International Journal of Law in Context

http://journals.cambridge.org/IJC

Additional services for ***International Journal of Law in Context:***

Email alerts: Click here
Subscriptions: Click here
Commercial reprints: Click here
Terms of use : Click here

Migration and access to health care in English medical law: a rhetorical critique

John Harrington

International Journal of Law in Context / Volume 4 / Issue 04 / December 2008, pp 315 - 335
DOI: 10.1017/S1744552309004029, Published online: 15 May 2009

Link to this article: http://journals.cambridge.org/abstract_S1744552309004029

How to cite this article:
John Harrington (2008). Migration and access to health care in English medical law: a rhetorical critique. International Journal of Law in Context, 4, pp 315-335 doi:10.1017/S1744552309004029

Request Permissions : Click here

CAMBRIDGE JOURNALS

Downloaded from http://journals.cambridge.org/IJC, IP address: 131.251.254.13 on 25 Feb 2014

International Journal of Law in Context, 4,4 pp. 315–335 (2009) Cambridge University Press
doi: 10.1017/S1744552309004029 Printed in the United Kingdom

Migration and access to health care in English medical law: a rhetorical critique

John Harrington
Professor of Law, The Liverpool Law School, University of Liverpool[1]

Abstract

This paper develops a rhetorical critique of recent cases on migration and access to health care in Britain. It argues that the national territory, once a taken-for-granted starting point for reasoning in medical law, has lost its common-sense status as a result of neoliberal globalisation. This is evident in recent decisions involving on the one hand HIV-positive asylum seekers coming to the UK and on the other hand British 'health tourists' seeking funding for treatment elsewhere in the European Union. Courts are aware that many of these cases are likely to call forth the sympathy of audiences for the individual concerned, further undermining their privileging of the national scale. In curbing this 'politics of pity' they adopt a range of persuasive strategies.

Introduction

Heath care services across the world are increasingly commodified under the influence of international economic law and the reforming drive of national elites. The commodification of medicine is manifested in two contradictory tendencies (Harrington, 2007). On the one hand, access is expanded through the creation of cross-border markets benefiting well-resourced patients (Chanda, 2002) On the other hand, access is restricted through the global strengthening of monopoly patent rights over essential drugs ('t Hoen, 2002). Both tendencies generate pressure for mobility, though this is differentially realised in practice. 'Health tourism' from rich to poor countries, or as between rich countries, is encouraged as a means of reducing the burden on domestic systems and as an invisible export for the receiving nation. World trade law is devoted to assisting this sort of population movement (Arnold, 2005). The health catastrophe unfolding among the majority of the world's population equally encourages migration in search of treatment: from poor to rich countries (Aginam, 2000). However, this movement is resisted by an extensive legal and security apparatus at the frontiers of the developed world.

These developments in health care are reflected in the changing case-load of national courts. In Britain, for example, the 1970s and 1980s were marked by legal challenges to the allocation of resources within the National Health Service (NHS) (Newdick, 2005, p. 98). The decisions in these cases presumed a territorially bounded health system over which parliament was sovereign. By contrast, the last ten years have seen an increase in patients seeking to travel abroad for health care, which is either not funded or prohibited by law in the United Kingdom (Newdick, 2006). Equally, incomers to Britain have challenged adverse immigration and asylum decisions on the basis that their most basic health needs would otherwise go unmet. The courts have strained to apply common law and statute, as well as the relevant provisions of European Union and European human rights law, in the resolution of these cases. An adequate explication of these decisions in terms of legal doctrine is of the greatest practical importance to lawyers, litigants and policy-makers. My objective in this paper is somewhat different,

1 An earlier version of this paper was presented at the conference 'Theorizing the Global Legal Order', held at Swansea University on 21–22 May 2008. I am grateful to participants for their insightful comments and suggestions. Thanks are also due to Ambreena Manji for commenting on earlier drafts.

