

Who Guards the Guardians? Ian Kennedy, Bioethics and the 'Ideology of Accountability' in British Medicine

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Summary. This article charts the history of bioethics in Britain through the work of the academic lawyer Ian Kennedy. From the late 1970s, Kennedy claimed that external oversight, which he termed 'bioethics', was needed to make medicine accountable to patients and the public. I believe these arguments provide a window onto the historical factors that generated the demand for bioethics, and help us determine why it became influential in recent decades. I detail how Kennedy's argument resonated with the Conservative enthusiasm for audit and consumer choice in the 1980s. Contrary to traditional portrayals of bioethics as a critique of medicine, I also show that Kennedy promised it would benefit doctors by improving decision making and maintaining public confidence. This analysis reframes bioethics as an important constituent of the 'audit society': fulfilling the neo-liberal demand for oversight and the medical demand for legitimacy.

Keywords: bioethics; audit; accountability; neo-liberalism

In 1978, the *British Medical Journal* reported how increasing numbers of American lawyers, philosophers theologians and sociologists were now tasked with 'acting as society's conscience in matters once left to the medical profession'.¹ It outlined how this outside involvement emerged during the late 1960s and 1970s, following public unrest over human experimentation, the allocation of organs and kidney dialysis, and new technologies such as *in vitro* fertilization (IVF) and genetic engineering. These so-called 'bioethicists' quickly become public authorities on medical ethics, with their presence 'required by regulation on any number of academic and national policy-making committees'.² This, readers were informed, marked the 'flowering of bioethics in America'.³

As this report made clear, and as several historians have since detailed, bioethics is a new form of expertise that reflects profound shifts in the politics of medicine and the biomedical sciences. To David Rothman, it marks a 'critical departure' from the prior tradition of medical ethics, where doctors governed their own conduct through professional codes and bedside

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¹Culliton and Waterfall 1978, p. 1270.

²Ibid. The term 'Bioethics' was coined in 1970 by the biochemist Van Rensselaer Potter, who used it to describe an ethics derived from biomedicine. Months later, the philosophers Andre Hellegger and Sarget Shriver used it to describe the ethical examination of

medicine and biology when they opened an Institute for the Study of Human Reproduction and Bioethics at Georgetown University, a private Jesuit college in Washington DC. See Cooter 2004.

³Culliton and Waterfall 1978, p. 1270.

training.⁴ And it represents a significant change in the relationship between medicine and other professions such as philosophy, law and theology. While scholars in these fields often commented on medicine during the nineteenth and early twentieth centuries, few, if any, disputed that doctors were best qualified to determine their own conduct. Following the emergence of bioethics, however, many non-physicians played a critical role in developing regulatory standards for medicine and the life sciences, and took the lead in publicly defining the ethical issues raised by clinical practice and research.⁵ Bioethics can also be read as a decisive shift in the location and exercise of ‘biopower’, which Michel Foucault defined as the range of actors and strategies deployed to govern individual and collective health.⁶ As Brian Salter states, bioethicists have become critical to the exercise of biopower: dictating ‘the values that permit or proscribe the development of health technologies ... that may subsequently act as modes of population or individual control’.⁷

These factors make bioethics a rich subject for historical investigation. But our understanding of its emergence and the reasons for its influence are contested. The first histories of bioethics, penned by bioethicists, established what Elizabeth Armstrong and others have since critiqued as an ‘origin myth’.⁸ These participant accounts portray bioethics as a radical response to the ethical issues raised by new technologies and human experiments, which took shape when philosophers, lawyers, sociologists and theologians drew on civil rights campaigns by standing up for the rights of patients, research subjects and even laboratory animals.⁹ Such accounts establish a dichotomy between a conservative medical profession and radical bioethicists; and Rothman reinforces this juxtaposition in *Strangers at the Bedside*, adopting ‘a twofold classification of doctors and outsiders’ and claiming that outside involvement ‘came over the strenuous objections of doctors, giving the entire process an adversarial quality’.¹⁰

Others have recently questioned these ‘origin myths’. Tina Stevens, for instance, argues that ‘bioethical impulses found their way into enduring social institutions not because they represented the social challenges of the 1960s but because they successfully diffused those challenges’.¹¹ Like John Evans, Stevens claims that American bioethicists rose to prominence because they helped legitimise research and clinical practice: avoiding fundamental questions about medical power or authority and instead formulating guidelines ‘for the use of procedures and technologies that it largely accepted as inevitable’.¹² Roger Cooter, meanwhile, argues that the bioethical emphasis on patient choice was a shallow appropriation of civil rights rhetoric which failed to analyse how ‘choice’ was an ideological construct that varied across, and was determined by, institutional, social and cultural settings.¹³

Several historians and sociologists have recently heeded Cooter’s plea that bioethics should never be ‘understood apart from the social, political and ideological context in which it is conducted’, and have studied the emergence and operation of bioethics in locations other than the United States, including Singapore, France and Iceland.¹⁴

⁴Rothman 1991, p. 189.

⁵Rabinow and Rose 2006, p. 203.

⁶Foucault 2000; cf Rabinow and Rose 2006.

⁷Salter 2004a.

⁸Armstrong in Rothman, Armstrong and Tiger (eds) 2007; Adams 2010; Cooter in Pickstone and Cooter (eds) 2000.

⁹Harris in Harris (ed.) 2001; Jonsen 1998; Toulmin 1982.

¹⁰Rothman 1991, pp. 10–11.

¹¹Stevens 2000, p. xii.

¹²Stevens 2000, p. 158; Evans 2002.

¹³Cooter in Pickstone and Cooter (eds) 2000.

¹⁴Cooter in Pickstone and Cooter (eds) 2000, p. 466.

