted from compassion, which appears to be a fairly minimal requirement.[59] Although the Swiss right to die societies can impose their own more rigorous requirements, the law itself contains none of the safeguards – such as a psychiatric assessment – which should be part of any well-developed assisted dying law.[60]

People who travel abroad in order to access assisted dying do so at the risk of others. They almost always need the assistance of family and friends in order to make their journey. The next part will consider whether those who assist are being punished for their actions, regardless of motive, or whether the law appears to be lenient towards people who have acted compassionately.

II. Legal uncertainty

This part outlines what the law regards as a lawful end-of-life practice compared to an unlawful one. It will then consider whether those who assist the suicide of another are being prosecuted for their actions, and whether both juries and the judiciary are reluctant to convict those who acted compassionately when performing an unlawful end-of-life practice. Also, it will briefly address the risk of euthanasia being unlawful and give evidence of the practice happening underground.

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[55] Sarah Boseley and Clare Dyer, 'I believe I must end my life while I am still able', *The Guardian*, 25 January 2006 <https://www.theguardian.com/society/2006/jan/25/health.medicineandhealth> accessed 23 January 2019.
[56] *Ibid*.
[57] Jackson and Keown, *op. cit*., 34.
[58] *Ibid*.
[59] *Ibid*.
[60] *Ibid*.

Lawful and unlawful practices

It is often argued that euthanasia should be legalised due to the current line that the law draws between lawful and unlawful life-shortening practices being incoherent and morally irrelevant.[61] In intensive care units, it is common for patients to die following the withdrawal of treatment that had been maintaining their life.[62] Death is also hastened in end-of-life care by the use of sedatives and painkilling drugs, which are accepted as proper medical treatment.[63] Withdrawing treatment, such as artificial nutrition or medical ventilation, can result in the patient dying from starvation or suffocation, which is longer and more distressing than the quick and painless death which would be prompted by a fatal injection.[64]

There is no logical reason why we do not allow doctors to give patients lethal injections, which result in a more pleasant death than those currently lawfully caused by doctors who engage in life-shortening practices.[65] There are some instances of killing, such as murder, that are clearly morally worse than some instances of letting someone die.[66] However, there are also instances of letting someone die, such as not resuscitating a patient who could easily be saved, that are clearly morally worse than some instances of killing, such as a mercy killing at the patient's request.[67]

Both withholding and withdrawing life-sustaining treatment are, in law, omissions.[68] It has been argued that we owe extensive positive duties (that is to say, duties to assist), so that letting someone die becomes as morally unacceptable as killing them.[69] The moral distinction between killing and letting die has been rejected because intentionally terminating the life of an innocent human is always wrong, whether it is done by an act

[61] Jackson, *op. cit.*, 956.
[62] Jackson and Keown, *op. cit.*, 13.
[63] *Ibid*., 13.
[64] *Ibid*.
[65] Jackson, *op. cit.*, 956.
[66] Tom L. Beauchamp, *Intending Death: The Ethics of Assisted Suicide and Euthanasia* (Englewood Cliffs, NJ: Prentice Hall, 1995), 9.
[67] *Ibid*., 9.
[68] Shaun D. Pattinson, *Medical Law and Ethics*, 5th edition (London: Sweet & Maxwell, 2017), 545.
[69] *Ibid*., 545.

or an omission (that is to say, the sanctity-of-life position).[70] Also, rejections have been made because it is believed that we are responsible for anything that we voluntarily and knowingly bring about, irrespective of whether we bring it about by an act or an omission.[71]

On the other hand, Dworkin et al. make the argument that the obligation not to take life is clearly of a higher priority than the obligation to save lives.[72] If there is a morally significant difference between administering lethal drugs and withholding or withdrawing life-preserving therapy, it is because the former involves killing while the latter involves letting someone die, and there is a morally significant difference between the two.[73] No legal wrong is committed by an omission unless there is a legal obligation to act, which there will not be where a patient validly refuses treatment or where treatment is not in the patient's best interest.[74]

Andrew Ashworth writes of the 'conventional view' which maintains that the criminal law should be reluctant to impose liability for omissions.[75] Supporters of the conventional view argue that there is a moral distinction between acts and omissions, maintaining that failure to perform an act with foreseen bad consequences is morally less bad than performing an act with the identical foreseen bad consequences.[76] The view only accepts criminal liability of omissions which are regarded as exceptional and require special justification for the criminal law to impose duties to assist other individuals.[77] This argument stems from individual autonomy and liberty.[78] One aim of the law is to maximise individual liberty, so as to allow each individual to pursue a conception of the good life with as few constraints as possible.[79] The conventional view holds that freedom of action should be curtailed only so far as is necessary to restrain individuals from causing injury or loss to others.[80] Therefore, it can be argued that there is a moral difference between killing and letting die, as individual autonomy should only be restricted when a person's actions cause loss to another, such as an act of voluntary active euthanasia.

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[70] *Ibid*.
[71] *Ibid*.
[72] Gerald Dworkin, R.G Frey and Sissela Bok, *Euthanasia and Physician-Assisted Suicide* (Cambridge: Cambridge University Press, 1998), 92.
[73] *Ibid*., 92.
[74] Pattinson, *op. cit*., 545.
[75] Andrew Ashworth, 'The Scope of Criminal Liability for Omissions' (1989) *Law Quarterly Review*.
[76] *Ibid*.
[77] *Ibid*.
[78] *Ibid*.
[79] *Ibid*.
[80] *Ibid*.

The doctrine of double effect

It is an accepted and well-established principle of law that doctors are entitled to administer painkilling or sedative drugs in quantities which may also hasten death.[81] In *Bland*,[82] Lord Goff referred to:

> the established rule that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient's life.[83]

This is known as the doctrine of double effect, which distinguishes between results that are intended and results that are foreseen as likely, but unintended, consequences of one's actions.[84]

Thus, a doctor who intentionally causes the death of a patient by an overdose, or who intentionally uses an unusually large dose of pain-killing medication that has the side-effect of causing the patient's death, may be said, on both occasions, to have intended to relieve suffering with knowledge that the patient's life will likely end.[85] Critics of the doctrine of double effect argue that the doctrine unjustifiably accepts less humane methods of ending human life, such as a slow death caused by medication which reduces pain over time and can involve painful days or weeks of a life that a patient wishes to not live.[86]

Although euthanasia is illegal, it appears lawful to end a patient's life as long as the doctor only foresees, and does not intend, death.[87] Palliative care experts have claimed that if painkilling drugs are used properly they should never have the effect of hastening death.[88] The doctrine of double effect does not require there to have been a prior request for pain relief that could hasten death.[89] Therefore, there do not appear to be safeguards protecting those who make a request in the agony

[81] Jackson, *op. cit.*, 938.
[82] *Airedale N.H.S. Trust Respondents v Bland Appellant* [1993] 2 W.L.R. 316, [1993] A.C. 789.
[83] *Ibid*.
[84] Jackson, *op. cit.*, 938.
[85] Beauchamp, *op. cit.*, 12.
[86] *Ibid*., 12, 13.
[87] Jackson and Keown, *op. cit.*, 14.
[88] *Ibid*., 14.
[89] *Ibid*., 15.

of the moment.[90] One reason that euthanasia is disapproved of is due to its opponents' belief that you cannot be sure that a person experiencing distress has made a competent and rational choice. However, this could also be argued in relation to the doctrine of double effect, as the decision could have been made without any prior consideration.

The non-prosecution of those who assist

Despite euthanasia and assisted suicide being unlawful life-shortening practices, the law shows inconsistency, as prosecutions of those who assist are rare and convictions even rarer.[91] Virtually all of the UK citizens who have travelled to Dignitas clinics to access assisted dying have been helped by family or friends.[92] The non-prosecution of these individuals who assist shows how the law – in which assisted suicide is a serious crime – and the reality are very different.[93] Police investigations have taken place when family members have returned to the UK; however, no one has yet faced prosecution.[94]

When considering the reluctance to prosecute, *Purdy* should be considered and its impact recognised. Debby Purdy suffered from primary progressive multiple sclerosis for which there was no known cure.[95] Purdy knew that there would come a time when her suffering would be unbearable and she would want to end her life; however, she would be unable to do so without assistance.[96] Purdy's husband was willing to accompany her to Switzerland, but she was concerned that he would be prosecuted for an offence under section 2 of the Suicide Act 1961.[97] Purdy sought information from the Director of Public Prosecutions (DPP) as to the factors which he would take into consideration in deciding whether a prosecution should be brought, but the DPP declined to give that information.[98]

Before *Purdy* reached the Court of Appeal, the DPP, Keir Starmer QC, published a detailed explanation of his reasons for not prosecuting the parents of Daniel James, who died at Dignitas accompanied by his

[90] *Ibid*., 15.
[91] Jackson, *op. cit*., 957.
[92] *Ibid*., 922.
[93] *Ibid*., 957.
[94] *Ibid*., 922.
[95] *Regina (Purdy), op. cit*..
[96] *Ibid*.
[97] *Ibid*.
[98] *Ibid*.

parents.[99] Starmer decided not to prosecute, in spite of the seriousness of the offence and the fact that there was sufficient evidence to prosecute.[100] Starmer, taking the unprecedented step of publishing the reasons for his decision, wrote: 'I have concluded that a prosecution is not needed in the public interest.'[101] This landmark case was the first to rule out a prosecution on the grounds of public interest alone.[102]

> When *Purdy* reached the House of Lords, the House held:
>
> > the Director was under a duty to clarify his position as to the factors which he regarded as relevant for and against prosecution in such a case and he would be required to promulgate an offence-specific policy identifying the facts and circumstances which he would take into account in deciding whether a prosecution under section 2(1) of the 1961 Act should be brought.[103]

As a result of this decision, in 2010, the DPP issued a policy statement which sets out the factors that count in favour and against a public interest in prosecuting individuals who commit the offence of assisting and encouraging suicide.[104] The policy states that a prosecution is less likely to be required if 'the suspect was wholly motivated by compassion' and 'the suspect reported the victim's suicide to the police and fully assisted them in their enquiries …'[105] The policy enables individuals who are going to assist a family member on their journey to Dignitas to avoid prosecution. Despite the illegality of assisting suicide, the DPP is essentially giving those who assist the suicide of another a chance to 'get away with' a criminal offence.

The case of Sir Edward and Lady Downes was the first to be decided under the 2010 policy,[106] in which the son helped the couple to end their lives by booking them a hotel room in Switzerland and accompanying

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[99] Jackson, *op. cit*., 922.
[100] Afua Hirsch and Robert Booth, 'CPS will not prosecute relatives who help terminally ill to die', *The Guardian*, 10 December 2008 <https://www.theguardian.com/society/2008/dec/10/assisted-suicide-daniel-james-cps> accessed 24 January 2019.
[101] *Ibid*.
[102] *Ibid*.
[103] *Regina (Purdy)*, *op. cit*.
[104] Sabine Michalowski, 'Relying on Common Law Defences to Legalise Assisted Dying: Problems and Possibilities', (2013) 21 *Medical Law Review* 3 337, 338.
[105] The Director of Public Prosecutions, 'Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide', CPS, February 2010 <https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide> accessed 24 January 2019.
[106] Jackson, *op. cit*., 925.

them on their final journey.[107] The DPP, who decided not to prosecute the son, said that it would not be in the public interest to prosecute and, although there were factors tending in favour of prosecution, the available evidence indicated that 'Mr Downes was wholly motivated by compassion.'[108]

A reluctance to convict

Both juries and the judiciary have shown leniency towards doctors whom they judge to have acted compassionately.[109] To be guilty of murder, the defendant's conduct must have 'contributed significantly' or been 'a substantial cause' of death; it need not be the sole cause.[110] Although doctors have been prosecuted, no doctor who fulfilled a patient's end-of-life request has ever been convicted of the full offence of murder.[111]

This relates back to the *mens rea* element for a crime of murder. Only if death or grievous bodily harm was a virtually certain consequence of the defendant's action, and the defendant realised that this was so, may the jury find that the defendant intended death or grievous bodily harm.[112] In *Matthews v Alleyne*, it was held that acting deliberately with the appreciation of a virtual certainty of death did not necessarily amount to an intention to kill; instead it was evidence from which intent to kill could be inferred.[113] Following this Court of Appeal decision, even though doctors may be acting deliberately, recognising that death is virtually certain, that does not mean that they had the intention to kill and therefore do not have the *mens rea* for murder. Therefore, the law on murder itself provides some flexibility in which other factors may be taken into account by the jury who are deciding on the issue of the *mens rea*.

Cox[114] is the only case to result in a doctor's conviction; however, he was convicted for attempted murder, rather than murder.[115] Dr Cox cared for an elderly patient, Mrs Boyes, who was dying in great pain and pleaded

[107] Stephen Bates, 'Son of Sir Edward Downes will not be charged over assisted suicides', *The Guardian*, 19 March 2010 <https://www.theguardian.com/society/2010/mar/19/edward-downes-assisted-suicide-son> accessed 24 January 2019.
[108] *Ibid*.
[109] Jackson, *op. cit*., 916.
[110] *Ibid*., 916.
[111] *Ibid*.
[112] Herring, *op. cit*., 139.
[113] *R. v Matthews, R. v Alleyn* [2003] EWCA Crim 192, [2003] 2 Cr. App. R. 30.
[114] *R v Cox* [1992] 12 BMLR 38.
[115] Jackson, *op. cit*., 917.

with Dr Cox to end her life.[116] Dr Cox used potassium chloride to end Boyes' life and was later charged with attempted murder,[117] since the cause of death could not be proved as her corpse had been cremated.[118] The judge, Ognall J, directed the jury by saying that Dr Cox injected Boyes with two ampoules of undiluted potassium chloride, which had no therapeutic purpose and no capacity to afford her any relief from pain and suffering whilst still alive.[119] Ognall J went on to say that if it is proved that Dr Cox injected Boyes with potassium chloride in circumstances which make you sure that by that act he intended to kill her, then he is guilty of the offence of attempted murder.[120] It was not surprising that Dr Cox was convicted, given the evidence against him.[121] However, Dr Cox was only given a suspended prison sentence and was not removed from the medical register; instead he was merely required to undergo training again.[122] Dr Cox's sentence reflects how judges are trying to avoid punishing those who carry out euthanasia for compassionate reasons, as they are not willing to treat those individuals in the same way that a murderer would usually be treated.