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

however. I wish to examine the connections between decisions of this sort and the broader political and economic context in which they are made. In particular, I am concerned to investigate judicial responses to the changing global geography of health care. Put briefly, these responses are informed by the declining plausibility of national territory as an implicit frame for disputes regarding access to health care and uncertainty as to what frame, if any, is to replace it.

In seeking to clarify the tensions and shifts in judicial reasoning I draw on classical and modern theories of rhetoric. These offer tools for analysing the strategic dimensions of judicial speech and linking it to its changing contexts. My investigation takes as its focus the 2005 decision of the House of Lords in *N v Secretary of State for the Home Department*[2] (hereinafter *N*). Their Lordships ruled in that case that a failed asylum seeker infected with HIV could not challenge her deportation, even though this would result in the effective cessation of life-sustaining treatment. Given its pedigree, this decision is of great formal importance within the British legal system. But, as is clear, it also influences the prospects and behaviour of individuals and institutions in the rest of the world. The House of Lords can, thus, be seen as a 'node' within an emerging network of global health governance, which includes courts, governments, companies, international bodies and non-governmental organisations in different locations.[3] The power of such nodes lies, not only in their capacity to compel certain behaviours, but also in the development of more or less legitimate rhetorics as regards global health problems (Braithwaite and Drahos, 2000, p. 528).

This essay is arranged as follows. In the next section I consider in detail the facts and reasoning of the House of Lords in *N*, which was subsequently confirmed by the European Court of Human Rights.[4] The following sections focus on the 'means of persuasion' in rhetoric elaborated by Aristotle and others. These refer to the common-sense assumptions shared between speaker and audience, the emotions evoked in the audience by the speaker, and the positive character traits of the speaker which may sway an audience. Their combined force depends on the local and historical context within which they are deployed. Thereafter I seek to show the importance of state policies and institutions in 'producing' spaces and scales. Britain's National Health Service made a profound contribution to the material production of national space and the creation of a nationally defined common sense regarding health care entitlements. More recent reforms, as well as the broader trends already mentioned, mean that the national scale is no longer wholly predominant in the organisation and representation of health care delivery in Britain. The judgments in *N* are then considered from this perspective. It will be seen that national scale of health care entitlement was deployed to check N's cross-border quest for therapy. But what was previously implicit now had to be openly asserted by judges under scrutiny, not just from the rest of the legal community, but also from activists, the media and the general public. Moreover, the House was concerned to contain and displace the emotions raised by the facts of the case in order to secure the plausibility of their own judgments. This rhetorical strategy can be explained with reference to Hannah Arendt's work on the risks presented by an untrammelled 'politics of pity'.

The decision in *N v Secretary of State for the Home Department*

N concerned a Ugandan national who had sought asylum in Britain in 1998. Ms N had been kidnapped by the insurgent Lord's Resistance Army and held for two years.[5] On being captured by

2 [2005] UKHL 31.

3 On nodal governance in the area of global health, see Burris, Drahos and Shearing (2004) and Dodgson, Lee and Drager (2002).

4 *N v. United Kingdom*, Application No. 26565/05, Judgment of 27 May 2008 (ECtHR).

5 It was suggested by Baroness Hale that this matter, though not raised before the House of Lords, could have been given fuller consideration in the original decision on her refugee status [2005] UKHL 31 at para [58].

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

the Ugandan army she was subjected to rape and further ill-treatment. Soon after her arrival in Britain Ms N was diagnosed as HIV-positive, having a CD4 cell count of 10; the normal count is 500. She was successfully treated with anti-retroviral drugs, which restored her CD4 cell count to 414. With the therapy she would remain well for decades; without it she would die in great pain inside two years. Her application for asylum was refused by the Home Secretary. She claimed before an Immigration Appeal Tribunal (IAT) that deportation would violate her right to freedom from torture and inhuman and degrading treatment under Article 3 of the European Convention on Human Rights (ECHR). In Uganda anti-retroviral therapy was more expensive than she could afford. A terrible death would be the inevitable consequence of her forced return.