These studies move beyond the 'origin myth' emphasis on contested technologies and civil rights to show how bioethics originated for historically and socially specific reasons in different times and places.¹⁵ All, moreover, reject any dichotomy between medicine and bioethics, showing how bioethicists have become 'a necessary supplement to the imperatives of political decision making' in many countries by acting as a broker between society, politicians and the medical profession.¹⁶ To Salter and Jones, bioethics is best viewed as an 'instrument of compromise' that placates public and political concerns while legitimating high profile and remunerative projects.¹⁷

Nevertheless, more work is needed, as bioethics is influential in many locations not yet covered by these critical studies. For instance, in Britain, as elsewhere, bioethicists are sought-after 'ethics experts' with prominent positions on regulatory committees and considerable public authority.¹⁸ But our appreciation of how and why they attained this status is sketchy at best. Existing accounts of British bioethics, like a chapter in the *World History of Medical Ethics*, recapitulate 'origin myths' by claiming that radical politics fostered greater discussion of British medicine in the 1960s and 1970s.¹⁹ While it is true that issues such as human experimentation and IVF drew attention to medical ethics in this period, doctors continued to police themselves, with the *British Medical Journal* portraying bioethics as an 'American trend' in 1978.²⁰ Lawyers, philosophers and others did not engage with medical decisions or regulation until the 1980s; but this involvement was quickly influential, fostering the growth of what the *Guardian* called an 'ethics industry', where non-physicians led 'a national debate on ethical questions arising from modern developments in medicine' and, as in the USA, chaired public inquiries into technologies like IVF.²¹ Again, however, existing histories portray this involvement as adversarial and resisted by doctors, claiming that early bioethicists like the academic lawyer Ian Kennedy launched an 'iconoclastic attack on medical paternalism' that 'ruffled many feathers in the medical establishment'.²²

This article seeks to move beyond such accounts by exploring how and why bioethics became an influential approach in 1980s Britain: charting the broad factors that fostered outside scrutiny of medicine, and showing how particular individuals fashioned themselves into 'ethics experts'. My analysis centres on the academic work and public activities of Ian Kennedy, who is a major figure in the history of British bioethics. Since the late 1960s, Kennedy has written on medical definitions of death and mental illness, euthanasia, the doctor–patient relationship and the rights of AIDS patients. His early work notably stressed that decisions should rest solely with the medical profession; but after encountering bioethics during a spell in the USA, he became a strong advocate of external involvement with medicine. During the 1980s, Kennedy used the prestigious BBC Reith Lectures to promote external oversight of doctors, which he called 'bioethics', and went on to become a member of the General Medical Council, the Commission on the Safety of Medicines and the government's Expert Advisory Group on AIDS. During the 1990s, he chaired a government inquiry into human–animal transplants, and between 2004 and

¹⁵Reubi 2010; Fox and Swazey 2008; Fortun 2008; Salter and Jones 2005.

¹⁶Rose 2007, p. 97.

¹⁷Salter and Jones 2005, p. 716.

¹⁸Dyer 1994.

¹⁹Boyd in Baker and McCullough (eds) 2009.

²⁰Culliton and Waterfall 1978, p. 1271.

²¹Williams 1991.

²²Boyd in Baker and McCullough (eds) 2009, p. 489.

2009, he led the Labour government's Commission for Healthcare Audit and Inspection. A 2002 knighthood for 'services to bioethics' indicates that Kennedy was a principal figure in this changing landscape; indeed, one lawyer claims that he 'virtually invented the field in the United Kingdom'.²³

While Adam Hedgecoe claims that a focus on critical figures and events replicates a major flaw of the narrow 'origin myths', I believe that studying individuals like Ian Kennedy provides an important window onto the history of bioethics, by highlighting how it arose thanks to the engagement between professional agendas and broader socio-political concerns.²⁴ As John Pickstone argues, detailed studies such as this do not detract from the 'big picture', but are necessary to deepening our understanding of the mutual interplay that lies behind wholesale changes in the organization of knowledge and expertise.²⁵ Moreover, studying individual bioethicists can bring to light differences of opinion that help us move beyond the misleading view that bioethics is one field or approach: showing instead how it is a pluralistic set of activities whose participants, boundaries and outlook are constantly negotiated.²⁶

Concentrating on what Jasanoff terms 'official bioethics', which encompasses the public and regulatory activities of bioethicists, I detail how Kennedy's calls for external oversight of medicine became influential in the 1980s, when Margaret Thatcher's Conservative government argued that professions should be exposed to outside scrutiny in order to render them accountable to their end-users.²⁷ This provides an empirical study of a trend that several writers have identified as central to our contemporary political landscape: that is how a leftist critique of professions, stressing the need for client empowerment, mapped onto a neo-liberal desire to reform professions and public services on consumerist lines.²⁸ It is no coincidence, I argue, that bioethics emerged as a recognised approach in Britain when the Conservatives promoted external oversight as a way of ensuring public accountability and consumer choice.

This analysis provides a framework for understanding the broad context in which British bioethics emerged and operated: connecting with major themes in contemporary history, such as the declining trust in professions and the rise of measures designed to enforce public accountability, which Michael Power has characterised as the 'audit society'.²⁹ Power details how the 1980s saw the growth of mechanisms designed to monitor professional actions, whose main ingredient was reliance on experts independent from the profession in question. The early history of bioethics, I argue, offers substantive evidence in support of Power's thesis. What is more, it deepens our understanding of the interaction between political ideologies and professional agendas that helped instantiate the 'audit society'. The new regimes of external oversight, like bioethics, were not simply the product of the Conservative demands for audit and accountability, but also depended on the presence of individuals and professional groups willing to define themselves as the new arbiters of best practice.³⁰ With this in mind, we can see Kennedy's criticism

²³Gostin 1997, p. vi; MacLean 2001.

²⁴Hedgecoe 2009, p. 333.

²⁵Pickstone 2007.

²⁶De Vries *et al.* in De Vries *et al.* (eds) 2007.

²⁷Jasanoff 2005, p. 173.

²⁸Dean 2010; Rose 1999.