Moor[123] further demonstrates that juries are not willing to convict someone whom they judge to have acted compassionately. Dr Moor was accused of killing George Liddell, an 85-year-old terminally ill patient, into whom he had injected a fatal dose of diamorphine.[124] Hooper J, during his summing up, told the jury:

> You may consider it a great irony of this case that a doctor who goes out of his way to care for George Liddell ends up facing the charge that he does. You may also consider another great irony of the case is that the doctor who takes time out on his day off to tend to a dying patient ends up on this charge.[125]

Dr Moor, who admitted to helping up to 300 patients to die 'pain-free deaths', was cleared of the murder charge.[126]

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[116] *Cox, op. cit.*
[117] *Ibid.*
[118] Keown, *op. cit.*, 11.
[119] *Cox, op. cit.*
[120] *Ibid.*
[121] Keown, *op. cit.*, 11.
[122] *Ibid.*, 11
[123] *R v Moor* [1999] Crim LR 2000.
[124] Alexander McCall Smith, 'Euthanasia: The Strengths of the Middle Ground', (1999) 7 *Medical Law Review* 194, 199.
[125] 'GP cleared of murdering 85-year-old patient', *The Guardian*, 11 May 1999 <https://www.theguardian.com/uk/1999/may/11/5> accessed 14 March 2019.
[126] *Ibid.*

It is evident that when a doctor is found guilty of carrying out euthanasia, or the doctor himself admits to such acts, the courts do not feel that it is necessary to punish them with the usual sentence for murder. It is therefore necessary to consider whether euthanasia should remain illegal if no one is ever truly punished when committing the 'crime'.

Euthanasia happening 'underground'

Due to the risk that doctors might be charged with murder or assisted suicide if they help end a patient's life, it has been practically impossible to accumulate information about doctors' participation in euthanasia.[127] An argument can be made that if euthanasia is taking place anyway, but in secret, then why not legalise the practice to enable it to be tightly regulated, rather than happening 'underground'.[128] As doctors who perform voluntary euthanasia are not being punished, taking away that risk by legalising voluntary active euthanasia would allow doctors to act openly and seek advice.

Assisted deaths are currently happening without any safeguards, such as a second opinion or psychiatric assessment, and without any monitoring procedures to ensure that the euthanasia was voluntary and justified.[129] Roger Magnusson published survey evidence of euthanasia happening underground, from which he concluded: 'wherever you turn, somewhere between 4% and 10+% of doctors have illegally assisted a patient to die.'[130] In a survey of Australian general surgeons, 5.3 per cent reported administering a lethal injection,[131] while 36.2 per cent reported giving an overdose of drugs with the intention of hastening death, with more than half of those respondents doing so without a clear request by the patient.[132] In a 1994 survey of British doctors, it was reported that 45 per cent of doctors answering the question had been requested by a patient to hasten death; 12 per cent of these respondents complied.[133] Magnusson gave examples of euthanasia taking place underground, referring to one case in which a 'doctor injected a young man on the first occasion they met, despite concerns from close friends that the patient was depressed',

[127] Jackson, *op. cit*., 957.
[128] *Ibid*., 958.
[129] Jackson and Keown, *op. cit*., 35.
[130] R.S. Magnusson, 'Euthanasia: Above Ground, Below Ground', (2004) *Journal of Medical Ethics* 441, 442.
[131] *Ibid*., 442.
[132] *Ibid*., 442.
[133] *Ibid*.

and another case in which 'a patient brought his death forward by a week so as not to interfere with the doctor's holiday plans.'[134]

Euthanasia being illegal is leading to the deaths of people who have not been given the help and support that they truly need. This is also a fear associated with the slippery slope argument, which is that legalising euthanasia will result in a slide to euthanasia not as a last resort. Legalisation would allow patients to get the correct treatment and for doctors to consult others on what that treatment should be. As assisted suicide can sometimes be justified and both juries and the judiciary are not willing to punish doctors who perform euthanasia illegally without safeguards, it would be in the public interest for assisted dying to be legalised, with effective safeguards in place to protect patients. Therefore, it should be considered whether safeguards can be put in place in order to effectively manage the practice of assisted dying.

The sanctity-of-life principle is examined in the next part, in order to determine whether it could provide a safeguard for the vulnerable against involuntary euthanasia, helping to avoid the slippery slope if euthanasia were to be legalised.

III. Sanctity of life

This part begins by briefly discussing what the sanctity-of-life principle means and the arguments behind the principle. It will then consider the sanctity-of-life principle as a safeguard to protect the vulnerable, by determining whether the principle is absolute. There will also be a brief discussion of the quality-of-life principle and the circumstances in which the quality-of-life principle overrules the sanctity-of-life principle, compared to those in which the sanctity-of-life principle prevails.

At the centre of much of the debate on euthanasia is the principle of the sanctity of life.[135] There has been significant disagreement over what the sanctity-of-life principle actually means, and it has been used by judges and commentators to mean very different things.[136] The traditional doctrine of the sanctity of life holds that human life is created in the image of God and is, therefore, possessed of an intrinsic dignity which entitles it to protection from unjust attack.[137] It has been argued that assisted dying is

[134] *Ibid*., 443.
[135] Jonathan Herring, *Medical Law and Ethics*, 6th edition (Oxford: Oxford University Press, 2016), 537.
[136] *Ibid*., 537.
[137] Keown, *op. cit*., 38.

incompatible with the sanctity of human life, or with the principle that every human life is intrinsically valuable.[138]

The principle grasps the idea that human life is a fundamental basic good.[139] The idea that human life possesses an intrinsic dignity grounds the principle that one must never intentionally kill an innocent human, be that by an act or an omission.[140] Lord Goff noted in *Bland* that the sanctity-of-life principle is:

> a principle long recognised not only in our own society but also in most, if not all, civilized societies throughout the modern world, as is evidenced by its recognition in Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms.[141]

Under this principle, the right not to be intentionally killed is enjoyed regardless of inability or disability.[142]

The arguments behind the principle

There are two main arguments behind the sanctity-of-life principle. The first is derived from the religious belief that life is the property of God, so therefore it is not ours to dispose of as we please.[143] Ronald Dworkin, an American philosopher, when considering the sanctity-of-life principle, said that the distinction between the intrinsic value of life and its personal value for the patient explains why people think that euthanasia is wrong in all circumstances.[144] People may think that a person should bear the pain until his life ends naturally, because they believe that deliberately ending a human life denies its inherent, cosmic value.[145] They believe that God alone should have the exclusive power to decide the moment of an individual's death.[146] When an individual decides to end his or her own life, s/he takes away God's power to give and take life.[147] A person who possesses these religious beliefs would not themselves ever make a request

[138] Jackson and Keown, *op. cit.*, 37.
[139] Herring, *Medical Law and Ethics*, *op. cit.*, 537.
[140] Keown, *op. cit.*, 38.
[141] *Bland*, *op. cit.*
[142] Keown, *op. cit.*, 39.
[143] Jackson and Keown, *op. cit.*, 37.
[144] Ronald Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia and Individual Freedom* (New York, NY: Vintage Books, 1994), 195.
[145] *Ibid.*, 195.
[146] Jackson and Keown, *op. cit.*, 37.
[147] *Ibid.*, 37.

for euthanasia; however, that should not necessarily stop others who do not share the same beliefs from accessing euthanasia.[148]

The second common argument behind the principle derives from the idea that if we can envisage circumstances in which death might rationally be preferred to life, then we must believe that some lives are essentially not worth living.[149] This reflects the quality-of-life principle, which will be discussed later in this part.

Sanctity as a safeguard

An effective law on euthanasia would include safeguards which protect the vulnerable from involuntary euthanasia, in order to avoid the slippery slope. When considering the sanctity-of-life principle as a safeguard, the landmark case of *Re A* should be considered.

In *Re A*, the hospital made an application for a declaration that it could lawfully carry out separation surgery on the new born conjoined twin girls.[150] Medical evidence found that if they were not separated, both the girls would die within a few months.[151] If separated, the doctors were convinced that the stronger sister, Jodie, would have a life which was worthwhile, although the weaker sister, Mary, would die within minutes.[152] The application was granted by the Court of Appeal who held that the proposed operation was an act of necessity to avoid inevitable and irreparable evil, and its purpose was to preserve a life and not to cause death.[153] Robert Walker LJ stated that the operation would be in the best interest of each twin since it would give the stronger twin a reasonably good prospect of a long and reasonably normal life, and, although the others death would be an inevitable consequence, she would obtain bodily integrity and human dignity, which was her right.[154]

Re A generated considerable academic controversy.[155] John Harris, who rejected the Court of Appeal's reasoning, instead believed that the

[148] *Ibid.*
[149] *Ibid.*, 38.
[150] *Re A*, *op. cit.*
[151] *Ibid.*
[152] *Ibid.*
[153] *Ibid.*
[154] *Ibid.*
[155] Jackson, *op. cit.*, 992.

operation was justified as Mary was never a 'person' and death would not deprive her of a life.[156] Harris argued:

> there is something about Mary's life expectancy that makes plausible the decision in *Re A* … It is that the life expectancy of Mary between the time when the operation would take place and her inevitable death, would not have been expectancy of what might be called 'biographical life', not a life of a person.[157]

Re A shows that the quality-of-life and best-interest principles can overrule the sanctity-of-life principle, demonstrating that the principle will not absolutely protect the vulnerable from involuntary euthanasia, and therefore will not help to avoid the slippery slope fear. The 'best interest' appears to work as a guiding principle which serves to promote the well-being or benefit of the individual.[158] The benefit to, or best interests of, a patient can amount to diverse outcomes, for example, the withdrawal of treatment to enable a peaceful and dignified death of a person in a minimally conscious state, or force-feeding to sustain the life of a patient with anorexia.[159] In some circumstances, the outcomes appear to sit entirely in conflict with the patient's wishes and preferences, and it can be difficult to reconcile the idea of force and even a hastened death with best interests.[160] There is a fine balance to be struck between the need to take every necessary action to preserve the patient's life and those circumstances in which this is recognised as being no longer appropriate.[161] When considering what is in the best interests of a critically ill, incapacitated patient, an attempt is made to determine whether survival would result in a life of more satisfaction, enjoyment or the like than suffering and distress.[162] This determination invites questions about the patient's current quality of life compared with others or with their own prior quality of life.[163]

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[156] *Ibid*., 992.
[157] John Harris, 'Human Beings, Persons and Conjoined Twins: An Ethical Analysis of the Judgment in *Re A*', (2001) 9 *Medical Law Review*, 221, 233.
[158] Helen J. Taylor, 'What Are "Best Interests"? A Critical Evaluation of "Best Interests" Decision-making in Clinical Practice', (2016) 24 *Medical Law Review,* 176, 182.
[159] *Ibid*., 182.
[160] *Ibid.*
[161] *Ibid.*
[162] Richard Huxtable, 'Autonomy, Best Interests and the Public Interest: Treatment, Non-treatment and the Values of Medical Law', (2014) 22 *Medical Law Review,* 459, 471.
[163] *Ibid*., 471.

Bland further illustrates the quality-of-life and best-interest principles overruling the sanctity-of-life principle. Tony Bland sustained catastrophic and irreversible damage to his brain, leaving him in a condition known as persistent vegetative state (PVS).[164] The trust responsible for the hospital where Tony was being treated sought declarations that: (i) they might lawfully discontinue all life-sustaining treatment and medical support designed to keep him alive; and (ii) they might lawfully discontinue medical treatment to the patient except for the sole purpose of enabling the patient to end his life and die peacefully with the greatest dignity and the least of pain, suffering and distress.[165] The House of Lords held that the sanctity-of-life principle, which was not absolute, was not violated by ceasing to give medical treatment – involving invasive manipulation of the patient's body which conferred no benefit upon him – to a PVS patient who had been in that state for over three years.[166] Lord Mustill, when referring to Tony Bland's best interests, held:

> Now that the time has come when Anthony Bland has no further interest in being kept alive, the necessity to do so, created by his inability to make a choice, has gone; and the justification for the invasive care and treatment, together with the duty to provide it have also gone.[167]

Re A and *Bland* demonstrate that the sanctity-of-life principle is not absolute, as the courts are willing to be, and have been, flexible with the principle in certain circumstances. Evidently, it can be seen that the principle does not offer a way of absolutely protecting the vulnerable to avoid the slippery slope fear. If euthanasia were to be legalised, it appears that this principle would not prevent the slide to, or avoid the practice of, involuntary euthanasia taking place. It is clear that the courts are willing to be lenient with the principle, and therefore it cannot be said that this principle will absolutely provide a safeguard against the practice of involuntary euthanasia.

Quality of life versus sanctity of life

[164] *Bland*, *op. cit.*
[165] *Ibid.*
[166] *Ibid.*
[167] *Ibid.*

The quality-of-life principle is concerned with assessing whether the patient's life is worthwhile.[168] This principle holds that certain lives are not worth living, so therefore it is right to end them.[169] A life may fall below the minimum quality threshold for reasons of disease, injury or disability.[170] This principle rejects the arguments behind the sanctity-of-life principle, that all human life is intrinsically valuable. Some believe that what makes a life good is the experiences and social interactions with other human beings.[171] Therefore, a life without experiences and relationships would be a life that has lost all its goodness.[172]

It has been argued that the end of life should be attended by a degree of dignity that reflects the quality of the life lived up until that time.[173] To enable a person to die with dignity, before reaching the stage at which they are dependent on others for even the most basic of functions, should be available to people who value dignity over the sanctity of life. In the context of dying, the word dignity engenders a sense of serenity and powerfulness.[174] One negative consequence of the tremendous advances in life-sustaining treatment is that, on some occasions, the dying process is unnecessarily prolonged.[175] For many people, it is not death that they fear, but the possibility of dying in an agonising and undignified manner.[176]

This idea of a dignified death was argued for by Tony Nicklinson, who suffered a stroke which left him paralysed and unable to speak.[177] Before then Tony was a very active and outgoing man.[178] Tony made a statement talking about his life after his stroke, in which he said:

> I need help in almost every aspect of my life. I cannot scratch if I itch, I cannot pick my nose if it is blocked and I can only eat if I am fed like a baby – only I won't grow out of it, unlike the baby. I have no privacy or dignity left … I am fed up with my life and don't want to spend the next 20 years or so like this. Am I grateful that the Athens doctors saved my life? No, I am not. If I had my time again, and knew then what I know now, I

[168] Herring, *Medical Law and Ethics, op. cit.*, 537.
[169] *Ibid.*, 537.
[170] Keown, *op. cit.*, 42.
[171] Herring, *Medical Law and Ethics, op. cit.*, 537.
[172] *Ibid*., 537.
[173] Hazel Biggs, *Euthanasia: Death with Dignity and the Law* (Oxford: Hart, 2001), 145
[174] *Ibid*., 149.
[175] Margaret Otlowski, 'Active Voluntary Euthanasia: Options for Reform', (1994) 2 *Medical Law Review*, 161.
[176] *Ibid*.
[177] *Nicklinson, op. cit.*
[178] *Ibid*.