The IAT, Court of Appeal and House of Lords all rejected this claim. Under s.2(1) Human Rights Act 1998 they were required to take into account the jurisprudence of the European Court of Human Rights, and in particular its 1997 decision in *D v. UK*.[6] There D successfully invoked Article 3 of the Convention to resist his deportation from Britain to St Kitts. He had entered the final stages of AIDS-related illness. Given the lack of medical facilities in St Kitts, the absence of any family support there, and his residence in a UK hospice, it would amount to inhuman and degrading treatment to return him. The difficult task of distinguishing the facts of *D* from N's case was achieved through a close study of the subsequent Strasbourg jurisprudence.[7] In all except two out of nine cases an appeal to remain in a Convention state on grounds of mortal medical need under Article 3 was rejected. The European Court of Human Rights had confined the ratio of *D v. UK* to cover only cases where the applicant was already terminally ill.[8] By contrast, those benefiting from anti-retroviral therapy were invariably in good health at the time of the trial. Though their deportation to a developing country would mean the end of therapy and certain death, they fell outside the facts of *D* and thus also outside the protection of Article 3. These decisions were clearly influenced by the development of (costly) anti-retroviral therapies in the years after D was decided (Palmer, 2005, p. 537).

As Laws LJ had held in the Court of Appeal in *N*, the protection afforded in *D v. UK* was an 'extension of an extension' of the core meaning of Article 3.[9] The Convention aimed to protect individuals from inhuman and degrading treatment by signatory states. In *Chahal v. UK*[10] this had been extended to cover the direct actions of non-signatory states. There it was held that a Sikh militant could not be deported from Britain for fear of being tortured on arrival by agents of the Indian state. Article 3 was further extended in *D* to include circumstances of extreme human need caused by no direct state action at either end. In the present case Laws LJ, and a unanimous House of Lords, held that the scope of Article 3 should be confined to this extent. Beyond *D*, there might be 'other exceptional cases, with other extreme facts where the humanitarian considerations are equally compelling'.[11] But the facts in *N* were not of this order. Thousands in a similar position arrive in the UK every year.[12] The reasoning of the House of Lords was subsequently endorsed by a majority of the European Court of Human Rights (ECtHR), which confirmed that there had been no violation of Article 3.[13]

6 (1997) EHRR 425.

7 The fullest discussion is to be found in the judgment of Lord Hope, with which the other Law Lords concurred, see [2005] UKHL 31 at paras [37–48].

8 One case concerned a patient with long term psychotic illness (*Bensaid v. UK* (2001) 33 EHRR 205), It was considered to come within the ratio of *D v. UK*. All the others involved HIV-positive migrants.

9 [2003] EWCA Civ 1369 at para [37].

10 (1997) 23 EHRR 413.

11 [2005] UKHL 31 per Lord Hope at para [70].

12 [2003] EWCA Civ 1369 per Laws LJ at para [40].

13 Application No. 26565/05, Judgment of 27 May 2008 (ECtHR).

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

The uses of rhetoric

It is clear that the decision in *N* did not simply unfold from fundamental principles. Rather the conclusion of the House of Lords was arrived at by way of disanalogy. The facts of *N* were held to be insufficiently similar to those in *D* to allow the same rule to be applied in the later case. Analogy and disanalogy are familiar forms of legal reasoning.[14] But they are never logically compelling in and of themselves.[15] This is borne out by the opinion of the ECtHR minority in *N*. For the dissenting judges, the 'practical realities' of the case were that N would endure great suffering soon after returning to Uganda.[16] By contrast with the ECtHR majority and the unanimous House of Lords, they held that any difference with D's case was merely superficial.[17] Whichever view of a precedent case is taken, judges are required to make a specific effort to show that their conclusion is plausible.[18] In doing so, they deploy a variety of persuasive strategies historically comprehended within the study of rhetoric.