²⁹Power 1997.

³⁰Power's original work was criticised for a 'top down' approach and lack of specific case studies; but this has since been rectified by studies on the history of oversight in social services, teaching and local government, while Power has since expanded and

of self-regulation and calls for outside scrutiny as a fundamental constituent of the 'audit society', which helped create the demand for bioethics.

By showing that Kennedy was not quite the radical iconoclast we have been led to believe, this analysis also undermines the claim that bioethics was in any way an 'iconoclastic' critique of medicine. Kennedy regularly argued that bioethics would benefit doctors, by relieving them of difficult decisions and helping overcome declining political trust. Rather than simply challenging the authority of the medical profession, then, he was presenting it with a new means of legitimacy in a changed political climate. While some doctors were initially reluctant, many senior figures endorsed his proposals. I thus argue that we can appreciate the growth of bioethics in the 1980s by seeing how figures like Kennedy positioned it as a crucial mediator between politicians and doctors: promising to fulfil the neo-liberal demand for oversight whilst also safeguarding medicine.

From Paternalism to Patient Empowerment

Ian McColl Kennedy was born in the West Midlands on 14 September 1941, into what he described as a 'poor working-class' family.³¹ His parents, a teacher and an electrician, encouraged their three sons to make the most of the opportunities provided by the postwar welfare state. In 2003, Kennedy recalled that: 'My father in particular was anxious to inculcate in us the notion that we were getting what opportunities we were enjoying by virtue of the taxes and the welfare state, on the back of those who had gone to war ... It was our duty to give something back, if we made it.'³² As Tony Judt and Harold Perkin have detailed, Kennedy grew up in a postwar era where public services and professions were highly regarded.³³ This was especially true of medicine, following the 1948 creation of the National Health Service (NHS), the production of antibiotics and development of so-called 'magic bullets' against diseases like polio. Despite their misgivings prior to the formation of the NHS, control of medical decisions and conduct was left wholly to doctors. This was evident in the civil law's position in medical negligence cases. In the 1957 case *Bolam v Friern Hospital Management Committee*, involving a man who sued doctors for failing to restrain him during electroconvulsive therapy, the court ruled that a doctor's conduct should be judged by reference to how a reasonable doctor would behave in similar circumstances. Even in the rare instance that doctors found themselves in the courtroom, then, they were still free to determine the legal standard of care.³⁴

This high esteem was reflected by the fact that two of Ian Kennedy's brothers studied medicine at university, while he went on to read law at University College London (UCL) before attaining a Master of Laws degree from the University of California, Berkeley. During his time in the United States, Kennedy argues, the civil rights movement strengthened his existing 'sense of social justice, of entitlement of anybody, no matter where they're from, to have an even break, to have a chance'.³⁵ Kennedy returned to Britain

refined his thesis. See Power 2005; for professional case studies see Campbell-Smith 2008; Lowe 2007; Munro 2004.

³¹Donnelly 2003, p. 22.

³²Ibid.

³³Judt 2010; Perkin 1989.

³⁴*Bolam v Friern Hospital Management Committee* [1957] 2 All Er 118; Price 2010.

³⁵Kennedy 2010.

in 1965, when he was appointed lecturer in law at UCL. While teaching jurisprudence, he became interested in the longstanding issue of when a human began and ceased to be legally defined as a person. The point at which a person died was then subject to considerable debate, thanks to the development of artificial respirators for brain damaged and seriously ill patients. Since death was legally defined as 'absence of vital functions' like circulation and breathing, and since a fundamental requirement in the crime of murder was that the killing must have been of a 'life in being', various groups questioned whether a patient dependent on a ventilator was alive or dead and, consequently, whether a doctor who turned a machine off could be charged with murder.³⁶ Lawyers such as Glanville Williams had written on this problem in the 1950s, but interest grew in the 1960s following advances in transplantation surgery, and an awareness that these 'twilight' patients were a source of transplantable organs.³⁷

In 1969, Kennedy wrote an article investigating 'the legal problems surrounding the moment of death'.³⁸ He outlined how the legal view of death 'seems no longer to fit the realities of modern medicine and proves unworkable in certain circumstances'.³⁹ As he would throughout his career, Kennedy condemned the 'very English reluctance to do anything about the situation until it has caused difficulty' and called for guidelines to prevent legal challenge.⁴⁰ Notably, however, he claimed that 'it would be improper to comment' on when death occurred and stressed that decisions 'should be left wholly to the medical profession'.⁴¹ The law, Kennedy continued, should only change 'once there is an established consensus in the medical world'.⁴² In 1972, whilst working at the University of California, Los Angeles (UCLA), he endorsed the medical view that death occurred when brain function was irreversibly damaged and reiterated that 'the doctor's judgement must prevail'.⁴³

Kennedy's stance reflected the prevailing 'hands off' attitude to doctors among lawyers. This persisted despite the fact that positive postwar attitudes towards medicine had been undermined during the 1960s and 1970s: by uncertainty over death and transplants, the exposure of birth defects caused by the 'miracle' morning sickness drug Thalidomide, and the publication of Maurice Pappworth's *Human Guinea Pigs*. While these issues prompted a growing discussion of medical ethics, much of this interest came from within medicine, from 'whistle-blowers' like Pappworth and the London Medical Group (LMG), which was formed by medical students in 1963.⁴⁴ At the same time, a small number of academics from other disciplines began to discuss the ethics of new technologies and clinical practices: including Kennedy, the theologians Alastair Campbell and Gordon Dunstan, and the philosopher Robin Downie. Along with doctors, they contributed to a new *Journal of Medical Ethics*, which resulted from a merger between the LMG and a Society for Study of Medical Ethics (formed by ex-LMG members). Alastair Campbell used his first editorial, in 1975, to claim the journal would 'hold no brief for one particular professional, political or religious viewpoint'.⁴⁵

³⁶Wolstenholme (ed.) 1966.