> would not have called the ambulance but let nature take its course.[179]

The sanctity-of-life principle is upheld in cases, such as *Nicklinson*, which involve patients who wish to die, but it does not protect the extremely vulnerable, such as Tony Bland and the weaker twin in *Re A*, who were unable to communicate any wish for a hastened death. The quality of life overruling the sanctity of life in *Re A* and *Bland*, but not in *Nicklinson* or *Pretty*, shows that there is a problem of inconsistency in implementing the principle. Therefore, the sanctity-of-life principle will not provide a safeguard against the slippery slope, as it will not absolutely protect the vulnerable groups of society that would be in need of protection if euthanasia were to be legalised.

IV. Autonomy

This discusses the meaning of autonomy and why supporters of euthanasia believe that a person's autonomous choice to die should be respected. It also briefly compares which autonomous choices people are and are not allowed to make under English law. It will then consider the impossibility of knowing whether a person's request to die is their genuine wish, and will briefly examine the Dutch approach to demonstrate how requiring autonomy would not effectively safeguard against the slippery slope.

The principle of autonomy

For the majority of euthanasia supporters, the crucial ethical concept is the principle of autonomy.[180] Jonathan Herring expressed it thus: 'the notion of autonomy is that people should be free to lead their lives as they wish and have control over their own bodies.'[181] However, this is as long as their choices do not harshly impact on others.[182] The criminal law is necessary to prevent one person's exercise of autonomy interfering with another's.[183] Only where an activity causes a significant amount of harm to

[179] *Ibid*.
[180] Herring, *Medical Law and Ethics, op. cit.*, 538.
[181] *Ibid*., 539.
[182] *Ibid*., 538.
[183] Herring, *Criminal Law, op. cit*., 18.

others or to society is the law justified in prohibiting a person's autonomy.[184]

Under the principle, it is believed that a person's decision should be respected, not because it is a good choice, but because it is that individual's own choice.[185] It should be irrelevant whether other people might think that choice to be foolish.[186] Our capacity for choice is without a doubt highly important, as it is through our choosing that we shape our lives and impact the lives of others around us.[187]

The majority of people campaigning for the relaxation of the law only support voluntary active euthanasia.[188] This means that the majority believe that only once a patient has made their final decision, deciding that life is no longer worth living, and actually asks for euthanasia should it then be considered.[189] When a patient is of the view that continuing life in a suffering and incapacitated state is an indignity, which is not consistent with their own assessment of what makes life worth living, that person should be allowed to obtain voluntary active euthanasia.[190] According to Ronald Dworkin, a leading advocate of legalisation:

> Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny.[191]

Each individual may have their own view on what a good death is, be that holding on in order to live for as long as possible, or dying prior to life becoming undignified or full of pain.[192] Tony Nicklinson, who wanted to exercise his autonomy, asked the following question:

> Why should I be denied a right, the right to die of my own choosing when able bodied people have that right and only my disability prevents me from exercising that right?[193]

Individuals like Tony Nicklinson may feel that it is unfair that they are stopped from choosing death in countries where assisted suicide is illegal, but able-bodied individuals can exercise a right to suicide. The dictionary

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[184] *Ibid*., 18.
[185] Herring, *Medical Law and Ethics*, *op. cit*., 538.
[186] *Ibid*., 539.
[187] Jackson and Keown, *op. cit*., 88.
[188] Keown, , *op. cit*., 50.
[189] *Ibid*., 50.
[190] *Ibid*.
[191] Dworkin, *op. cit*., 217.
[192] Herring, *Medical Law and Ethics*, *op. cit*., 539.
[193] *Nicklinson*, *op. cit*.

defines fair as *treating people equally without favouritism or discrimination*[194] – this is the ordinary, layman understanding of the word. Equality rights arguments in favour of the legalisation of assisted suicide focus on those individuals who are physically unable to commit suicide without assistance, such as the severely disabled.[195] Given that suicide is a legal act in most jurisdictions, the basis for such arguments is that an individual who requires assistance in order to carry out an end-of-life decision is denied the choice which is available to others.[196] For persons who, because of illness or disability, are physically unable to kill themselves unassisted, the prohibition of assisted suicide has violated their right to equality.[197] The prohibition results in disparate treatment of those who cannot physically commit suicide without assistance.[198]

The right-to-equality argument supports only a right to assisted suicide for those unable to commit suicide without assistance.[199] The current law produces an unfair result, due to people not being treated equally, as only capable individuals can exercise the autonomous choice of ending their life. Disabled individuals who cannot end their life without assistance do not share the same possibility.

Lawful and unlawful autonomous choices

English law is not willing to respect various choices, however autonomous, even if the autonomous choice does not involve a risk of harm to anyone except the person making it.[200] Supporters of euthanasia argue that a patient's right to make decisions about their medical treatment should stretch to being able to decide when and how they will die.[201] A patient's right to make decisions about their medical treatment is generally restricted to a right to refuse treatment.[202] Patients do not have a right to demand that their doctors treat them in a particular way.[203] Therefore, although the principle of autonomy necessitates that doctors honour a competent patient's refusal of life-prolonging medical treatment, it cannot

[194] 'Fair', in *English Oxford Living Dictionaries* <https://en.oxforddictionaries.com/definition/fair> accessed 21 March 2019.
[195] Penney Lewis, *Assisted Dying and Legal Change* (Oxford: Oxford University Press, 2007), 29.
[196] *Ibid*., 29.
[197] *Ibid*., 30.
[198] *Ibid.*
[199] *Ibid*.
[200] Jackson and Keown, *op. cit*., 88, 89.
[201] Jackson, *op. cit*., 953.
[202] *Ibid*., 954.
[203] *Ibid*.

demand that doctors comply with a request for assisted dying.[204] So the law generates the irrational results that people can choose to die lingering deaths by refusing to eat, but they cannot choose a more pleasant death provided by a willing doctor.[205]

British philosopher, John Stuart Mill, articulated the harm principle, in which he argued: 'The only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others.'[206] Essentially, the harm principle is that each person should be allowed to do and say what they like, provided that it does not harm the interests of others.[207] An activity which is seen as immoral or harmful to the actor is not a good enough reason to justify criminalising it.[208] This supports the view of proponents of euthanasia who argue the principle of autonomy, as it reinforces the idea of autonomy which Herring argued – that people should be permitted to live their lives as long as their choices do not harshly impact others.

Challenging the autonomy argument

Opponents of euthanasia also appeal to the principle of autonomy. Opponents worry that if euthanasia were to be legalised, people would be killed who really want to stay alive.[209] Unless the principle of autonomy is going to be absolute and allow every person requesting assisted dying to have access to it, then we need to find a stopping point in order to separate those whose autonomous choices should be respected and those whose should not.[210]

How autonomous?

If a law permitting euthanasia for competent people is to be accepted, the law would have to insist that those people not be killed unless they have made a clear request to die.[211] However, someone with a terminal illness, whose care is expensive or burdensome, or whose situation is agonising for their family members, may feel guilty about the money and attention

[204] *Ibid*.
[205] Dworkin, *op. cit*., 184.
[206] John Stuart Mill, *On Liberty* (New Haven, CT: Yale University Press, 2003), 80.
[207] Herring, *Criminal Law*, *op. cit*., 19.
[208] *Ibid*., 19.
[209] Dworkin, *op. cit*., 190.
[210] Lewis, *op. cit*., 24.
[211] Dworkin, *op. cit*., 190.

being devoted to them.[212] Requests for euthanasia will generally come from patients experiencing acute distress, whose judgements are impaired by the painful effects of terminal illness, clouded by the side-effects of medical treatment or distorted by clinical depression.[213] Such a person is particularly vulnerable to pressure and might prefer it if a doctor was unable to raise the question of whether they would like to consider an assisted death.[214] There is a real risk that many patients would make requests, not as a result of a free and informed decision, but instead because they felt abandoned or an unwanted burden on relatives, nurses and society.[215]

Some opponents of legalising assisted dying argue that autonomous suicide does not exist and that a desire for death is a sign of mental illness, not of a rational choice.[216] Opponents believe that a legal system in which people are denied the right to make an autonomous choice to die is better than one in which some people might be killed, under the label 'euthanasia', against their true wishes.[217] This links to the slippery slope argument, as it demonstrates that permitting voluntary euthanasia will likely lead to involuntary euthanasia, as the vulnerable are likely to feel forced to make a decision to end their life against their true wishes.

The Dutch approach

In the Netherlands euthanasia is officially condoned and extensively practised.[218] Since the Dutch Supreme Court declared, in 1984, that doctors who intentionally end the life of a patient could in certain circumstances successfully invoke the defence of necessity, and the Royal Dutch Medical Association published guidelines for voluntary active euthanasia, the lives of Dutch patients have been intentionally shortened by their doctors.[219] The Dutch experience of euthanasia can be examined to demonstrate whether legalising voluntary active euthanasia will be likely to result in the slippery slope fear.

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[212] *Ibid*., 190.
[213] Keown, *op. cit*., 54.
[214] Dworkin, *op. cit*., 190.
[215] Keown, *op. cit*., 55.
[216] Lewis, *op. cit*., 24.
[217] Herring, *Medical Law and Ethics*, *op. cit*., 541.
[218] John Keown, *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (Cambridge: Cambridge University Press, 1995), 261.
[219] Keown, *Euthanasia, Ethics and Public Policy*, *op. cit*., 93.

Autonomy gone too far

The Dutch government has gathered evidence which allows us to see whether or not the Dutch law has been able to ensure effective control.[220] Since 1990, the Dutch government has commissioned a number of studies to record how the practice of assisted dying has developed.[221] In 1990, the government appointed the Remmelink Committee to report on the practice by physicians of terminating the life of a patient.[222] The Commission asked P.J. Van der Maas to carry out a survey in order to obtain qualitative and quantitative information about the practice.[223]

The 1990 survey disclosed evidence of non-compliance with the guidelines and incidences of involuntary active euthanasia.[224] The survey showed that annually in the Netherlands, there were around 1,000 cases of involuntary euthanasia, in which the patient's life was terminated by their physician without an explicit request from the patient.[225] Of these 1,000 cases, 72 per cent of the patients had never expressed a desire to terminate their lives, and in 8 per cent of the cases physicians performed involuntary euthanasia despite the existence of other treatment alternatives.[226] There may have been no discussion with the patient and no known wish of the patient for a hastened death, due to virtually all of the cases involving seriously ill and terminally ill patients, who were suffering a great deal and were no longer able to express their wishes.[227] However, there were a small number of cases in which the decision could have been discussed with the patient.[228] The survey also indicated that around 13,691 cases were listed under a different name – for example, 'Pain Relief', in which doctors administered a lethal overdose of morphine without the patient's knowledge, with death as the only purpose – but were nothing else than involuntary active euthanasia.[229]

The survey threw doubt on whether voluntary active euthanasia was restricted to patients who were suffering unbearably and received only as a

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[220] *Ibid*., 91.
[221] Sheila A.M. McLean and Laura Williamson, *Impairment and Disability: Law and Ethics at the Beginning and End of Life* (Abingdon: Routledge, 2007), 164.
[222] Keown, *Euthanasia, Ethics and Public Policy*, *op. cit*., 99.
[223] *Ibid*., 99.
[224] *Ibid*., 111, 112.
[225] Rena Patel, 'Physician-Assisted Suicide: Is It Time', (1999) 35 *Cal W L Rev* 333, 339.
[226] *Ibid*., 339.
[227] Keown, *Euthanasia, Ethics and Public Policy*, *op. cit*., 112.
[228] *Ibid*., 112.
[229] Richard Fenigsen, 'The Report of the Dutch Governmental Committee on Euthanasia', (1991) 7 *Issues L & Med* 339, 342.

last resort.[230] Interviews took place in which doctors were asked for the reasons which patients most frequently gave for requesting euthanasia.[231] In the majority of cases – 57 per cent – the reason was loss of dignity; in 46 per cent, not dying in a dignified way; in 33 per cent, dependence; and in 23 per cent, tiredness of life.[232] Doctors were asked whether there were alternatives available to the treatment given: 77 per cent replied that the alternative was palliative and only 14 per cent said that there was no alternative treatment.[233]

The Netherlands continued to carry out studies in 1995 and 2001.[234] All three studies adopted virtually the same method, which allows for comparisons between them.[235] They show that euthanasia accounted for 1.7 per cent of all deaths in 1990, 2.4 per cent in 1995 and 2.6 per cent in 2001.[236] In addition, termination of life without explicit request only decreased from 0.8 per cent in 1990 to 0.7 per cent in 1995, and remained the same in 2001.[237]

Evidently, the Dutch government has failed to successfully safeguard the practice of voluntary active euthanasia. Legalising euthanasia has led to many patients who felt that they had no dignity or were tired of living receiving euthanasia, instead of the palliative care that they needed in order to make life worthwhile. The Dutch law has failed to protect these vulnerable individuals, by allowing them to choose euthanasia when they truly desire greater care and support. This supports the logical slippery slope argument, under which it is believed that if voluntary active euthanasia is justified out of respect for patient self-determination, how can it be right to deny it to any patient who autonomously asks for it, whether or not they are unbearably suffering.[238] Legalising euthanasia in the Netherlands has resulted in a number of irrational hastened deaths, as there has been a ‘slide’ from euthanasia requested by a patient suffering unbearably to euthanasia requested by a patient who is merely tired of life. The Dutch approach demonstrates that legalising euthanasia will inevitably result in the slippery slope, leading to

[230] Keown, *Euthanasia, Ethics and Public Policy*, *op. cit.*, 117.
[231] *Ibid*., 117.
[232] Otlowski, *op. cit.*, 428.
[233] Keown, *Euthanasia, Ethics and Public Policy*, *op. cit.*, 119.
[234] Stephen W. Smith, ‘Evidence for the Practical Slippery Slope in the Debate on Physician-assisted Suicide and Euthanasia’, (2005) 13 *Medical Law Review,* 17, 33.
[235] *Ibid*., 33.
[236] *Ibid*.
[237] *Ibid*.
[238] Keown, *Euthanasia, Ethics and Public Policy*, *op. cit.*, 87.

the deaths of vulnerable individuals who would have received the care that they desired if euthanasia were not an option.

Autonomous slide

Supporters of euthanasia believe that it should be respected, not where a person's life is valueless, but preferably where it has lost its value for that person.[239] This would mean that a person who cannot express a view should not be killed, due to us not knowing how he values his life.[240] Under the empirical slippery slope argument, it is believed that there will be an unavoidable and uncontrollable tendency for euthanasia to be carried out in cases where the request is neither clear, informed nor considered; where the patient is not competent; where the patient is not terminally ill or suffering unbearably; and where alternatives are available but overlooked.[241]

Permitting voluntary euthanasia would work against the interests of vulnerable people, who in fact only require better care.[242] Those suffering poverty, confusion or general vulnerability could be pressured into agreeing to euthanasia against their wishes.[243] If euthanasia was not an option, these vulnerable people would be protected, therefore avoiding the slippery slope.