By contrast with logical demonstration, rhetoric is concerned with things which admit of being otherwise (Aristotle, 1991, p. 77 [1357a]). It treats of the probable, not the certain; the reasonable not the rational. It focuses on the skill of a speaker, such as a judge or advocate, in crafting and presenting arguments. As such it offers a mode of reading cases sensitive to the common law's traditional lack of system, as well as recent theoretical insights into contingency and indeterminacy in law.[19] It also allows us to relate a particular decision to its broader social and political setting, without falling into simple determinism. This is so because, as Kenneth Burke pointed out, persuasion is more likely where a speaker achieves 'consubstantiality' or identification with her audience.[20] She must show that she is 'one of them', speaking their language and sharing their values and understanding of the world.

In Peter Goodrich's words, given this public dimension, rhetorical analysis can be seen as:

> 'political criticism in its classical sense of the study of arguments related to the historical situation and immediate needs of the community (*polis*) to which the speech or discourse is addressed.'[21]

This approach to health care law contrasts strongly with the dominant mode of analysis, which seeks to ground judicial and academic reasoning in timeless and universal principles of human rights and bioethics.[22] It is true, of course, that such principles have played a growing role in medical jurisprudence since the incorporation into British law of the European Convention on Human Rights.[23] But, in themselves, they do not offer much help in tracking the development of the relevant law in a given jurisdiction over time.[24] Rather, their exclusive use in commentaries tends to have a

14 See Stone (1965).

15 For fuller discussion, see Sunstein (1996).

16 Application No. 26565/05, judgment of 27 May 2008 (ECtHR) – Joint Dissenting Opinion of Judges Tulkens, Bonello and Spielmann at paras [12–13].

17 Application No. 26565/05, judgment of 27 May 2008 (ECtHR) – Joint Dissenting Opinion of Judges Tulkens, Bonello and Spielmann at paras [18–25].

18 See Hutchinson (2000, p. 170).

19 See Teubner (1997) and Davies (1996).

20 Burke (1969, p. 55).

21 Goodrich (1986, pp. 171–72).

22 See Kennedy (1991, p. 11).

23 For example, see Dupré (2006).

24 This lack of fit is explored in Miola (2007).

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

dehistoricising effect, obscuring the influence of concrete developments in culture, politics and the economy upon legal reasoning in this area.

Means of persuasion

Classical writers elaborated a range of persuasive strategies, focusing on the style of delivery, as well as the content and organisation of speeches.[25] I wish to focus here only on the so-called 'forms of proof'. Each of these aims directly at establishing a relationship of consubstantiality between the speaker and their audience. Aristotle identified three such means of persuasion: logos (including shared common-sense assumptions), pathos (the audience's feelings) and ethos (the speaker's character).[26] Their deployment requires an exercise of skill and judgment on the part of the individual speaker. But, as will be seen, the means of persuasion available at any given time and place are socially produced. In examining each form of proof, I consider its specific relevance to health care law reasoning and, more specifically, the decision of the House of Lords in *N*.

In the theory of rhetoric, logos refers to the truth, consistency and plausibility of the argument itself (Hollander, 1996, p. 179). Its most important feature, for present purposes, is the topic or commonplace.[27] As the name suggests, these are common-sense assumptions, shared between speaker and audience, from which an argument can progress. The persuasive strength of a given topic depends on its timeliness, its relevance to the matter under discussion and the extent to which the audience addressed identifies with it. Specific topics constitute the tradition of any given discipline or subdiscipline, like law or health care law. Legal topics are heterogeneous in nature. They include precedent cases, statutes and constitutional provisions (Viehweg, 1974, p. 31). The good faith practice of law dictates that these formal sources cannot be ignored (Hutchinson, 2000, p. 33). However, as was seen above, they never finally determine the outcome of a given case. The meaning and applicability of a given precedent, for example, has to be established using a range of argumentative resources (p. 189). These include a broader category of topics to do with the nature of reality and the values to be advanced in judicial decision-making.[28] Unlike the norms of positive law, topics of this sort cannot be said to be valid or invalid. Rather they gradually enter the law, just as they may gradually fade out of it. The implicit common sense of one period may thus become the object of criticism or ridicule in another.