³⁷Williams 1958. On ventilated patients as 'twilight' individuals, see Wolstenholme (ed.) 1966.

³⁸Kennedy 1969, p. 103.

³⁹Kennedy 1969, p. 106.

⁴⁰Ibid.

⁴¹Kennedy 1969, pp. 111, 115.

⁴²Kennedy 1969, pp. 115, 113.

⁴³Kennedy 1972, p. 40.

⁴⁴Whong-Barr 2003.

⁴⁵Campbell 1975, p. 1.

This interdisciplinary scrutiny took place amidst a growing critique of professional expertise. Several historians have detailed how the late 1960s and 1970s saw the emergence of a 'new politics', where concerns over class identity and economic security were replaced by campaigns for better human rights and individual autonomy.⁴⁶ Change was often driven by new social movements that incorporated civil rights and libertarian ideologies to campaign for the autonomy of distinct groups, including patients. These movements increasingly criticised professions as obstacles to empowerment, as unaccountable and self-serving power blocs.⁴⁷ They drew inspiration from the Austrian philosopher Ivan Illich, who claimed medical control over definitions of health and illness reinforced professional power and fostered a 'debilitating' client mentality among patients and society.⁴⁸ The most high-profile group in Britain was the National Association for Mental Health, which rebranded itself as MIND in the early 1970s. Guided by the American civil rights lawyer Larry Gostin, MIND assumed a more critical stance *vis-à-vis* medical authority: exposing professional misconduct, challenging regulatory injustices and campaigning for a 'rights-based' approach to mental illness.⁴⁹

But despite this radical backdrop, the philosophers, lawyers and theologians who engaged with medical ethics in the 1960s and 1970s did not critique medicine. They portrayed themselves as ancillaries to doctors: providing guidance on certain issues but not seeking an active role in policy formation. In 1976, Campbell argued their aim was simply to help doctors make 'more informed decisions'.⁵⁰ Like Kennedy, he did not critique self-regulation and stressed: 'The final decisions remain medical ones and the responsibility remains with that profession'.⁵¹ This stance clearly irked Ivan Illich, who ridiculed medical ethics as little more than 'medical masturbation' at a 1975 LMG meeting.⁵²

This was not the case in the United States. Here, amidst the growing interest in civil and human rights, philosophers, lawyers and theologians claimed that patients and experimental subjects had an inviolable right to self-determination that was ill-served by medical paternalism. Following controversies over the withholding of syphilis drugs from African Americans in Alabama, and non-consented experiments on institutionalised children in New York, the Yale lawyer Jay Katz argued that fundamental questions needed to be asked about 'the nature of authority assigned to physicians'.⁵³ Katz claimed doctors possessed no unique expertise that justified making them the sole arbiters of medical ethics, and proposed that patients and experimental subjects should be safeguarded through 'more active participation of non-scientists in research decisions'.⁵⁴ Echoing Plato's question in the *Republic*, he asked: 'Who is to keep guard over the guardians themselves?'⁵⁵

These demands were clearly successful, and bioethicists soon had a say in the development of regulatory policies. In 1974, President Richard Nixon responded to controversies over human experimentation by establishing a fixed-term National Commission for the Protection of Human Subjects in Biomedical and Behavioural Research. The Act that established the Commission notably stipulated that no more than five of its eleven

⁴⁶Johnson and Freeman (eds) 1999.

⁴⁷Dean, 2010, pp. 180–2; Rose 1999, pp. 141–3.

⁴⁸Illich 1977, p. 19.

⁴⁹Crossley 2006.

⁵⁰Campbell 1976, p. 2.

⁵¹Ibid.

⁵²Campbell 2009.

⁵³Katz 1972a, p. 606.

⁵⁴Katz 1972b, p. 1.

⁵⁵Katz 1972a.

members should be doctors or scientists, with the majority drawn from philosophy, law, theology, sociology or the general public. The Commission's recommendations, issued as the *Belmont Report*, made respecting patient autonomy a guiding principle for all biomedical researchers.⁵⁶ The influence of bioethics in the USA was confirmed in 1978, when President Jimmy Carter formed a permanent Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

Although the *British Medical Journal* dismissed bioethics as an 'American trend' in 1978, there were signs this approach was making inroads in Britain, primarily due to Ian Kennedy, now working at King's College London. Rejecting his previous support for medical paternalism, Kennedy became a strong advocate of patient empowerment and outside involvement in the development of professional guidelines. In a 1976 *Criminal Law Review* article, he argued that patients had a fundamental right to autonomy that overrode the medical view that 'decisions concerning a person's fate are better made for him than by him'.⁵⁷ This, he claimed, included terminally ill or elderly patients who wished to discontinue treatment that was keeping them alive.

The same year, in the *Journal of Medical Ethics*, Kennedy stated that decisions regarding ventilated patients were 'not merely medical matters', but 'involved considerations of morals, ethics and religion as well as law and medicine'.⁵⁸ Contrary to his previous belief that decisions should 'be left wholly to the medical profession', he now proposed that doctors adopt a code of practice 'worked out by the medical profession after consultation with lawyers, theologians and other interested parties'.⁵⁹ After meeting a BBC radio producer, Kennedy had the chance to make these arguments in public. Between 1976 and 1978, he presented several one-off programmes on the care of disabled babies, euthanasia and reform of the Mental Health Act.⁶⁰ In his 1977 documentary *The Check-Out*, Kennedy asserted that euthanasia was 'a matter on which not just doctors or lawyers, but all of us, must have our say and our way'. The only way to ensure this, he concluded, was to give 'all interested parties' a role in the development of regulatory codes.⁶¹

What influenced Kennedy's retreat from paternalism? During the early 1980s, he voiced support for Illich's views on medical power, and praised Gostin's 'brilliant' work with MIND.⁶² Yet his greatest influence appeared to be the bioethical discourse he encountered in the 1970s, first at UCLA and then during a year at the University of California, San Diego. Kennedy admits he was struck by the arguments of US bioethicists 'when we were doing nothing in this country'.⁶³ This was evident in a 1979 lecture, when he outlined and praised Jay Katz's 'brilliant insights'.⁶⁴

Seeing bioethics as a major influence on Kennedy's work also helps us ascertain why he became so influential. Like Katz, who promised not to 'indict science or stifle research', Kennedy claimed oversight would benefit medicine: providing doctors with a workable framework that reflected the changed social climate and helped them overcome the radical critiques of Illich *et al.*⁶⁵ He spent most of his *Criminal Law Review* piece assuring

⁵⁶Ibid.