V. Slippery slope?

This part restates some of the fears associated with the empirical slippery slope argument and considers the difficulties in determining whether an individual has the mental capacity to consent to euthanasia, and the impossibility of knowing whether a person is mentally competent. It also briefly discusses some of the House of Lords' previous Bills proposing the legalisation of assisted dying and why they have not yet been successful.

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[239] Herring, *Medical Law and Ethics, op. cit.*, 552.
[240] *Ibid*., 552.
[241] Keown, *Euthanasia, Ethics and Public Policy, op. cit.*, 71.
[242] Herring, *Medical Law and Ethics, op. cit.*, 554.
[243] *Ibid*., 554.

The empirical argument

There is great concern that legalising voluntary euthanasia will inevitably lead to euthanasia being performed in cases where the request is not informed, considered or coming from a competent adult, and will lead to practices taking place on those who are not terminally ill or unbearably suffering.[244] John Keown, when discussing the empirical slippery slope argument, stated that if one attempts to draft specific criteria and strict safeguards in order to ensure that assisted dying only takes place after an explicit and considered request is made by a competent and informed patient – with a terminal illness or experiencing unbearable suffering – as a last resort, it will prove to be problematic, or even impossible.[245]

If legislation is drafted which states that euthanasia will only be received by a competent adult, issues will arise as to how you can be sure that someone is competent. Without a way of determining whether someone is competent and has the capacity to make a decision about ending their life, legalising euthanasia will most definitely lead down a slippery slope to euthanasia of vulnerable individuals who are incompetent to make an end-of-life decision.

The required mental capacity

An individual who possesses legally recognised decision-making authority will be said to have capacity.[246] The law on capacity purports to focus upon functioning (process and rationality), rather than on the substance of, or the reasons (and values) underpinning, the decision.[247] There are many challenges that come with the question of when and under what circumstances an individual has the mental capacity to choose and to consent to assisted dying.[248]

In 2018, a 29-year-old Dutch woman named Aurelia Brouwer was allowed to end her life with the help of Dutch doctors in the Netherlands.[249] The Netherlands 2002 Termination of Life on Request and Assisted Suicide (Review Procedures) Act permits euthanasia if a physician is satisfied that the patient's request is 'voluntary and well-

[244] Keown, *Euthanasia, Ethics and Public Policy*, *op. cit*., 71.
[245] *Ibid*.
[246] Pattinson, *op. cit*., 136.
[247] Huxtable, *op. cit*., 463.
[248] Keown, *Euthanasia, Ethics and Public Policy*, *op. cit*., 74.
[249] Linda Pressly, 'The troubled 29-year-old helped to die by Dutch doctors', *BBC News*, 9 August 2018 <https://www.bbc.co.uk/news/stories-45117163> accessed 6 November 2018.

considered', that the patient's suffering is 'lasting and unbearable', and that 'there [is] no other reasonable solution'.[250]

Aurelia did not suffer from a terminal illness, but instead suffered various psychiatric illnesses which included depression, personality disorder, attachment disorder, anxiety and psychosis.[251] Aurelia's doctors would not approve her requests for euthanasia, so she applied to the End of Life Clinic in The Hague.[252] Aurelia had clarity and argued that she was competent to make the decision. However, her death wish could have been a symptom of her psychiatric illness.[253] Dr Frank Koerselman, an outspoken critic of euthanasia in cases of mental illness, said:

> How could I know – how could anybody know – that her death wish was not a sign of her psychiatric disease? The fact that one can rationalise about it, does not mean it's not a sign of the disease.[254]

Aurelia's death is an illustration of the slippery slope inevitably associated with legalising euthanasia.[255] A request must be voluntary under Dutch law, as would most likely be required under English law if euthanasia were to be legalised. It could be argued that Aurelia's decision was not voluntary and was instead caused by the many psychiatric illnesses from which she suffered. As someone with a mental illness could be requesting death as a symptom of that illness, it is important that doctors are able to recognise for mental illnesses so that euthanasia is not received by a patient requesting as a result of such an illness, in order to avoid a 'slide' to involuntary euthanasia.

Recognising mental incompetence

Almost all arguments in favour of voluntary active euthanasia appeal to the importance of respecting a competent person's decision about whether their pain warrants an end to their life.[256] Patients are identified as

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[250] 'Dutch law on termination of life on request and assisted suicide (complete text)', The World Federation of Right to Die Societies <https://www.worldrtd.net/dutch-law-termination-life-request-and-assisted-suicide-complete-text> accessed 14 February 2019.
[251] Pressly, *op. cit.*
[252] *Ibid.*
[253] *Ibid.*
[254] *Ibid.*
[255] Harriet Sherwood, 'A woman's final Facebook message before euthanasia: I'm ready for my trip now ...', *The Guardian*, 12 March 2018 <https://www.theguardian.com/society/2018/mar/17/assisted-dying-euthanasia-netherlands> accessed 30 January 2019.
[256] Beauchamp, *op. cit.*, 13.

competent when their cognitive faculties are such that they are able to make a decision with respect to the given situation.[257] Those who are rendered completely immobile with full consciousness are often treated as incompetent.[258] While the ability to communicate is not required to be competent, it is essential for acting on the apparent will of an individual.[259] It also follows that a minimum condition for possession of capacity is the ability to communicate.[260] The Mental Capacity Act 2005 lays down a two-stage test for capacity.[261] Section 2 states:

> A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.[262]

This is a cognitive-functional test of capacity.[263] Section 3 states:

> a person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision.[264]

The determination of decision-making capacity is a matter of significant controversy among researchers and clinicians.[265] There is a substantial amount of disagreement about how to ensure that determinations of capacity are conducted in a scientific manner, with reliable and objectively verifiable procedures.[266] The reality is that a number of doctors would be unsuccessful in making sure that a request for euthanasia was free, informed and competent, and without any alternatives.[267] Doctors would be unsuccessful due to their lack of expertise to determine whether a patient has the capacity to make a decision about their death or whether the decision was a result of clinical depression or pressure.[268] They may also fail because of the lack of time and resources that they have in order to

[257]Pattinson, *op. cit*., 136.
[258] *Ibid*., 138.
[259] *Ibid*., 138.
[260] *Ibid*., 138.
[261] *Ibid*., 139.
[262] Mental Capacity Act 2005, s.2.
[263]Pattinson, *op. cit*., 139.
[264] Mental Capacity Act 2005, s.3.
[265] Keown, *Euthanasia, Ethics and Public Policy*, *op. cit*., 74.
[266] *Ibid*., 74.
[267] *Ibid*., 72.
[268] *Ibid*.

make assessments.[269] In the absence of a workable theory or method for assessing decision-making capacity, any legalisation of euthanasia will be open to abuse and will put the vulnerable at risk of an involuntary death, resulting in the slippery slope fear.[270]

If euthanasia were to be legalised, it would be absolutely essential to ensure that a patient's request had been made voluntarily.[271] Euthanasia is most often requested by patients who are extremely ill, and whose judgement could be distorted by depression which has resulted from the illness.[272] Diagnosing depression in terminally ill patients is tough due to many of the symptoms of depression – such as weight loss and loss of energy – also being symptoms of illnesses such as cancer, or side-effects of medication.[273] As it would be difficult to guarantee that a patient's wish to die was genuine and not a symptom of their treatable depression, it is argued that we should be exceedingly reluctant to comply with requests for euthanasia.[274]

The risk of legalisation

The House of Lords has continuously (though without success) proposed Bills for 'Assisted Dying for the Terminally Ill'. In 2004, the House of Lords proposed a Bill to '[e]nable a competent adult who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request'.[275] The Bill defined competent as 'having the capacity to make an informed decision'.[276] Under the 'Qualifying Conditions' section, several conditions were given which a physician must satisfy before assisting a patient to die,[277] one being that the attending physician shall have 'examined the patient and the patient's medical records and have no reason to believe the patient is incompetent'.[278]

In 2006, the Royal College of Psychiatrists made a statement in response to the 2004 Bill, explaining that studies of the terminally ill have

[269] *Ibid.*
[270] *Ibid.*, 74.
[271] Jackson and Keown, *op. cit.*, 48.
[272] *Ibid.*, 48.
[273] Jackson, *op. cit.*, 962.
[274] Jackson and Keown, *op. cit.*, 48.
[275] House of Lords, 'Assisted Dying for the Terminally Ill Bill [HL]' (www.parliament.uk, 2003–2004) <https://publications.parliament.uk/pa/ld200304/ldbills/017/04017.1-4.html#j01> accessed 14 February 2019.
[276] *Ibid.*
[277] *Ibid.*
[278] *Ibid.*

clearly shown that 'depression is strongly associated with the desire for a hastened death, including the wish for physician-assisted suicide or euthanasia', and that, after effective treatment for depression, most patients change their minds about wanting to die, etc. In 2014, the president of the Royal College, commenting on the 2006 Bill, wrote:

> There is no guidance within the Bill as to how capacity should be determined, what standard of competence should be reached or any specific consideration in assessment of capacity for this decision.[279]

In 2006, Lord Joffe introduced a Bill to '[e]nable an adult who has capacity and who is suffering unbearably as a result of terminal illness to receive medical assistance to die at his own considered and persistent request; and for connected purposes'.[280] The Select Committee on the Assisted Dying for the Terminally Ill Bill was formed to consider the terms of the Bill.[281] The Committee established a number of key issues which it believed should be taken into account by any Bill proposing the legalisation of assisted dying, which the 2006 Bill failed to incorporate.[282] They advised that consideration be given to a requirement that all applicants for physician-assisted suicide receive a psychiatric assessment in order to confirm both that the request was based on a reasoned decision and free from external pressure, and that the applicant was not suffering from a psychiatric or psychological disorder causing impaired judgement.[283]

Later, in 2014, Lord Falconer introduced a Bill to '[e]nable competent adults who are terminally ill to be provided at their request with specified assistance to end their own life; and for connected purposes'.[284] The Bill requires two doctors – having examined the patient and the patient's medical records – to be satisfied that the patient is 'terminally ill'; has the capacity to decide to commit suicide; and has a 'clear and settled intention' to end his or her life, which has been formed

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[279] Annabel Price and Simon Wessely, 'Assisted Dying for the Terminally Ill: The Debate Continues', Royal College of Psychiatrists, 2014 <http://bit.ly/2jMcWJX> accessed 1 October 2018.

[280] House of Lords, 'Assisted Dying for the Terminally Ill Bill [HL]' (www.parliament.uk, 2005–2006) <https://publications.parliament.uk/pa/ld200506/ldbills/036/06036.1-4.html#j001> accessed 14 February 2019.

[281] McLean and Williamson, *op. cit.*, 161.

[282] John Keown, 'Physician-assisted Suicide: Lord Joffe's Slippery Bill', *Medical Law Review*, Vol. 15, No. 1, Spring 2007, 126–35, at 128.

[283] *Ibid.*

[284] House of Lords, 'Assisted Dying Bill (HL Bill 6)' (www.parliament.uk, 2014) <https://publications.parliament.uk/pa/bills/lbill/2014-2015/0006/lbill_2014-20150006_en_2.htm> accessed 23 April 2019.

'voluntarily' and 'on an informed basis and without coercion or duress.'[285] However, the Bill allows two registered medical practitioners to approve a request, even if neither has any particular expertise in assessing capacity; in diagnosing or treating mental illness; in diagnosing 'terminal illness'; or in palliative medicine.[286]

Almost all of the so-called 'safeguards' in the 2014 Bill were previously rejected as unsafe when they appeared in Lord Joffe's Assisted Dying Bill in 2006.[287] The Bill has been criticised as the determination of 'terminal illness', 'mental capacity' and 'clear and settled' are all very difficult to ascertain clinically, even by professionals, and are open to flexible definitions.[288] There is also no psychiatrist involved in the determination of 'mental capacity'.[289] The Bill was promoted on grounds of 'autonomy'; however, it only applies to mentally competent, terminally ill adults.[290] Therefore, it is, at its heart, discriminatory and will be open to challenge and extension under equality legislation.[291]

If assisted dying were to be legalised, the slippery slope would not yet be avoidable. The House of Lords has not yet been successful in drafting criteria that dictate how mental capacity should be determined and how doctors can guarantee that a person is mentally competent. Those who suffer from mental health challenges will be at risk if euthanasia is legalised, as doctors do not always successfully recognise for mental illnesses. Therefore, requests will be granted that are not truly voluntary, resulting in the slippery slope fear.

Conclusion

This paper aimed to determine whether legalising euthanasia would result in a slippery slope to wanton killing. This was achieved by investigating the current state of affairs and the main issues that animate the debate.

In part one, it became clear that all forms of euthanasia in England and Wales are illegal and that the law on these practices is unlikely to

[285] John Keown, 'Physician-assisted Suicide: Some Reasons for Rejecting Lord Falconer's Bill' (2014) <https://www.carenotkilling.org.uk/public/pdf/falconer-bill---john-keown.pdf> accessed 23 April 2019.
[286] *Ibid.*
[287] 'Lord Falconer's Assisted Dying Bill' (2014) <https://www.carenotkilling.org.uk/public/pdf/falconer-bill---overview,-arguments,-problems.pdf> accessed 23 April 2019.
[288] *Ibid.*
[289] *Ibid.*
[290] *Ibid.*
[291] *Ibid.*

change in the foreseeable future, thereby resulting in patients continuing to travel abroad to receive assisted dying. In part two, it was shown that the current law, which distinguishes between lawful and unlawful life-shortening practices, is inadequate and incoherent. The law permits the withdrawal of life-sustaining treatment which results in distressing and unpleasant deaths, but does not allow doctors to administer a lethal injection which would result in a preferable death. However, as Andrew Ashworth argued, this is due to there being a moral distinction between killing someone and letting someone die. Despite euthanasia being illegal, those who carry out euthanasia or assisted suicide are not punished for their actions, due to doctors acting compassionately with good intentions, and prosecutions not being in the public interest.

Although euthanasia currently happens underground without safeguards in place, as seen in part two, this poses less of a risk than legalising euthanasia, as the slippery slope appears to be unavoidable. In parts three, four and five, it was seen that effectively safeguarding euthanasia in order to protect the vulnerable appears impossible, and therefore legalisation would result in the slippery slope fear of irrational hastened deaths. In part three, it was shown that the sanctity-of-life principle is not absolute and therefore would not safeguard the vulnerable from involuntary euthanasia. The principle does not appear to protect those who are judged to have no further interest in being kept alive and are unable to communicate any wish to die, as was seen in *Re A* and *Bland*. In part four, autonomy was considered as a safeguard. It appears impossible to determine whether a choice to die is that individual's true wish or a result of society pressurising the individual to make that choice. Therefore, legalisation would result in the deaths of individuals who felt pressured to make an unwanted request. Requiring autonomy – therefore safeguarding the practice by only allowing a person who has made a clear request to die to access euthanasia – would result in a slippery slope. Autonomy would be exercised by everyone equally, resulting in deaths of individuals who are not terminally ill but instead merely tired of life, which is the fear associated with the logical slippery slope. Allowing euthanasia to an individual who makes a voluntary request because of unbearable suffering would inevitably lead to individuals who make voluntary requests as they are tired of life being able to exercise the same option.