Health care law is particularly suited to this kind of topical analysis. Its doctrinal substance is wholly borrowed from longer-established fields, such as tort, equity and criminal law. Historically its distinctiveness can be seen to lie in an underlying set of commonplaces to do with the nature of clinical work and the purpose of the health service. These include the notion that medicine is both a progressive science and a matter of 'art' or fine judgment.[29] In the following sections I argue that a further topic of 'national space' has characterised decisions concerning access to NHS care. These diverse topics were articulated by courts to justify and reinforce professional domination over patients and the health service as a whole. To this extent health care law reproduced and contributed to the broader common sense of Keynesian welfarism.[30] However, as the post-war welfare state is reformed, sovereign clinical judgment, the progress of medical science and the priority of national

---

25 For an introductory overview, see Barthes (1994, p. 1).

26 Aristotle (1991, p. 75 [1356a]).

27 See Balkin (1996).

28 In classical terms, it can be said that precedents and statues are 'extrinsic proofs', beyond skill (*atechnoi*), whereas commonplaces are proofs within skill (*entechnoi*), see Barthes (1994, p. 54).

29 These are discussed in Harrington (2004, 2002).

30 On this conjuncture and its subsequent dissolution, see Jessop (2002).

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

space are all challenged. These developments have had a substantial impact on the rhetoric of health care law

A speaker will use pathos in order to evoke emotions, such as pity, envy and rage, in order to gain the approval of the audience.[31] Pity is the most important of these emotions in the present context. According to Aristotle, it is apt to be felt by those who think they might suffer or who have suffered themselves.[32] Pity responds to the 'great evils for which chance is responsible', like death and disease.[33] It may be directed towards the speaker herself or a third party referred to in the speech. In either case, its successful evocation depends on there being sufficient proximity and identification as between the audience and the object of its pity. Pathos must not be confused with purely subjective emotion. Just as the rhetorical logos is made up of shared common-sense assumptions, so pathos draws upon public emotions, stock responses to specific situations (Barthes, 1994, p. 75). These responses are themselves 'nourished' by a common culture which produces and disseminates images of suffering and appropriate responses to it (Piper, 1991, p. 738).

Pathos is not common in judicial rhetoric, which cultivates an air of neutrality and objectivity.[34] However, this is less true of health care law cases, given the pressing questions of life and death which they often raise. In such instances the court becomes a kind of theatre of human suffering.[35] The visible presence of the patient litigant helps to furnish the necessary element of immediacy between them and the audience. Indeed, owing to extensive media coverage, the audience for such decisions is unusually wide. Judges are increasingly aware that activists, religious bodies and the general public are listening in on their decisions, so to speak. Moreover, the public emotions likely to be called forth are both particularly intense and well nourished by media representations and interest group publicity. Given this context, judges often develop compensatory rhetorical strategies to contain the pathos aroused by the facts of the case at hand. It will be seen that this was an important feature of the reasoning in *N*.

Ethos emphasises the speaker's status and authority in order to gain the confidence of their audience (Meyer, 1999, p. 10). It is implicit in the distinctive decoration of courtrooms and in the costuming of judges and barristers. It is also produced within the texts of decisions, as a connotation of the phrasing and the figures of speech used.[36] Peter Goodrich has demonstrated how many, ostensibly redundant, usages in legal speech tend to bolster the authority of the court in reaching a particular verdict.[37] Thus, controversial decisions on the withdrawal of medical treatment are often prefaced by 'oratorical definitions' in which the judge states what are fairly obvious limits to her competence, e.g. 'this court is a court of law, not a court of morals'.[38] Such statements evoke a distinctive judicial character, one associated with careful deliberation and frankness, a sympathetic persona.[39] As Barthes puts it, while she speaks the orator must also keep saying, 'follow me . . . esteem me . . . and love me'.[40] The specific characteristics (or virtues) valued in a speaker are not always and

31 Aristotle (1991, p. 75 [1356a]).

32 Aristotle (1991, p. 163 [1385b]).

33 Aristotle (1991, p. 163 [1385b]).

34 By contrast it has long been common in certain forms of advocacy, such as criminal defence, see Cicero (2001, p. 175 [2.197–204]).