⁵⁷Kennedy 1976a, p. 219. Emphasis in original.

⁵⁸Kennedy 1976b, pp. 3, 5.

⁵⁹Kennedy 1976b, p. 4.

⁶⁰Kennedy 2010.

⁶¹Kennedy 1988c, p. 314.

⁶²Kennedy 1980a, 1988a, p. 17. The latter reference is the transcript of a 1983 lecture given in Cambridge.

⁶³Kennedy 2010.

⁶⁴Kennedy 1988b, p. 27. This is a reprint of the 1979 Astor Memorial Lecture, given at Middlesex Hospital.

⁶⁵Katz 1972b, p. 5.

doctors that, barring a few exceptional cases, they would not be prosecuted for respecting a terminally ill patient's wish to die. Meeting the growing demand for self-determination, he concluded, was less likely to prompt a legal challenge than the traditional approach of 'doctor knows best'.⁶⁶ And in a 1979 lecture at the Middlesex Hospital, he sympathised that:

I think it is unfair that responsibility in many areas of human concern has been improperly shifted onto doctors by the rest of us, simply because we are happy to have others bear this responsibility, and because the doctor, at least initially, seems prepared to take it on.⁶⁷

Kennedy promised that a more active role for outsiders would help doctors resolve the 'many hard decisions which it is not really their job to make'.⁶⁸

This conciliatory approach made little headway, for Kennedy protested that 'the moment I offer guidance or suggest what should be done, I am met with a chorus of cries, all variations on the theme that I do not really understand, that these are medical matters after all, that I should not trespass on the professional competence of others'.⁶⁹ While doctors may have encouraged greater discussion of medical ethics, they were less enthusiastic about devolving power to outsiders. In 1977, the British Medical Association argued that outside involvement would damage the doctor-patient relationship, 'endanger research, increase waiting-lists and threaten the health and morale of doctors'.⁷⁰ But this attitude softened in the 1980s, when political changes fostered the 'audit society'.⁷¹ Kennedy's arguments carried greater weight amidst a Conservative emphasis on oversight and public accountability, and senior doctors conceded that paternalism appeared untenable. He consequently became central to a growing form of public debate and regulation, which newspapers and the medical press labelled 'bioethics'.

'Who's for Bioethics?'⁷²

In 1979, a year after he established a Centre for Medical Law and Ethics at King's College, the BBC invited Kennedy to give its prestigious Reith Lectures on Radio 4. His lectures, provocatively titled *Unmasking Medicine*, were broadcast in November and December 1980. The six half-hour talks covered a range of subjects and incorporated several influences. The first drew on Illich and Foucault to claim that medical definitions of health and illness should be understood 'in terms of power', as ideological judgements with profound social consequences.⁷³ The second and third drew on critics from within medicine, primarily Thomas McKeown, who argued that doctors focused too much on interventionist methods to the detriment of nutrition, education, living and working conditions. The fifth again used Foucault to critique definitions of mental illness. At the heart of each of these lectures lay Kennedy's central message:

The power now is with the professional. Only when it is realised that health is too important to be left to doctors, that it is a matter for all of us, will conditions be

⁶⁶Kennedy 1976a, p. 226

⁶⁷Kennedy 1988b, pp. 23–4.

⁶⁸Kennedy 1988b, p. 24.

⁶⁹Ibid.

⁷⁰Anon 1977, p. 1238.

⁷¹Power 1997.

⁷²Anon 1986, p. 1016.

⁷³Kennedy 1980a, p. 601.

created for the necessary redirection of effort and resources. Only then will any real movement towards health be achieved.⁷⁴

Lectures four and six proposed solutions to this 'dismal diagnosis'.⁷⁵ In the fourth, Kennedy argued doctors should 'conform to standards and principles set down by all of us'.⁷⁶ One solution, he argued, was to have medical ethics taught 'by an outsider, someone who is not deafened by the rhetoric of medicine'.⁷⁷ The sixth lecture endorsed a 'consumerist' approach to medicine: where outsiders, including patients, played a major role in 'establishing standards which doctors must meet in their practice, measuring the doctor's performance in light of these standards, and in creating means of redress if these standards are breached'.⁷⁸ These reforms, Kennedy concluded, were the only way to 'reshape medicine so it may better suit our needs'.⁷⁹ Introducing a book to accompany the Reith Lectures, he claimed this oversight involved 'ethics and law, together with sprinklings of philosophy, sociology and politics'. While he admitted there was no 'single label for it' in Britain, Kennedy noted that in the USA it 'goes by the name of "Bioethics"'.⁸⁰

Kennedy's enthusiasm for oversight, and his call for the public to 'take back control of medicine', dovetailed with the ideological core of Margaret Thatcher's Conservative Party, that won the 1979 general election. While they were in thrall to private enterprise, politicians on the right of the Conservative Party, including Keith Joseph and Nicholas Ridley, harboured deep distrust of state-supported professions and sought a coherent strategy for reforming them.⁸¹ In doing so, they drew less on leftist figures like Illich and more on neo-liberal theorists like William Niskanen, who believed that welfare states had allowed professions to become overly bureaucratic and self-serving, and argued the solution lay in remodelling them on market lines.⁸² As Nigel Lawson declared in 1980, the new government sought to 'break from the predominantly social democratic assumptions that have underlain policy in postwar Britain' by exposing many professions and public services to 'the disciplines of the market'.⁸³ This involved promoting outside scrutiny as a way of devolving power from professionals to end-users—to parents, patients, students, etc.—and enabling them to make decisions that furthered their own interests. Reflecting the Conservative commitment to 'rolling back the frontiers of the state', this scrutiny was not performed directly by politicians but was entrusted to an array of consultants and agencies who acted as proxy for consumer interests.⁸⁴