The Netherlands approach, discussed in part four, further demonstrates how legalising euthanasia will result in a slippery slope. It is clear from the survey evidence that not only do Dutch doctors administer

lethal drugs to individuals who have not made an explicit request, but euthanasia is also certainly no longer only granted to those suffering unbearably and as a last resort. The majority of people requesting euthanasia are doing so due to loss of dignity, and many others are tired of living. The treatment that these patients truly require is better care and support; however, the Dutch law – by permitting euthanasia – is pressuring these patients to choose death. If the law did not permit such acts, more attention might be given to improving care homes and palliative care, which would result in patients feeling as though their life is worth living. Therefore, excluding euthanasia from the set of options better protects the vulnerable from requesting euthanasia against their true wishes.

Effectively safeguarding euthanasia would also involve producing a set of strict criteria and precise guidelines that leave no room for a 'slide' to involuntary euthanasia. In part five, it was seen that attempts have been made to create a law permitting assisted dying. However, the House of Lords has not yet been successful in drafting criteria that avoid the slippery slope. Euthanasia could only reasonably be granted to a competent adult who has made a voluntary and informed decision. However, it is still impossible to be certain that a patient is competent and has the required mental capacity to choose and consent to euthanasia. Doctors are unable to accurately assess for the required mental competence, as they do not have the time or expertise to determine whether the request was the patient's true wish or a result of clinical depression. Legalising euthanasia would result in many patients receiving euthanasia, when in fact, if their depression was recognised and treated effectively, they would not continue to request death.

Legalising any form of euthanasia, be that voluntary active euthanasia or physician-assisted suicide, would naturally, and most definitely, lead down a slippery slope towards the practice of involuntary euthanasia. Euthanasia being illegal ensures that these vulnerable individuals are protected, as they do not have the option to request death, and therefore do not die as a result of a mental illness or against their true wishes. There has not yet been any success in producing an even near to perfect set of safeguards that would protect every vulnerable individual from involuntary euthanasia. Therefore, it is considerably safer to keep the practice of euthanasia illegal in order to avoid the slippery slope, which would result in vulnerable patients dying unwanted, hastened deaths.

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Legal Opinion

What Next for the Internet Blocking Order after the *Cartier* Case?

Louis Mancini

Abstract

The internet blocking order is a relatively recent invention of the UK courts, applied initially to infringement of copyright law via the UK courts' use of section 97A of the Copyright, Designs and Patents Act 1988. The *Newzbin2* case was the first case to grant such an order against an internet service provider (ISP) so as to block users accessing websites that were infringing or facilitating infringement of copyright material. After *Newzbin2* the question remained, what of other intellectual property rights which had no equivalent provision to section 97A? The answer was given in the 2016 *Cartier* case which extended the internet blocking order to incidents of trademark infringement. This work will explore whether the judgement in that case was correct, whether the legislative basis is suspect, and also whether the blocking order is a violation of natural justice. After *Cartier*, questions still remain as to other areas of law that this order could be extended to, including defamation, privacy and comparative advertising, and whether such hypothetical orders are against a person's freedom of expression.

Keywords: internet blocking order; Copyright, Designs and Patents Act 1988; internet service provider; the *Cartier* case; registered trademarks

An introduction to *Cartier*

Cartier International AG v British Sky Broadcasting Ltd[292] is a recent and important expansion on the internet blocking order. The case is formally known as the '*Cartier* case'[293] and it extended the blocking order to incidents of trademark infringement.

Who were the parties involved?

This case was heard in the Court of Appeal by Lord Justice Briggs, Kitchin and Jackson. The respondents were Richemont who own many UK registered trademarks for Cartier, Montblanc, IWC and other brands. The appeal was by five English internet service providers, Sky, BT, EE, TalkTalk and Virgin, who will be collectively known as 'the ISPs'. Between them they have a market share of around 95 per cent of UK broadband users.

What were the facts of the case?

It was an appeal case against orders made on 11 November and 5 December 2014 by Arnold J. The original case of *Cartier International AG v British Sky Broadcasting Ltd*[294] was heard in the Chancery Division by Arnold J and provided that the court had the jurisdiction to make website blocking orders where operators and/or users of the affected website were using the ISPs' services to infringe any intellectual property right.

The claimants were owners of UK registered trademarks in respect of a number of luxury brands. They claimed that those marks were being infringed by the operators of internet websites which were selling counterfeit goods.[295]

The claimants applied for an injunction requiring the defendants to block access to infringing websites. In the original case, Arnold J granted the application, holding that, on a purely domestic interpretation of it, section 37(1) of the Senior Courts Act 1981 gave the court the power to grant the orders sought, but in any event it was to be interpreted in

[292] [2016] EWCA Civ 658.
[293] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[294] [2014] EWHC 3765 (CH).
[295] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.

accordance with Article 11 of the Enforcement Directive.[296] Article 11 of Directive 2004/48 provides a principled basis for extending the court's jurisdiction and practice in relation to the grants of such injunctions to encompass, where appropriate, the services of an intermediary such as an internet service provider which had been used by a third party to infringe a registered trademark.

Section 37(1) of the Senior Courts Act 1981 provides that '[t]he High Court may by order grant an injunction … in all cases in which it appears to the court to be just and convenient to do so.' This allowed the judge in *Cartier* to grant the blocking order. The judgement also provides that section 37(1)[297] must be construed consistently with the third sentence of Directive 2004/48 Article 11, which states:

> Member states shall also ensure that right holders are in a position to apply for an injunction against intermediaries whose services are used by a third party to infringe an intellectual property right, without prejudice to Article 8(3)[298] of Directive 2001/29/EC.

Arnold J held that he had jurisdiction under section 37(1)[299] to grant the order. He identified threshold conditions to be satisfied before a website blocking order was made. First, the ISPs had to be intermediaries within the meaning of Article 11. Secondly, either the users or the website operators had to be infringing the trademarks. Thirdly, the users or website operators had to use the services of the ISPs. Fourth, the ISPs had to have actual knowledge of that use. He concluded that the orders were proportionate and struck a fair balance between the respective rights engaged.

Judgement in *Cartier*

The judgement in the 2016 *Cartier*[300] case held that Arnold J had not erred in granting the orders sought.

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[296] DIRECTIVE 2004/48/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 29 April 2004 on the enforcement of intellectual property rights (hereinafter 'Directive 2004/48'), Art. 11.
[297] Senior Courts Act 1981, s.37(1).
[298] Directive 2001/29/EC of the European Parliament and of the Council of 22 May 2001 on the harmonisation of certain aspects of copyright and related rights in the information society, Art. 8(3).
[299] Senior Courts Act 1981, s.37(1).
[300] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.

The ISPs appealed the original decisions and the main issues on the appeal were: (i) whether the court had jurisdiction in a case involving infringement of registered trademarks; (ii) if so, what the threshold conditions were and whether they were satisfied; (iii) if they were, what principles were to be applied by the court in considering whether to make a blocking order and whether the judge had applied them correctly.[301]

The ISPs firstly argued that the court had no jurisdiction to make website blocking orders in cases involving infringement of registered trademarks because, whereas the United Kingdom implemented Article 8(3)[302] of the Information Society Directive by amending the 1988 Act[303] to insert S97A,[304] which allowed for orders against copyright infringement, the United Kingdom did not pass any legislation to implement the third sentence of Article 11.[305] The claimants responded by stating that the court had the jurisdiction to make such orders pursuant to section 37(1).[306] They stated that the court had the necessary jurisdiction upon a purely domestic interpretation of section 37(1);[307] and secondly, if it did not, then section 37(1)[308] could and should be construed consistently with the third sentence of Article 11,[309] in accordance with the Marleasing principle, to achieve that result. The judge adopted a two-stage approach to his judgement. He firstly considered the domestic interpretation of section 37(1)[310] and held that, upon a purely domestic interpretation the court had jurisdiction to make the orders sought. He then considered whether section 37(1)[311] should be interpreted in accordance with the third sentence of Article 11,[312] and he held that, even if the court did not have the power to make the orders on a purely domestic interpretation, the section[313] could and should be construed in accordance with the third sentence of Article 11[314] by virtue of the Marleasing principle.

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[301] *Ibid.*
[302] Directive 2000/31/EC of the European Parliament and of the Council of 8 June 2000 on certain legal aspects of information society services, in particular electronic commerce, in the Internal Market ('Directive on Electronic Commerce'), Art. 8(3).
[303] Copyright, Designs and Patents Act 1998.
[304] Copyright, Designs and Patents Act 1988, s.97A.
[305] Directive 2004/48, Art. 11.
[306] Senior Courts Act 1981, s.37(1).
[307] *Ibid.*
[308] *Ibid.*
[309] Directive 2004/48, Art. 11.
[310] Senior Courts Act 1981, s.37(1).
[311] *Ibid.*
[312] Directive 2004/48, Art. 11.
[313] Senior Courts Act 1981, s.37(1).
[314] Directive 2004/48, Art. 11.

The judge held that the court had the jurisdiction to make the orders sought. The court's powers to grant an injunction where it is just and convenient to do so were wide and might be used in cases where they had not been exercised before. The judge also held that Article 11[315] of the Enforcement Directive provided a principled basis for the court to extend its injunctive powers to a new category of case in which an ISP's services had been used by a third party to infringe a registered trademark. The judge made it clear that the ISPs were not guilty of any wrongdoing. They had not infringed, nor had they engaged in a common design with the website operators offering counterfeit goods for sale. They did not owe the respondents a common law duty of care to take reasonable care to ensure that their services were not used by the website operators. The question was whether there was a principled basis for making the blocking injunctions against the ISPs, which was confirmed by the judge.

The ISPs argued that the blocking orders sought would amount to a limitation on the ISPs' rights under Article 16,[316] and on their subscribers' rights under Article 11,[317] of the Charter. Article 52[318] provides that any limitation on the exercise of the rights and freedoms recognised by the Charter must be provided for by law and respect the essence of those rights and freedoms.[319] The ISPs argued that the blocking orders are not provided for by law in two important respects. Firstly, the court had no statutory or other proper basis under English law. The ISPs contended that, whereas section 97A[320] of the 1988 Act confers an express power on the court to grant an injunction against ISPs where they have actual knowledge of copyright infringement, there is no equivalent in relation to registered trademarks. Secondly, the orders require the ISPs to block access to other websites which Richemont or their solicitors say are engaged in unlawful activities. This confers upon Richemont an ability to secure the blocking of other sites at their discretion and without the supervision of the court. This was rejected. The judge held that the granting of the orders did not give rise to any illegitimate or otherwise inappropriate limitation on the exercise of the rights and freedoms recognised by the Charter of Fundamental Rights of the European Union.[321]

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[315] *Ibid*.
[316] Charter of Fundamental Rights of the European Union [2010] OJ C 83/389, Art. 16.
[317] Charter of Fundamental Rights of the European Union [2010] OJ C 83/389, Art. 11.
[318] Charter of Fundamental Rights of the European Union [2010] OJ C 83/389, Art. 52.
[319] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[320] Copyright, Designs and Patents Act 1988, s.97A.
[321] Charter of Fundamental Rights of the European Union [2010] OJ C 83/389.

The judge considered that the court's discretion under section 37(1)[322] to grant website blocking orders is not unlimited and that it must be exercised consistently with the terms of the Enforcement Directive,[323] Articles 3[324] and 11,[325] and with the terms of the E-Commerce Directive,[326] Articles 12[327] and 15.[328] The judge identified the following threshold conditions to be satisfied before a blocking order is made. Each of the first three conditions follows from the wording of Article 11.[329] The fourth condition follows from the E-Commerce Directive,[330] for if the ISPs could be required to block websites without having knowledge of the infringing activity, then this would effectively impose an obligation to monitor.[331]

Firstly, the ISPs must be intermediaries within the meaning of the third sentence of Article 11.[332] The third sentence of the said Article 11 provides:

> Member states shall also ensure that right holders are in a position to apply for an injunction against intermediaries whose services are used by a third party to infringe an intellectual property right, without prejudice to Article 8(3) of Directive 2001/29.[333]

The ISPs conceded before the judge that they are intermediaries. Therefore, the judge held that condition was met. As discussed by Markus Hecht and Birgit Clark, this represents a recent judicial trend to extend the scope of intermediary liability, not only as regards the 'sphere' concerned but also with regard to the rights concerned.[334]

The second threshold was that either the users or the operators of the website must be infringing the claimant's trademarks.[335] Richemont argued that the operators of the target websites were infringing by offering and exposing for sale, selling and supplying counterfeit goods which were

[322] Senior Courts Act 1981, s.37(1).
[323] Directive 2004/48.
[324] Directive 2004/48, Art. 3.
[325] Directive 2004/48, Art. 11.
[326] Directive 2000/31.
[327] Directive 2000/31, Art. 12.
[328] Directive 2000/31, Art. 15.
[329] Directive 2004/48, Art. 11.
[330] Directive 2000/31.
[331] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[332] Directive 2004/48, Art. 11.
[333] Directive 2001/29, Art. 8(3).
[334] Birgit Clark and Markus Hecht, 'Landlord Liability for IP Infringements: CJEU Holds that Operators of Physical Marketplace Are Intermediaries under the Enforcement Directive in Tommy Hilfiger', [2016] *E.I.P.R.* 2016, 38(11), 703–7.
[335] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.

identical to those for which the trademarks were registered and which bore signs identical to the trademarks.[336] The judge was satisfied that all the allegations of infringement had been established. The judge held that the operators of each target website were offering and advertising for sale and selling counterfeit goods in a manner that was aimed at consumers in the United Kingdom, and that the operators had used signs which were identical to the registered trademarks in relation to goods which were identical to those for which the trademarks were registered.[337] This finding was not challenged.