35 On this notion, see Marshall (1984).

36 See Barthes (2000, p. 58).

37 Goodrich (1986, p. 192).

38 For a medical law example, see *Re A (Conjoined Twins: Surgical Separation)* [2000] 3 FCR 577 (CA per Ward LJ at 584).

39 See Cicero, (2001, p. 171 [2.182]).

40 Barthes (1994, p. 74).

CAMBRIDGE JOURNALS

http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

everywhere the same.[41] Like commonplaces, their persuasive force varies with the form of speech used (e.g. judicial or political), but also as between different historical periods and geographical locations.

In practice, any given argument will involve a 'complex articulation' of all three modes of persuasion (Meyer, 1999, p. 51). Each is prominent in the reasoning of appellate courts. Judges at this level are typically faced with problematic cases, where a novel interpretation of the common law or statute is sought, or where a ruling one way or the other will have significant social and economic consequences. The overall rhetorical effort will have to be commensurate with the novelty of the question. As well as showing mastery of formal legal sources, a judge will deploy imagery, figures of speech and common-sense assumptions to reinforce her argument.[42] However, the problematic nature of such cases often reveals that formerly well-established topics are no longer adequate to the task of persuasion. Frank assertions of judicial authority may be used to compensate for this decline in plausibility.[43] A new or alternative common sense may be articulated. Judicial innovation of this sort can also be understood as a form of political deliberation, often involving an appeal to the audience's passions and sense of reasonableness. Health care law cases are particularly prominent in this regard, as they often involve distressing facts and morally controversial issues thrown up by scientific progress and attracting the attention of the general public. *N* was a clear example. Their Lordships deployed elements of pathos and ethos with some care in order to support their reassertion of the national frame for health entitlements. In the following section I consider the social and political origins of this territorially defined common sense and the important role of the NHS in producing it.

National space and the NHS

I claimed above that national territory is an important topic of health care law in Britain. The present section seeks to explain how it achieved this status. The explanation rests on a fundamental insight from human geography, namely that space is socially produced. The arbitrariness of this production is generally naturalised and hidden.[44] Specific spatial frames are widely shared and acted on, for example, by the population of a given territory. They are taken for granted, offering a common starting point for political and legal argument. However, this obviousness may be lost in times of economic crisis and political conflict. As a result of these struggles, new spaces and new scales are often created, rivalling or replacing existing ones and functioning as topics of a new rhetoric.

Social theorists traditionally assumed that space was a neutral and transparent medium, innocent of politics and history.[45] However, the 'lived-in' space of individuals and human societies cannot be reduced to the timeless, abstract space of mathematics and geometry.[46] As Henri Lefebvre argued, space is actively and continually produced by human intervention. He identified three 'modes of spatialization'.[47]. First, the material construction of space in the form of fences, houses, railways, factories and hospitals. This is the world as experienced every day through tactile, sensual interaction with matter. Second, representations of space in maps, plans and statistical tables. This is the world as

41 There are 'as many types of individual as of society' (Plato, 1974, p. 277 [544d]).

42 For examples, see Klinck (1994).

43 On this 'coercive' dimension of judicial rhetoric, see Goodrich (1986, p. 194).

44 See Bourdieu (1977, p. 163).

45 'Space was treated as the dead, the fixed, the undialectical, the immobile. Time on the contrary was richness, life, dialectic' (Foucault, 1980, p. 70).