This ethos ensured that across teaching, academia, medicine, social services and local government, reliance on professional expertise gave way to new mechanisms of external audit designed to enforce value-for-money, public accountability and consumer choice. Change was gradual and proceeded well into the 1990s, but Lawson's speech demonstrates that the Conservatives voiced their intentions early on. This was certainly not lost on the medical profession. While some doctors rejected the Reith Lectures as populist

⁷⁴Kennedy 1980a, p. 602.

⁷⁵Chorlton 1980, p. 3.

⁷⁶Kennedy 1980b, p. 713.

⁷⁷Kennedy 1980b, p. 715.

⁷⁸Kennedy 1980c, p. 2.

⁷⁹Ibid.

⁸⁰Kennedy 1981a, p. vii.

⁸¹Dean 2010; Rose 1999; Perkin 1989, pp. 472–80.

⁸²Niskanen 1973.

⁸³Lawson 1980, pp. 6–7.

⁸⁴Lawson 1980, p. 5; Rose 1999.

'doctor-bashing', senior figures like J. D. Swales urged colleagues to heed Kennedy's proposals because they 'enjoy the advantage of following the current political tide'.⁸⁵ Sir Douglas Black, the president of the Royal College of Physicians, similarly identified *Unmasking Medicine* as 'representative of the forces which seek to effect a radical change in the focus of medicine'.⁸⁶ While the psychiatrist Stephen Little criticised Kennedy for a lack of concrete proposals, he also conceded that: 'To follow the rhetoric of the present government, the public must become more fully informed of the pressures on its medical practitioners and administrators, of the shortcomings as well as the advances'.⁸⁷ And Michael Thomas, chair of the British Medical Association, stated that 'the era which required paternalism is past' and called for 'a situation where all doctors are willing to accept that the public has a right to take part in the decisions on major moral and ethical issues'.⁸⁸

This complicates the 'origin myth' that bioethics was opposed by a recalcitrant medical profession. Far from simply 'ruffling feathers', Kennedy's views resonated with senior doctors attuned to political changes, who saw the benefits, or inevitability, of external oversight. These changes were compounded between 1982 and 1984, when politicians and public figures echoed Kennedy's calls for external oversight of medicine. This often arose in discussion of IVF, after the Cambridge physiologist Robert Edwards admitted to experimenting on early human embryos *in vitro*. Several newspapers and politicians called for a public inquiry; and Kennedy used the controversy to publicly reiterate that regulation 'cannot be left to one professional group'.⁸⁹ He was now joined, moreover, by the Labour MP Leo Abse, who claimed medical ethics was 'too important to be left to doctors', and by the lawyer Geoffrey Robertson, who stated 'interdisciplinary co-operation and public participation' was needed to handle 'the present, not to mention the future, dilemmas of bio-ethics'.⁹⁰

When the government assembled an inquiry into IVF in July 1982, figures at the Department of Health and Social Services notably prioritised the appointment of 'an outside chair' and ensured that members of other professions outnumbered doctors and scientists on the committee.⁹¹ The inquiry was chaired by the philosopher Mary Warnock, who became a firm advocate of external oversight. Her inquiry's report bore the hallmarks of the broader 'audit society': recommending that IVF be scrutinised by a regulatory body with 'substantial lay representation' and a non-scientific chairman.⁹² In 1983, another outsider, the businessman Sir Roy Griffiths, was selected to lead an inquiry into NHS management. Reflecting the government's enthusiasm for market-oriented reform, the other inquiry members were executives from British Telecom, United Biscuits and Television South West. Their report claimed that: 'Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question'.⁹³

⁸⁵Cruikshank 1981, p. 312; Swales 1980, p. 1348.

⁸⁶Black 1981, p. 2044.

⁸⁷Little 1981, p. 190.

⁸⁸Thomas 1981, p. 182.

⁸⁹Kennedy 1982, p. 17.

⁹⁰Robertson 1982; Anon 1982.

⁹¹Wilson 2011.

⁹²Warnock 1985, p. 76. This inspectorate was established as the Human Fertilization and Embryology Authority in 1991.

⁹³Griffiths 1983, p. 2.

In a further blow to medical paternalism, the inquiry suggested the NHS would be better run by general managers recruited from outside the medical profession.⁹⁴

Surveying this changing landscape in 1984, the philosopher Raanan Gillon claimed the 1980s had witnessed the end of ‘medicine’s halcyon days when doctors—for the most part only senior doctors—discussed the dilemmas of medical ethics in privacy and leisure’. Now, he claimed, ‘everyone is muscling in’; and this was notably ‘abetted by the lawyer whom doctors love-hate, Professor Ian Kennedy’.⁹⁵ While he was no longer the sole advocate of oversight, Kennedy continued, in Gillon’s words, to ‘vigorously stir the pot’. Indeed, his regular calls for external scrutiny led the *Lancet* to dub him ‘the ubiquitous Ian Kennedy’.⁹⁶ As well as writing on IVF for *The Times*, he presented a radio documentary that called for inspectorates to ‘ensure proper accountability’ across many professions.⁹⁷ And in 1983, he hosted the BBC television series *Doctors’ Dilemmas*, where actors presented a doctor with an ethical dilemma and the outcome was scrutinised by a studio panel. As a review noted, the programme’s message, like all Kennedy’s work, was that growing demands for patient empowerment could only be answered by ‘interdisciplinary discussion and debate’.⁹⁸