The third threshold condition was that the users or the operators of the website must use the services of the ISPs. There was a major dispute as to whether the target websites had used the services of the ISPs to infringe.[338] Miss May, acting for the ISPs, submitted that this was a matter upon which the guidance of the Court of Justice was required. Miss May referred to the decisions of the Court of Justice in which this issue had arisen in relation to allegations of infringement of copyright.[339] These two cases were *LSG-Gesellschaft zur Wahrnehmung von Leistungsshutzrechten GmbH v Tele2 Telecommunication GmbH*[340] and *UPC Telekabel Wien GmbH v Constantin Film Verleih Gmbh.*[341] Miss May pointed out that the court had not yet considered the issue in relation to registered trademarks. The judge responded that he had no doubt that the services of the ISPs were being used. He said that the operators of the websites are infringing the trademarks by placing on the internet advertisements and offers for sale which are targeted at UK consumers. The ISPs have an essential role in these infringements, since it is via the ISPs' services that the advertisements and offers for sale are communicated to 95 per cent of broadband users in the United Kingdom. It is immaterial that there is no contractual link between the ISPs and the operators of the target websites. It is also immaterial that UK consumers who view the target websites may not purchase any goods, since the first type of infringement is already complete. Miss May, upon this judgement, submitted that there were two fundamental flaws. Firstly, she argued that the judge wrongly conflated the approach adopted in copyright cases, where the offending work is itself transmitted using the services of the service providers, with the approach to be adopted in the present case

[336] *Ibid.*
[337] *Ibid.*
[338] *Ibid.*
[339] *Ibid.*
[340] (Case C-557/07) [2009] ECR I-1227.
[341] (Case C-314/12) [2014] Bus LR 541.

where the substantive act of infringement – that is to say, the supply of the counterfeit goods – is performed by other means, such as by post or courier. Secondly, there was no evidence before the judge that the services of each of the ISPs were actually used to transmit any offers or advertisements from each of the target websites to any actual or potential customers in the United Kingdom.[342] The judge rejected this argument and held, in relation to her second point, that an ISP is an inevitable actor in any transmission of an infringement over the internet between one of its customers and a third party, since, in granting access to the network, it makes that possible. It must be held that an ISP which allows its customers to access protected subject matter made available to the public on the internet by a third party is an intermediary whose services are used to infringe a copyright or related rights[343] within the meaning of Article 8(3) of Directive 2001/29.[344] Therefore, the judge held that the third threshold condition was met.

The fourth criterion was that the ISPs needed to have knowledge of this. There was no dispute before the judge that if the operators of the target websites used the services of the ISPs to infringe, then the ISPs had knowledge of this. Accordingly, the judge held that the ISPs had actual knowledge.

Arnold J then turned to the principles that needed to be applied in considering whether to make a blocking order. These principles were that the relief should: (i) be necessary; (ii) be effective; (iii) be dissuasive; (iv) not be unnecessarily complicated or costly; (v) avoid barriers to legitimate trade; (vi) be fair and equitable and strike a 'fair balance' between the applicable fundamental rights; and (vii) be proportionate.[345] The judge also rightly observed that it was necessary to consider two other matters: first, the substitutability of other websites for the target websites; and secondly, the requirement in Article 3(2) of the Enforcement Directive[346] that remedies should be applied in such a manner as to provide safeguards against their abuse. The judge looked at each principle in turn and held that they were all met, and thus this allowed him to grant the blocking injunction.

[342] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[343] *Ibid*.
[344] Directive 2001/29, Art. 8(3).
[345] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[346] Directive 2004/48, Art. 3(2).

Was the judgement correct?

The judgement was met with mixed opinions and criticisms. The major argument stemmed from whether there was sufficient jurisdiction to grant the order, which was argued by the ISPs. This meant that section 37(1)[347] came under a lot of scrutiny. We will now look at the arguments stemming from this judgement.

Is the legal basis for blocking orders relating to trademarks suspect?

Althaf Marsoof evaluates the way that the blocking injunction has been implemented and raises an issue on whether the decision in *Cartier*[348] was correct.[349] He correctly discusses that, unlike in the context of copyright infringement, there is no statutory counterpart for trademarks. Arnold J relied on section 37(1)[350] which empowered the High Court to issue injunctions.[351]

He makes specific reference to the requirement that 'an intermediary's services must have been used'.[352] He argues that, unlike in the copyright context where an ISP's subscribers are often co-infringers with the operators of an infringing website, the same cannot be said when an internet user accesses a counterfeit website and makes a purchase that he/she believes to be authentic. Here the internet users are victims, rather than infringers. Nor could it be argued that counterfeit website operators, who usually operate from overseas, have used the services of domestic ISPs to commit infringements. Thus, the legal basis in the context of trademarks remains suspect. I agree with this, because the internet user has not used an intermediary's service, and nor have the counterfeit website operators. Therefore, this requirement has not been met, and thus there is no legitimate blocking order and it remains suspect.

Is the blocking order a possible violation of natural justice?

Natural justice requires a decision-maker to provide an opportunity to persons affected by a decision to make representation before a decision is

[347] Senior Courts Act 1981, s.37(1).
[348] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[349] Althaf Marsoof, 'The Blocking Injunction: A Critical Review of its Implementation in the United Kingdom in the Context of the European Union', [2015] *IIC* 2015, 46(6), 632–64.
[350] Senior Courts Act 1981, s.37(1).
[351] Marsoof, *op. cit.*
[352] *Ibid*.

ultimately made. Althaf Marsoof critically analyses[353] whether the blocking order is a violation of natural justice.

Natural justice follows two basic rules: firstly, no man is to be a judge in his own cause; and secondly, no man is to be condemned unheard. Natural justice governs the way in which a decision was taken and not the correctness of the decision.[354] Courts must observe the rules of natural justice.[355] Observance of the right to be heard is a fundamental principle of European Union law, which must be respected.[356]

The author notes that in the context of intellectual property, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) – which is one of the Several Covered Agreements of the World Trade Organization (WTO) – expressly requires all WTO members, which includes the United Kingdom, to ensure that the 'defendants shall have the right to written notice which is timely and contains sufficient detail, including the basis of the claims.'[357] 'Defendants' in Article 42 of TRIPS means the alleged infringers of IP rights. The fourth sentence of Article 42[358] expressly incorporates the right to be heard before a final decision is made. Thus, Article 42[359] incorporates the principles of natural justice into IP enforcement.[360]

These principles of natural justice enshrined in TRIPS[361] extend to blocking injunctions. Where a right-holder seeks to enjoin an ISP, compelling it to block access to a website that infringes IP rights, there are at least three parties whose rights or interests are at stake. In the context of the European Union, the EU Charter of Fundamental Rights[362] recognises the proprietary rights of IP owners, the interests of the ISPs and the freedom of speech protected for the authors of content and website operators.[363] By blocking access to a certain website, the interests of that website will be affected. The right-holders seeking to block websites do so on the basis that the website is infringing IP rights. This means that the dispute is between the right-holders and the website operators who are

[353] *Ibid*.
[354] *Halsbury's Laws of England*, 5th edition, 2008, vol. 61, para. 629 <LexisLibrary> accessed 6 February 2017.
[355] *Ibid*.
[356] *Halsbury's Laws of England*, 5th edition, 2008, vol. 47A, para. 297 <LexisLibrary> accessed 7 February 2017.
[357] Marsoof, *op. cit*.
[358] Agreement on Trade-Related Aspects of Intellectual Property Rights, Art. 42.
[359] *Ibid*.
[360] Marsoof, *op. cit*.
[361] Agreement on Trade-Related Aspects of Intellectual Property Rights.
[362] Charter of Fundamental Rights of the European Union [2010] OJ C 83/389.
[363] Marsoof, *op. cit*.

alleged to be IP infringers. Therefore, it may be argued that, before a blocking injunction is granted, a court must hear the website operators.[364] Failure to do so would be a breach of natural justice and violate Article 42 of TRIPS.[365]

Therefore, where a blocking order is sought, a court should afford the right of audience to the operators of the websites. This rejection of natural justice should not be allowed to happen in the United Kingdom. In all cases, the website operators who were the actual infringers of the IP rights were neither served with notice, nor were they heard.

Potential for collateral damage

Alpana Roy and Althaf Marsoof discuss the concern of collateral damage. A target website, or part-targeted for blocking, and several legitimate websites may share a single IP address. Thus, an ISP's action to block a shared IP address to prevent users accessing the infringing website may result in users being blocked from accessing other legitimate websites that share the same IP address, resulting in collateral damage.[366]

Where does the *Cartier* case leave us?

In their journal article,[367] Kateryna Frolova-Fox and Joseph Jones discuss that this judgement is indicative of the growing brand protection measures available in the UK. They also comment that the regime of website blocking orders from online piracy to trademark infringement is logical and provides an additional avenue for address. Whilst I agree, I still believe that the blocking order is not fit for purpose and will not stop the wider picture of illegal infringement.

This judgement, importantly, has validated a significant remedy for trademark owners – and, by implication, the public who benefit from the prevention of the sale of counterfeit goods. More importantly, it is noted

[364] *Ibid*.
[365] Agreement on Trade-Related Aspects of Intellectual Property Rights, Art. 42.
[366] Alpana Roy and Althaf Marsoof, 'Blocking Injunctions and Collateral Damage', [2017] *E.I.P.R.* 2017, 39(2), 74–8.
[367] Joseph Jones and Kateryna Frolova-Fox, 'Getting the Look for Less? The Blocking Cost: *Cartier International v BskyB* (Court of Appeal), [2017] *E.I.P.R.* 2017, 39(1), 58–65.

that this decision and its jurisprudence is likely to survive the vicissitudes of the UK's decision to withdraw from the European Union.[368]

The authors conclude that blocking injunctions remain fashionable for now, but that the remedy is very likely to go out of fashion soon by quoting the saying: 'fashion is a form of ugliness so intolerable that we have to alter it every six months.'

This extension has opened the door for further expansion of the internet blocking order. This decision will now push other right-owners to bring claims and seek blocking orders. It also now provides that there could be further expansion to the blocking order, given the wide scope that section 37(1)[369] appears to have been given by the court. Therefore, the next part will explore the potential areas for expansion and whether they are against a person's freedom of expression.

Where next for the internet blocking order? What areas could the blocking order extend to next?

In Rachel and Katharine Alexander's journal article[370] examining the *Cartier* case,[371] they discuss that the internet blocking order will be extended to other areas where online operators are infringing the law. They believe that these areas are privacy, defamation, breach of confidence, as well as other IP rights.[372]

How can the court extend the blocking order to these areas?

In the *Newzbin2*[373] case, Justice Arnold had the specific provision of section 97A of the Copyright, Designs and Patents Act 1998.[374] This meant that in *Cartier*[375] the judge had to find the power to grant an internet blocking order from section 37(1) of the Senior Courts Act 1981.[376] This granted the court the power to make a blocking order against trademark

[368] *Ibid.*
[369] Senior Courts Act 1981, s.37(1).
[370] Katharine Alexander and Rachel Alexander, 'What Cartier Means for the Future of Online IP Enforcement', [2016] *I.P.M.* 2016, Sep, 62–4.
[371] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[372] Alexander and Alexander, *op. cit*.
[373] *Twentieth Century Fox Film Corp v British Telecommunications Plc* [2011] EWHC 1981.
[374] Copyright, Designs and Patents Act 1998, s.97A.
[375] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[376] Senior Courts Act 1981, s.37(1).

infringement, where there was no such convenient provision like section 97A[377] with regards to trademark infringement.

Therefore, it is likely that section 37(1)[378] will be the statute to provide that power as it gives a wide power to grant an injunction in cases in which it appears just and convenient to do so, not just limited to intellectual property law.

Potential extension to 'comparative advertising'

The first potential area for extension is websites which advertise their products with a description linking their product to another reputable and trademarked brand, known as comparative advertising. The infringers do this to gain an unfair commercial advantage and it was confirmed in *L'Oreal v Bellure*[379] that this was trademark infringement.

Facts

The European Court of Justice was asked for a preliminary ruling in which it confirmed that the use of a comparison list showing which of their products corresponded to which branded perfumes infringed the registered trademarks for those perfumes.[380] Because of the European Court of Justice preliminary ruling, the Court of Appeal had to determine whether this was indeed infringement of trademark law.

The appellants had three ranges of products, each of which smelled like a famous, luxury branded perfume known by a well-known registered trademark.[381] The respondent alleged that the use of comparison lists showing which products corresponded to which of the respondent's perfume infringed its registered trademarks for those perfumes. The evidence submitted was that the appellants had obtained a major promotional advantage from using these lists.[382] The issue for the court here was whether, considering the European Court of Justice's preliminary ruling,[383] the use of the registered marks on and in relation to the

[377] Copyright, Designs and Patents Act 1998, s.97A.
[378] Senior Courts Act 1981, s.37(1).
[379] *L'Oreal SA v Bellure NV* [2010] EWCA Civ 535.
[380] *L'Oreal SA v Bellure NV* (Case C-487/07) [2010] Bus L.R. 303.
[381] *L'Oreal SA v Bellure NV* [2010] EWCA Civ 535.
[382] *Ibid.*
[383] *L'Oreal SA v Bellure NV* (Case C-487/07) [2010] Bus L.R. 303.

comparison lists fell within the Trademarks Directive, Article 5(1)(a),[384] and whether that use did not infringe because it complied with Directive 84/450[385] on misleading and comparative advertising. It was not in dispute that, in the comparison lists relating to perfumes, the appellants had used word marks registered by the respondents and others and that use was made in respect of products which were identical with those in respect of which those marks were registered, namely perfumes. The appellants submitted that the use of the word marks in these comparison lists was merely descriptive.[386]

Judgement

The judge held accordingly with the decision in the European Court of Justice.[387] Firstly, the decision in the European Court of Justice was that in same mark cases where the defendant claimed that his use was descriptive to take him outside of Article 5(1)(a) of the Trademarks Directive,[388] he would only succeed if his use was for 'purely descriptive purposes'.[389] In this case, the word marks belonging to the respondent and others were used in the comparison lists distributed by the appellant not for purely descriptive purposes, but for advertising. The European Court of Justice indicated that the use was within Article 5(1)(a)[390] and the use went beyond 'purely descriptive' because it was used for advertising.[391]

Even though the use fell within Article 5(1)(a),[392] it would not infringe trademark law if it complied with all the conditions in Article 3(a) of the Comparative Advertising Directive.[393] On this point the European Court of Justice held that, truthfully, the appellant's products had an essential characteristic, in the instant case the smell, of the trademark owner's product which amounted to saying that the product was an

[384] DIRECTIVE 2008/95/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 22 October 2008 to approximate the laws of the Member States relating to trademarks (hereinafter 'Trademarks Directive'), Art. 5(1)(a).
[385] Council Directive 84/450/EEC of 10 September 1984 relating to the approximation of the laws, regulations and administrative provisions of the Member States concerning misleading advertising ('Directive 84/450').
[386] *L'Oreal SA v Bellure NV* [2010] EWCA Civ 535.
[387] *L'Oreal SA v Bellure NV* (Case C-487/07) [2010] Bus L.R. 303.
[388] Trademarks Directive, Art. 5(1)(a).
[389] *L'Oreal SA v Bellure NV* [2010] EWCA Civ 535.
[390] Trademarks Directive, Art. 5(1)(a).
[391] *L'Oreal SA v Bellure NV* [2010] EWCA Civ 535.
[392] Trademarks Directive, Art. 5(1)(a).
[393] DIRECTIVE 2006/114/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 12 December 2006 concerning misleading and comparative advertising (hereinafter 'Comparative Advertising Directive'), Art. 3(a).

imitation[394] within paragraph (h) of Article 3.[395] Further, if comparative advertising failed to comply with paragraph (h),[396] it also took unfair advantage of the mark within the meaning of paragraph (g).[397] A use that was not permitted because the conditions of Article 3(a)[398] were not complied with was regarded as unlawful.[399] Failure to comply with these conditions meant that the use was 'without due cause' and so not within the exception to infringement of Article 6(1)(b) of the Trademarks Directive[400] because it was not in accordance with honest practice.[401]

The court also held that it was not necessary to decide whether there was also infringement of Article 5(2) of the Trademarks Directive.[402] The European Court of Justice concluded that, where a third party attempted, through use of a sign similar to a mark with a reputation, to ride on the coat-tails of that mark, the advantage resulting from such use was to be considered to be an advantage that had been unfairly taken of the distinctive character or repute of that mark.[403] Thus, there would also have been an infringement of Article 5(2).[404]

Will it extend to this area?