Kennedy used his high profile to reassert that oversight would benefit doctors. In his final Reith Lecture, he promised that if it were implemented, ‘it wouldn’t only be the patient who would gain. The doctor too would benefit, as would the practice of medicine’.⁹⁹ He expanded on these benefits in the *Journal of Medical Ethics*, rejecting his portrayal as a ‘doctor-basher’. Here, he criticised the tendency to label all non-doctors as ‘laymen’, which rhetorically stripped them of competence. He argued that philosophers and lawyers were trained to analyse ethical or legal issues, and that when confronted with particular dilemmas ‘it may be the doctor who is the layman’.¹⁰⁰ Kennedy claimed that external input would thus offer ‘great help to doctors if only they would understand that it offers a guide to what they need to do where none existed before’.¹⁰¹ In a 1984 article for the *Modern Law Review*, he sought to reassure doctors that involving outsiders in medical decisions would not increase litigation. He claimed, on the contrary, that forming a multidisciplinary inspectorate that issued codes of practice, on the lines of the US President’s Commission, would decrease claims against doctors by aligning medicine with public expectations.¹⁰² This was also evident in a revised book of the Reith Lectures, where Kennedy promised that bioethics would ‘produce guidelines for future conduct, tools for analysis, which will forearm the doctor’. He stressed his aim was not to supplant doctors, but was to develop ‘a relationship of partners in the enterprise of health’.¹⁰³ The stress on ‘partners’ helped Kennedy frame bioethics as a collaborative endeavour, where lawyers, philosophers, politicians and patients were ‘not interfering, but trying to help’.¹⁰⁴

By the mid-1980s, growing numbers of doctors appeared to agree. A *Nature* editorial, for instance, claimed that Warnock’s proposed inspectorate would benefit scientists by

⁹⁴Klein 2010, pp. 117–23.

⁹⁵Gillon 1984, p. 16.

⁹⁶Anon 1983b, p. 1026.

⁹⁷Kennedy 1981b, p. 206.

⁹⁸Gillon 1983, p. 715.

⁹⁹Kennedy 1980c, p. 777.

¹⁰⁰Kennedy 1981b, p. 207.

¹⁰¹Kennedy 1981b, p. 204.

¹⁰²Kennedy 1984.

¹⁰³Kennedy 1983, p. 124.

¹⁰⁴Kennedy 1983, p. 115.

making IVF 'socially palatable'.¹⁰⁵ And a *Lancet* review of *Doctor's Dilemmas* identified oversight as 'an uneasy but necessary compromise' that had become vital to protecting interests of 'the individual patient, those of the doctor, and those of scientific progress'.¹⁰⁶ If 'difficulties and decisions were aired more widely', it noted, 'decision-making might be more even and suspicions might be allayed'.¹⁰⁷ In 1986, another *Lancet* article claimed that what it now called 'bioethics' would safeguard 'not only patients but also doctors and the institutions in which they work'. Outside involvement, it concluded, would help doctors develop guidelines, prevent litigation and ration 'the available and now inadequate resources of the National Health Service'.¹⁰⁸

Unsurprisingly, then, Kennedy's expertise was increasingly sought as the 1980s progressed. Between 1984 and 1988, he was appointed to the General Medical Council, a parliamentary Commission on the Safety of Medicines, the government's Expert Advisory Group on AIDS, and a review of guidelines for research on fetuses and foetal tissues.¹⁰⁹ In 1990, he was a founding member of the new Nuffield Council on Bioethics, which was bankrolled by the Wellcome Trust and the Medical Research Council after political and medical demands for a national ethics committee.¹¹⁰ These appointments and the formation of a national council, which Kennedy had long endorsed, illustrate the political and medical utility of bioethics.¹¹¹ Recruiting lawyers and philosophers to medical bodies gave the impression that doctors were making themselves publicly accountable, safeguarding them from criticism. And their presence on advisory or regulatory committees helped politicians challenge vested professional interests, fulfilling the neo-liberal enthusiasm for oversight. But we cannot fully explain the growth of bioethics without also investigating the actions of putative 'ethics experts' like Ian Kennedy. Throughout the 1980s, as we have seen, Kennedy positioned himself between politicians and the medical profession: echoing political demands for oversight and empowered consumers, whilst promising that bioethics would 'forearm doctors'.

But this does not equate to the positivist accounts of 'moral progress' found in participant histories.¹¹² Despite the growing support for bioethics, only contentious new procedures like IVF were subject to interdisciplinary scrutiny into the 1990s, while many of the Nuffield Council's recommendations went unheeded.¹¹³ Moreover, to Kennedy's obvious frustration, judges still relied on the 'reasonable doctor' rule during malpractice suits, allowing doctors to continue setting the legal standard for clinical care.¹¹⁴ If we are to read bioethics as a decisive shift in the location of biopower, then these 'ethics experts' appear only to have made inroads into regulatory committees and public debate. In the clinic and the courtroom, as before, doctors remained the arbiters of best practice.

This, however, looked set to change at the turn of the twenty-first century. In 1999, Frank Dobson, Secretary of State for Health in Tony Blair's 'New Labour' government, responded to an public outcry over mismanagement of paediatric heart surgery at

¹⁰⁵Anon 1983a, p. 735.

¹⁰⁶Anon 1983b, p. 1026.

¹⁰⁷Ibid.

¹⁰⁸Anon 1986, p. 1016.

¹⁰⁹Kennedy 2010.

¹¹⁰Lewis 1988; Lock 1990.

¹¹¹Kennedy 1988b.

¹¹²Cooter in Pickstone and Cooter (eds) 2000, p. 435.

¹¹³O'Neill 2009.

¹¹⁴This frustration was evident in an updated version of his 1984 *Modern Law Review* article; see Kennedy 1988d.