I believe that there is great potential for it in the near future. *L'Oreal v Bellure*[405] confirmed that comparative advertising through comparison lists can be a trademark infringement. Therefore, where a website displays a comparison list which takes unfair advantage of the distinctive character or repute, it is an infringement of Article 5(2),[406] which is therefore an infringement of trademark. The *Cartier* case[407] established that the court can use section 37(1) of the Senior Courts Act[408] to grant an order for ISPs to block access to websites that are infringing registered trademarks. Therefore, the courts can force ISPs to block access to these infringing

[394] *L'Oreal SA v Bellure NV* [2010] EWCA Civ 535.
[395] Comparative Advertising Directive, Art. 3(h).
[396] *Ibid.*
[397] Comparative Advertising Directive, Art. 3(g).
[398] Comparative Advertising Directive, Art. 3(a).
[399] *L'Oreal SA v Bellure NV* [2010] EWCA Civ 535.
[400] Trademarks Directive, Art. 6(1)(b).
[401] *L'Oreal SA v Bellure NV* [2010] EWCA Civ 535.
[402] Trademarks Directive, Art. 5(2).
[403] *L'Oreal SA v Bellure NV* [2010] EWCA Civ 535.
[404] Trademarks Directive, Art. 5(2).
[405] *L'Oreal SA v Bellure NV* [2010] EWCA Civ 535.
[406] Trademarks Directive, Art. 5(2).
[407] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[408] Senior Courts Act 1981, s.37(1).

websites. The underlying message is that, if comparative advertising infringes Article 5(2) of the Trademarks Directive,[409] it is an infringement. If the use of the registered mark is not 'purely for descriptive purpose', and rather is used for advertising purposes, then it is an infringement. Therefore, registered trademark owners can apply to the court for an order to force ISPs to block access to websites displaying comparative advertising that infringes trademarks.

We have yet to see this happen – however, this is unsurprising because the *Cartier* case[410] was only heard and reported in 2016. This means that we are now likely to see applications to the court on this matter soon, thanks to *Cartier* handing down the legislative basis for these applications.

Potential expansion to 'defamation'

Defamation is a tort, a civil wrong. Defamation is the situation where a statement is made and the publication of this statement is likely to cause serious harm to the reputation of the claimant.[411] Defamation is very common on the internet. The internet provides users with the possibility to express views and opinions to a global audience.[412] Defamatory publications can range from online versions of mainstream newspapers or journals though to blogs and online discussion forums, such as Reddit. Due to the global nature of the internet, it raises some practical and jurisdictional questions – specifically, to what extent could intermediaries such as ISPs be held liable as publishers of defamatory material.[413]

Defamation is an area of law which I believe the internet blocking order will extend to quickly, especially to online forums such as Reddit where users can easily post defamatory statements at the click of a button. The ease of access to the internet means that it is very easy for defamatory material to be published there. Therefore, I believe that it will not be long before there are applications to the court to force ISPs to block access to websites that are displaying defamatory material. The courts have shown their utmost willingness to extend their powers of granting internet

[409] Trademarks Directive, Art. 5(2).
[410] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[411] Defamation Act 2013, s.1(1).
[412] *Halsbury's Laws of England*, 5th edition, 2008, vol. 57, para. 684 <LexisLibrary> accessed 14 February 2017.
[413] *Ibid.*

blocking orders with their use of section 37(1)[414] in the *Cartier* case. As discussed above, section 37(1)[415] gives the court the power to grant an injunction of this type where the court deems it 'just and convenient to do so'. It is not just limited to intellectual property infringements, so section 37(1)[416] would be the easiest way that the courts could block access to websites displaying defamatory material, and they have already very recently shown, in *Cartier*, great willingness to extend the internet blocking order.[417] Therefore, it seems almost inevitable that it will happen.

I am not convinced that it will work as a solution. Usually, when defamatory material is posted on the internet, the claimant will want a quick solution, which is generally the publication being taken down or the website blocked. At the current stage, as shown in *Newzbin2*[418] and *Cartier*,[419] applying for a blocking order through the courts is very time-consuming. Internet users will still be able to access the website displaying the defamatory publication until a court orders it to be blocked, which means that the defamatory publication could be available for a long period even after the application is made. The other disadvantage is that the defamatory publication has likely been published on several different websites, which means that the applicant would have to find all the websites that have it displayed and make an order against them all. Therefore, those looking for a quick fix will want to look elsewhere.

Outside the United Kingdom there appears to be movement on this subject. The Court of Justice of the European Union was asked for a preliminary ruling on a case from Cyprus. For our sake, it shall be referred to as the *Sotiris Papasavvas* case.[420] The case concerned an action for damages brought by Mr Papasavvas because of harm suffered by him caused by acts considered to constitute defamation. The action was brought against two journalists for acts which, in the claimant's opinion, constituted defamation. The claimant sought damages for harm allegedly caused to him by articles published online on two websites. He requested that the national court order a prohibitory injunction to prohibit the publication of the two articles online. Most of the facts are not relevant to us; however, one part is. The court ruled that Articles 12 to 14 of Directive

[414] Senior Courts Act 1981, s.37(1).
[415] *Ibid*.
[416] *Ibid*.
[417] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[418] *Twentieth Century Fox Film Corp v British Telecommunications Plc* [2011] EWHC 1981.
[419] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658
[420] Case C-291/13 *Sotiris Papasavvas v O Fileleftheros Dimosia Etairia Ltd, Takis Kounnafi and Giorgos Sertis* 2014/C 409/20.

2000/31[421] do not allow for information society service providers to oppose the bringing of legal proceedings for civil liability against them, and consequently, the adoption of a prohibitory injunction by a national court.[422] This shows, therefore, that in the national court in Cyprus they have jurisdiction to grant a prohibitory injunction against the online defamatory publications. This means that Cyprus has the jurisdiction to grant an equivalent to our internet blocking order for cases of defamation online. A second key result from this preliminary ruling is that, as it is a Court of Justice of the European Union ruling, it means that it can apply to English law and allow the English courts to grant an internet blocking order against ISPs, forcing them to block websites hosting defamatory materials.

Potential expansion to 'privacy'

Material that is against a person's right to privacy can often be found on websites. Article 8 of the European Convention on Human Rights[423] gives everyone 'the right to respect for his private and family life, his home and his correspondence'.[424] Article 8[425] confers that the right to privacy includes respect for private and confidential information, particularly the storing and sharing of such information. The right also extends to the right to control the dissemination of information about one's private life, including photographs taken covertly.[426]

Therefore, a blocking order could be a potential remedy to protect a person's right to privacy. A good example of infringement of privacy on the internet is the famous 'fappening' case. This happened in 2014 and followed American law, where a large collection of private pictures of celebrities were posted online and later disseminated by users onto websites like Reddit. Many of these images contained nudity and were clearly an invasion of privacy. Had this been English law, in this case a blocking order would have forced the ISPs to block access to the websites showing these infringing pictures. Therefore, I believe that, if a case like this were to arise in English law, the internet blocking order would be a

[421] Directive 2000/31, Art. 12, Art. 14.
[422] Case C-291/13 *Sotiris Papasavvas v O Fileleftheros Dimosia Etairia Ltd, Takis Kounnafi and Giorgos Sertis* 2014/C 409/20.
[423] European Convention for the Protection of Human Rights and Fundamental Freedoms 1950, Art. 8.
[424] European Convention for the Protection of Human Rights and Fundamental Freedoms 1950, Art. 8(1).
[425] European Convention for the Protection of Human Rights and Fundamental Freedoms 1950, Art. 8.
[426] 'Article 8 Right to a Private and Family Life' <https://www.liberty-human-rights.org.uk/human-rights/what-are-human-rights/human-rights-act/article-8-right-private-and-family-life> accessed 17 February 2017.

very good remedy and one that is likely to be used in the future, thanks to the *Cartier* case.[427]

How likely is it that it will extend to this area?

I believe that the extension is imminent, especially with the recent fear among British celebrities about a mass leak of sex tapes. This would be very similar to the original 'fappening' case.

The *International Business Times* released an article in January 2017 reporting that British celebrities are fearing for the worst after a mass leak of sex tapes online.[428] It is claimed that the archive that has been leaked includes pictures and videos of very high-profile celebrity men, including two of the BBC's household names, well-known British movie and soap actors, and pop stars too.[429] This information has led to claims, therefore, that it will become available on the internet soon, just like the 2014 incident of 'fappening'. Likely places for the pictures and videos to be put are Reddit, 4Chan and Imgur, among many other popular websites.

If this does happen, then clearly the British celebrities will want a remedy. Following on from the *Cartier* case,[430] it would now be possible to argue that an internet blocking order would work in this situation. Those affected could apply to the court for the grant of a blocking order that would force ISPs to block access to the sites displaying the private pictures and videos. Whilst it has yet to be seen whether the courts would accept and grant the order in these circumstances, it seems that there is the necessary power to do so, namely, section 37(1) of the Senior Courts Act 1981.[431] It would be obvious to the court that a breach of privacy would fall under the heading of 'just and convenient'. Therefore, there is sufficient scope to reasonably believe that the court could extend the blocking order to protect a person's right to privacy.

In my opinion, I honestly believe that the court would be willing to extend it in these circumstances, as it is clearly on grounds which would be 'just and convenient' to do so. Is it going to be an effective remedy? Probably not, considering the time and expense. However, if there is no

[427] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[428] 'The Fappening 2.0? Celebrities Fear New Sex Tape Hack after Intimate Videos Leak on X-Rated Website' <http://www.ibtimes.com/fappening-20-celebrities-fear-new-sex-tape-hack-after-intimate-videos-leak-x-rated-2476802> accessed 17 February 2017.
[429] *Ibid.*
[430] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[431] Senior Courts Act 1981, s.37(1).

other quick route for a person affected to get the material blocked, then this certainly would be worth considering.

Is the blocking order against an internet user's freedom of expression?

Freedom of expression is a right guaranteed under Article 10 of the European Convention on Human Rights,[432] which is incorporated into English law by the Human Rights Act 1998.[433] Article 10(1) provides that:

> … everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers …[434]

Article 10(2)[435] then goes on to provide that:

> the exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary.[436]

Freedom of expression is widely regarded as being a necessary feature in any state which purports to be a democracy.[437] The European Court of Human Rights held in *Sunday Times v The United Kingdom*[438] that 'freedom of expression constitutes one of the essential foundations of a democratic society.'[439] Therefore, as the UK purports to be a democracy, it should at all costs stay away from interfering with a person's freedom of expression, and should only do so in legitimate circumstances. Relating

[432] European Convention for the Protection of Human Rights and Fundamental Freedoms 1950, Art. 10.
[433] Human Rights Act 1998.
[434] European Convention for the Protection of Human Rights and Fundamental Freedoms 1950, Art. 10(1).
[435] European Convention for the Protection of Human Rights and Fundamental Freedoms 1950, Art. 10(2).
[436] *Ibid*.
[437] Neil Parpworth, *Constitutional and Administrative Law*, 8th edition (Oxford: Oxford University Press, 2014), 424.
[438] [1979] ECHR 6538/74.
[439] *Sunday Times v The United Kingdom* [1979] ECHR 6538/74.

back, this means that the courts should only interfere with an internet user's freedom of expression in circumstances in which it is legitimate to do so. This means that we should now look at the legitimacy of the internet blocking order in relation to a person's freedom of expression, guaranteed by Article 10 of the European Convention on Human Rights.[440] Article 10(2) provides the exceptions to freedom of expression, and, as shown above, state that interference with a person's freedom of expression can only be done where prescribed by law or when necessary in a democratic society.

BT, in the *Newzbin2* case,[441] put forward an argument, with regards to copyright, that the blocking order would be contrary to Article 10[442] because it is not prescribed by law. The main basis of this argument was that section 97A of the Copyright, Designs and Patents Act 1988[443] did not provide an adequate legal basis for the order sought. Arnold J rejected this argument, holding that the order sought was clear and precise, and merely required BT to implement an existing technical solution. In his view, the order fell well within the range of orders which were foreseeable by ISPs based on section 97A,[444] and still more Article 8(3) of the Information Society Directive.[445] Arnold J concluded that, on this basis, the order was one 'prescribed by law' within Article 10(2) of the European Convention on Human Rights[446] and hence not contrary to Article 10.[447] I agree with Arnold J on this point – I believe that he was correct in holding that it was prescribed by law, which it was by section 97A,[448] and that it was one that was foreseeable. This view was also backed up by Muzaffar Shah in his journal article, where he stated that there was no question that any interference with the subscribers' freedom of expression was potentially justified by the need to protect the rights of right-holders.[449] Whilst I agree that there is the legislative basis on copyright, I do not agree with Muzaffar Shah when he says that it was justified 'by the need to protect the rights of right holders'.

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[440] European Convention for the Protection of Human Rights and Fundamental Freedoms 1950, Art. 10.
[441] *Twentieth Century Fox Film Corp v British Telecommunications Plc* [2011] EWHC 1981.
[442] European Convention for the Protection of Human Rights and Fundamental Freedoms 1950, Art. 10.
[443] Copyright, Designs and Patents Act 1988, s.97A.
[444] *Ibid.*
[445] Directive 2001/29/EC of the European Parliament and of the Council of 22 May 2001 on the harmonisation of certain aspects of copyright and related rights in the information society (hereinafter 'Directive 2001/29'), Art. 8(3).
[446] European Convention for the Protection of Human Rights and Fundamental Freedoms 1950, Art. 10(2).
[447] European Convention for the Protection of Human Rights and Fundamental Freedoms 1950, Art. 10.
[448] Copyright, Designs and Patents Act 1988, s.97A.
[449] Muzaffar Shah, 'UK Order for Internet Service Provider to Block Access to Pirate Website Raises Concerns about Internet Censorship, Effectiveness', (2011) *W.D.P.R.* 2011, 11(9), 16–18.