Bristol Royal Infirmary by appointing Kennedy as chair of a public inquiry. Kennedy's report claimed patients were being let down by a paternalistic 'club culture' in the NHS, and recommended the establishment of a 'system of external surveillance ... to identify good and failing performance'.¹¹⁵ This proposal underpinned the 2004 formation of a Commission for Healthcare Audit and Inspection (CHAI), which was chaired by none other than Sir Ian Kennedy. As before, Kennedy stressed the CHAI would help doctors 'through the barriers that prevent them seeing patients as interactive partners'.¹¹⁶ It set out to do this by rating the performance of NHS trusts through an annual 'health check', which involved assessing vast data submissions, as well as through visiting 20 per cent of trusts each year.

But the inspectorate Kennedy had long championed was short-lived and contested. Its brief tenure coincided with a backlash against oversight, as doctors and public figures increasingly turned on the 'audit society'. Senior doctors claimed the 'ideology of accountability' had simply provided a Trojan horse for new professional elites to exercise 'hierarchical domination' of doctors.¹¹⁷ *The Lancet*, more damningly, claimed the CHAI's 'unaccountable' health checks 'inculcated an environment of prejudice, anxiety and resignation into the workplace'.¹¹⁸ This backlash was encapsulated by the philosopher Onora O'Neill's 2002 Reith Lectures, *A Question of Trust*. Like Kennedy, O'Neill was a founding member of the Nuffield Council on Bioethics and preceded him as its chair in the 1990s. But in contrast to *Unmasking Medicine*, she used the Reith Lectures to claim that systems designed to ensure public accountability simply deepened the mistrust they sought to remedy, and had become subjected to criticism themselves.¹¹⁹

This was certainly true of the CHAI, which provided a scapegoat when poor conduct was publicly exposed. Doctors argued their performance was suffering due to targets that bore 'little relation to local priorities', while politicians criticised the CHAI as symptomatic of an 'ill-defined' regulatory sector.¹²⁰ When the CHAI was quietly shelved in 2008, Kennedy bemoaned the increasing tendency to see 'regulation as part of the problem rather than the solution'.¹²¹

This complaint, notably, could just as well have been aimed at a new generation of bioethicists, who argued that preoccupation with 'a consumerist model of the professional-client relationship' had left bioethics 'stale and tedious'.¹²² They did so, notably, amidst a changing political landscape that may further constrain the demand for the oversight of medicine. As part of its ideological rejection of 'big government', and partly out of financial expediency, the Conservative-Liberal Democrat coalition is disbanding many regulatory bodies established in the 1980s and 1990s, with Prime Minister David Cameron promising 'no interference—just real power for professionals'.¹²³ Today, neither the government, nor many bioethicists, share Kennedy's belief that oversight is the best way to ensure public accountability. As Onora O'Neill pointed out, it appears there is 'no complete answer to the old question: "who will guard the guardians?"'¹²⁴

¹¹⁵Kennedy 2001, p. 3.

¹¹⁶Kennedy 2003, p. 1276.

¹¹⁷Charlton 1999, p. 3

¹¹⁸Horton 2004, p. 402.

¹¹⁹O'Neill 2002a.

¹²⁰Horton 2004; Santry 2008.

¹²¹Santry 2008.

¹²²Dawson 2010, p. 221. See also Ashcroft 2010.

¹²³Cameron 2010.

¹²⁴O'Neill 2002a, p. 6. Emphasis in original.

Conclusion

Accounts that historicise the 'new politics of medicine' often take a top-down approach, focusing primarily on the consumerist ambitions of neo-liberal politicians.¹²⁵ But I have demonstrated that bioethics, a major component of this 'new politics', emerged due to interaction between personal, political and professional agendas during the 1980s. Kennedy's belief that the inequities of the doctor–patient relationship could be redressed by involving outsiders in the development of medical guidelines reflected 'the sense of social justice' he inherited from civil rights campaigns of the 1960s and 1970s.¹²⁶ But while his proposals originated in leftist politics, they became influential in the 1980s and 1990s thanks to the way they mapped onto the neo-liberal desire for accountable and 'customer-focused' public services.¹²⁷ We have seen, moreover, that Kennedy's calls for oversight were not simply shaped by this broader 'audit society' but were an important constituent of it.

But the demand for oversight did not emanate solely from Kennedy or politicians. While there were disgruntled voices at the outset, doctors were certainly willing partners in the emergence of bioethics. This stemmed partly from their sensitivity to the 'political tide'; but it also stemmed from the way that Kennedy framed bioethics as advantageous to medicine. This undermines the 'origin myth' that portrays bioethics as a radical critique of a conservative and reluctant medical profession. Indeed, Kennedy acknowledged this in 2007, telling the *Guardian* he would have been ignored by politicians and doctors if he was nothing more than 'a pain in the neck'.¹²⁸

This helps us identify what bioethics is, and why it became influential. As Charles Rosenberg states, it is best viewed as a 'mediating element' between different professional groups and social worlds.¹²⁹ But as I outlined above, bioethics may no longer retain the socio-political appeal it recently enjoyed. While politicians shrink the regulatory excesses of the 'audit society', bioethicists now argue that the stress on oversight has damaged public trust and needs to be replaced by a focus on global health inequalities and a more 'principled autonomy'.¹³⁰ They warn that bioethics faces 'retrenchment and decline' unless it can meet this challenge and answer questions about its own legitimacy.¹³¹ With this in mind, we may come to see the 1980s and 1990s not as the beginning of bioethics in Britain, as per the 'origin myths', but as its high-water mark: when Ian Kennedy's emphasis on public accountability and patient autonomy complemented the neo-liberal demand for audit and consumer choice.

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¹²⁵Salter 2004*b*.

¹²⁶Kennedy 2010.

¹²⁷Dean 2010, p. 181.

¹²⁸Carvel 2007.

¹²⁹Rosenberg 1999, p. 38.

¹³⁰O'Neill 2002*b*; Dawson 2010.

¹³¹Turner 2009, p. 779.

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