Article 19 puts forward a very good argument as regards how blocking access to some parts of the internet affects a person's freedom of expression. The internet was designed to enable the free flow of information; however, technical measures restricting access to content are now worryingly commonplace in democratic countries.[450] Article 19 discusses the deep concerns stemming from blocking. Firstly, these measures are *prima facie* an interference with the fundamental right of every person to seek and exchange information and ideas.[451] Secondly, they are notoriously ineffective, as they involve risks of under- or over-blocking content and as such amount to a violation of the right to freedom of expression.[452] This backs up my earlier point that the blocking order is a relatively ineffective remedy and is likely to lead to over-blocking in the future, where we effectively end up with internet censorship. It also raises a very valid point that blocking is deeply intrusive of a user's right to privacy and freedom of expression as the content of the material exchanged between users is analysed.[453]

This is a controversial area with differing views. In my opinion, I agree that the restriction and interference with how a person uses the internet is a clear interference with their right to freedom of expression.[454] Whilst I agree with Arnold J, in the copyright context, that it was prescribed by law and foreseeable, I do not agree with that when it comes to other areas. I do not believe that, in trademark law, it is sufficiently prescribed by law, because the courts have relied on a very wide and general power under section 37(1) of the Senior Courts Act[455] to be able to grant the blocking order. It merely relies on where a court deems it 'just and convenient'. I also do not agree that a trademark owner's rights should be put before a person's right to freedom of expression, as argued by Muzaffar Shah.[456] I believe this because, if everybody else's rights come before a person's freedom of expression in terms of the internet, then (a) do we really have freedom of expression? And (b), we are likely to see a very quick censorship of the internet. If the internet becomes censored and only small amounts of websites are left, then that will affect a large

[450] 'Freedom of Expression Unfiltered: How Blocking and Filtering Affect Free Speech' <https://www.article19.org/data/files/medialibrary/38586/Blocking_and_filtering_final.pdf> accessed 16 February 2017.
[451] *Ibid.*
[452] *Ibid.*
[453] *Ibid.*
[454] *Ibid.*
[455] Senior Courts Act 1981, s.37(1).
[456] Shah, *op. cit*.

amount of trade and jobs, and will likely hit intellectual property right-holders hard.

In my view, the blocking order is clearly against a person's right to freedom of expression. It restricts access to content, which clearly infringes a user's right, and I don't believe that an IP right-owner's right should come before a person's right to freedom of expression. I believe that this restriction of freedom of expression will eventually lead to an internet censorship which will have a big impact on the United Kingdom.

The internet blocking order in Europe

The internet blocking order is not just limited to the United Kingdom. Blocking orders are compatible with EU law, as was confirmed in the CJEU decision in *Telekabel*.[457]

In 2015 the German Federal Court of Justice considered GEMA's request for a blocking order against Deutsche Telekom, which is Germany's largest ISP. The order was sought to prevent access to 3dl.am which hosted several links to files in places such as Netload and Rapidshare. These files included copies of works whose relevant rights are administered by GEMA.[458]

The internet blocking order was also considered in Sweden. In 2015 the Stockholm District Court refused to issue a blocking order against a Swedish ISP to prevent access to Pirate Bay and Swefilmer. The reason for this was that Swedish copyright law states that an injunction can be granted against a non-direct infringer only if this contributes to the infringing acts of a third part. The Swedish court held that this would not be the case for an ISP.[459]

Conclusion

The potential for expansion of the internet blocking order is vast. Section 37(1)[460] has been interpreted in such a wide manner by the courts that it opens the door to many areas of law, especially defamation, privacy and

[457] Case C-314/12 UPC Telekabel Wien GmbH v Constantin Film Verleih GmbH and Wega Filmproduktionsgesellschaft mbH (2014).
[458] 'Blocking Orders Across Europe: Personality Disorder or Are the Swedes Right?' <http://ipkitten.blogspot.co.uk/2015/12/blocking-orders-across-europe.html> accessed 8 March 2017.
[459] *Ibid*.
[460] Senior Courts Act 1981, s.37(1).

comparative advertising. There is no possible way to determine where it will go next, but there certainly is the potential for it to expand further.

Digital piracy is a significant and prominent issue, not only in the United Kingdom, but globally. The UK government tried to tackle the issue through the Digital Economy Act 2010,[461] which was ultimately unsuccessful. The courts have had to try and tackle the issue themselves. They got the ball rolling with the issuing of an internet blocking order in relation to copyright infringement in *Newzbin2.*[462] This was the first of its kind and the first attempt by the courts to tackle this issue. This then led on, in 2016, to an extension of this blocking order to cases of trademark infringement, thanks to the decision in the *Cartier* case.[463] The courts enabled themselves to do this using section 37(1) of the Senior Courts Act 1981.[464] The use of section 37(1)[465] has therefore triggered the potential for the internet blocking order to be extended to different areas of intellectual property law and areas of law where online operators are infringing the law.

L'Oreal v Bellure[466] held that comparative advertising that took advantage of another trademarked brand/product for an unfair commercial advantage is an infringement of that trademark. Thus, this is very likely to be the next area that it is extended to. *Cartier* was only decided very recently, in 2016, so while there have been no attempts to extend it to product descriptions, I am confident that it will happen in the future.

Defamation is also a very likely area. Defamatory material can be put on internet sites such as Reddit, 4Chan and other similar sites. Therefore, those defamed are going to want those sites blocked. Privacy is the final area that I looked at, and it is very like defamation in that those affected by the display of private information will want the websites blocked to stop the public from viewing it. I do not believe that it is an effective remedy, considering that those affected will want quick fixes. Obtaining an internet blocking order currently requires a court case, which takes time and therefore will not be the quick fix.

Finally, I believe that the internet blocking order is against a person's right to freedom of expression. The order restricts access to

[461] Digital Economy Act 2010 (c.24).
[462] *Twentieth Century Fox Film Corp v British Telecommunications Plc* [2011] EWHC 1981.
[463] *Cartier International AG v British Sky Broadcasting Ltd* [2016] EWCA Civ 658.
[464] Senior Courts Act 1981, s.37(1).
[465] *Ibid*.
[466] *L'Oréal SA v Bellure NV* [2010] EWCA Civ 535.

content which clearly infringes a user's right, and I am of the belief that a person's human right should come before the right of a registered IP owner. I also strongly believe that putting an IP right-owner's interests before those of a person's human rights will eventually lead to censorship of the internet. Therefore, this solution is only ever likely to be a partial solution.

Louis Mancini, Goughs Solicitors

Book Review

Digital Copyright, Law and Practice, by Simon Stokes, 5th Edition, July 2018

(287 pages + preface, acknowledgements and index)

Mark Wing

This 287-page fifth edition, published in July 2018 (and legally correct as of April 2018), aims to bring up to date the author's consideration of digital copyright issues, a huge, complex and rapidly moving area. The author is a partner at Blake Morgan Solicitors and has many years' experience working in the subject matter of the book. In the preface to the fifth edition he describes the work as a 'concise, practical and introductory guide' – and bearing this objective in mind, just how well does it achieve the author's stated aim? Given that a large number of copyright works are created and disseminated digitally these days, a book that looks at this as a specialist topic, drawing together all the relevant threads – several not strictly speaking copyright per se, such as e-commerce and competition law – is both required and timely.

Should this book achieve its aims, its potential use to practitioners in particular – who need to take a wide view of all the issues in a practical context and understand the links between them – is particularly salient. It is clear from the outset that this is not really a hard-core academic work but instead takes a more broad-brush approach, and so is perhaps aimed mostly at practitioners or those working in the digital copyright industries. This is abundantly clear, for example, in chapter 9 which is devoted entirely to practical advice on managing digital copyright, including precedents. That being said, if reference is made (as it is here) to more advanced or detailed sources, it can be a useful companion to an academic library.

At the time of publication, the book is ambitious in including such extremely cutting-edge areas as blockchain, the (at the time) still to be

finalised Digital Single Market Directive, and artificial intelligence and digital copyright. These inclusions are welcome, but by their very nature and the publication process, the book was already out of date on the DSM Directive proposals on publication. Realistically, there is nothing that the author could have done about this, but it would appear that a further updated edition will be required in the near future, or alternatively a companion website. This does not really affect the overall value of the book to any great extent.

The book starts with a very useful and necessary glossary of technical terminology. In a profession as technically conservative as law often is, the terminology of the digital industry can appear to be impenetrable to the outsider.

Chapters are organised in the following manner: Chapter 1 – Why Digital Copyright Matters; Chapter 2 – Digital Copyright the Basics; Chapter 3 – Digital Database Law and the Internet; Chapter 4 – Digital Moral Rights; Chapter 5 – Digital Rights and Competition Law; Chapter 6 – Software Copyright; Chapter 7 – Digital Copyright and E-Commerce; Chapter 8 – Digital Copyright: From Web 2.0 to Blockchain; Chapter 9 – Protecting and Managing Your Digital Copyright Assets. Each chapter also contains a useful summary of key points at the end.

Chapter 1 forms an introduction and overview of the continuing importance of copyright, the challenges to it posed by digitisation, and the history of relevant legislation. This part of the work would generally be more useful to a lay reader or law undergraduate than an experienced IP law practitioner or academic, but nonetheless, given the nature of the book, the chapter has its place in contextualising what comes next.

Chapter 2 delves into a more traditional and detailed discussion of the rules of UK copyright law as applied to digital media – protected works and originality, authorship, duration, related rights, infringement, remedies, defences and exceptions, followed by a more detailed discussion of ownership. The discussion of issues surrounding equitable ownership of copyright is particularly pleasing and clear, given the complexity of this subject matter. This is a solid, clearly written and focused chapter, giving more than enough contextualised information on copyright law for those needing more than the basic outline of chapter 1. This is also quite a comprehensive chapter and has plenty of footnotes for those seeking more depth, along with references to the quite bewildering array of case law on the subject emanating from both the UK courts and CJEU. At 2.6 there is a

short but effective discussion of the implementation of the Electronic Commerce and Information Society Directives and an interesting discussion of the DMCA, the US equivalent. This type of content would not normally be found in a 'pure' IP law-only textbook and is welcome.

Chapter 3 deals with digital database law, and, as one would expect, it covers both copyright in databases and the *sui generis* database right. Here, there is an analysis of the main statutory provisions and a detailed discussion of the key UK/EU authorities and their scope, including the famous *BHB* case from the UK and the corresponding CJEU ruling, as well as a lesser, though useful, discussion of *Football Dataco*. The chapter is broader in scope than just the EU Database Directive and includes consideration of related issues such as metasearch engines, website 'scraping' and future developments, along with a short, though well-informed, section of practical suggestions which, if adhered to, will improve the chances of securing database protection in the many areas which may, or may not, be within the scope of database protection.

Chapter 4 deals with moral rights. Given the ease with which digital works are altered and disseminated, this is a necessary inclusion, though this feels like a weaker chapter than those prior to it, simply because this area is little litigated on in the UK, and UK moral rights – introduced in the Copyright Designs and Patents Act 1988 – are hedged round by so many exceptions, are frequently waived contractually, generally do not apply to employees and in some cases have to be positively asserted, so are much more limited in nature than in other jurisdictions such as France. Moral rights in performances, a quite new addition to UK law dating from 2006, are also a welcome inclusion. Paradoxically, the main practical advice proffered for this chapter is to seek a contractual waiver of such rights!

Chapter 5 deals with digital rights and competition law. This is another related area which may not be found in a traditional textbook, and certainly not as applied to the technology sector. It covers, as one might expect, parts 1 and 2 of the Competition Act 1998 and the EU law on which those provisions are based, as well as the various ways of ensuring that behaviour is not a breach of part 1 through a relevant block exemption or through the legal exception regime. Potential penalties from the Competition and Markets Authority, and (for the time being at least) the European Commission, are also dealt with. The golden nugget here for a practitioner or industry reader is 5.5 – Implications for Digital Copyright Businesses. Many IP practitioners' knowledge of competition law, based

on this reviewer's own experience, is shaky, and how it applies to digital businesses even more so. Hence, the discussion on pages 116 to 133 makes the book worthy of purchase on its own and is something that the non-contentious IP practitioner, innocently drafting contracts in the office, should have foremost in his mind.

Chapter 6 considers software copyright, and a substantial part of this chapter is an appraisal of what is protected, including an outline of the Software Directive and a quite detailed review of the key cases from UK law, before moving on to free and open source software.

Chapter 7 looks at digital copyright and e-commerce. The chapter starts by considering legal and practical issues with content re-use from analogue to digital works, then looks at licensing and surrounding issues and the need to grant clear rights contractually to the extent required. A detailed discussion of licensing and linking follows, including the various types commonly encountered in the digital environment, such as 'shrink wrap', 'click wrap' and 'browse wrap' licences. Complex issues regarding linking and framing to content, meta tagging and service provider liability also receive a good treatment, with the usual commendable clarity of expression. Issues surrounding protection of images online, search engines, online infringement and digital rights management, and a brief mention for the Digital Single Market are also discussed in this wide-ranging chapter.

Chapter 8 looks at issues surrounding the read/write web – or Web 2.0 as it is otherwise known – along with a variety of other miscellaneous issues. Web 2.0 relates, of course, to activities such as social media, blogs and web broadcasting. The importance of terms and conditions for those hosting such activities as Facebook are rightly emphasised, though the key complexities of jurisdictional issues surrounding Web 2.0 are only briefly mentioned in passing. There is some overlap with chapter 7 on the issue of liability for hosting and/or infringing content, though here it is viewed from a different perspective. The hot topics of e-publishing, big data AI and blockchain complete this chapter.

The practical focus of the book is evidenced in chapter 9 which is devoted exclusively to the management of digital assets and includes a list of checklists and precedents. The 'issues for industries' section will be particularly useful for practitioners with new clients in those sectors mentioned; ditto, the checklists will be useful in meeting typical client objectives. Less useful, perhaps, are the actual precedents themselves. For

a practitioner, they may offer useful ideas or suggestions, but for other readers – for example, those engaged in the digital industries – trying to use these could amount to the maxim ‘a little knowledge is a dangerous thing’.

Generally the book is very clearly and concisely written – with none of the self-aggrandising language or sophistry often encountered in works by pure academics – and therefore is accessible to a wide audience. One of its main strengths is the author’s considerable displayed practical as well as academic expertise which brings together sources and subject matter which, if they were to be sought elsewhere, would require several textbooks and access to various legal databases. Does it succeed in its author’s stated goal of being a ‘concise, practical and introductory guide’? A few minor quibbles aside, it is this reviewer’s view that it does, and that it should be a companion work on the desk of any practitioner who deals with this area of law on a day-to-day basis. As an academic, this reviewer also appreciated the clear writing and the wide-ranging and well-informed scope of the work. In several areas that are not part of this reviewer’s regular syllabus, the work was also extremely educational in raising awareness of digital issues and the broader picture.

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