46 The notion of 'lived-in' space is drawn from the work of Martin Heidegger; see further Elden (2004, p. 1880).

47 Lefebvre (1991, p. 33)

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

conceived or 'read' by engineers, planners and public health specialists. Third, idealisations of space in myths, utopias and arcadias.[48] These are rooted in the emotional history of individuals and peoples. They 'overlay physical space, making symbolic use of its objects'.[49] These three modes must not be seen as hierarchical. Each interacts with the others (Harvey, 2006, p. 131). Maps and plans decisively shape the built environment. Construction projects can destroy mythic landscapes or create new ones.[50]

In contemporary society the state plays a central role in each mode of spatialisation. State institutions penetrate everyday life, creating the material, cultural and human infrastructure of the capitalist economy, as well as mapping the spaces thus created. The state seizes upon territorial myths and legends, reproducing them as its own.[51] The figure of the nation is at the heart of this spatialisation. As Nicos Poulantzas put it:

> 'The modern nation . . . tends to coincide with the State and acquires flesh and blood in state apparatuses; it becomes the anchorage of state power in society and maps out its contours.'[52]

The state produces the nation by producing the national territory, not just at the borders, but also within. The school system, transport authorities, the army and the broadcast media are good examples of these 'state apparatuses'.[53] National curricula in history and literature, a uniform system of road signage, frontier posts and television weather maps all secure the common-sense nature of the national territory (Bourdieu, 2000, p. 97). In the rest of this section I will argue that the NHS has also functioned as a state apparatus of this sort, actively producing British national space in the post-war period.

Established in 1948, the NHS was the most prominent institution of the Keynesian welfare state in Britain.[54] It was created through the merger of innumerable smaller concerns, e.g. voluntary, charitable and local authority hospitals.[55] Local fragmentation was to be replaced by national ownership and regional organisation.[56] Direct lines of accountability would link clinical practice with the Secretary of State himself.[57] Moreover, it defined and sought to meet a uniform entitlement to health care across the territory. Under the old system the best hospital facilities were available where they were least needed. Access to care often depended on the location of the patient or their ability to pay.[58] Henceforth care would be funded out of general taxation and free at the point of use to all UK residents.

The NHS contributed to the production of the national scale in each of the three modes elaborated by Lefebvre. It created space materially through its standardised infrastructure of hospitals and clinics. It also represented space, in the (only apparently) mundane form of health statistics.

48 Lefebvre calls these 'representational spaces'. I have adapted this usage for the sake of clarity.

49 Lefebvre (1991, p. 39)

50 For example, see Berman (1983, p. 173)

51 See Elden (2004, pp. 215–26, 236–41).

52 Poulantzas, (1978, p. 99).

53 The latter should be understood broadly to include, not just public bodies, but commercial and charitable institutions whose work is orchestrated by the state; see Poulantzas (1978, p. 133).

54 For an overview, see Berridge (1999).

55 General practice remained at arms length from the new system; see Webster (2002, p. 10).

56 For example, a 1937 survey of South Wales revealed that 93 municipal hospitals were controlled by 46 local authorities, alongside 48 voluntary hospitals; see Webster (2002, p. 5).

57 In the words of the Service's founder, Aneurin Bevan, 'every time a maid kicks over a bucket of slops in a ward an agonized wail will go through Whitehall', quoted in Foot (1962, p. 195).

58 See Bevan (1978, p. 104).

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

These allowed the measurement of health inequality and health improvement across the nation.[59] Beyond this, in linking solidarity with citizenship, the Service contributed to an idealisation of national space. By putting care of the ill ahead of commerce, Britain was at the forefront of civilised nations. As Charles Webster put it, Health Service staff:

> 'achieved a sense of corporate unity [believing] they were part of a prestigious national service, capable of achieving in peacetime something like the feats of collective action and patriotic sacrifice recently witnessed in the special circumstances of total warfare.'[60]

Of course the actual contribution of the NHS to homogenising national space failed to match the ideal in each of three modes outlined above. Up to 1974 NHS resource allocation tracked the distribution of existing facilities rather than current need (Timmins, 2001, p. 339). Health inequalities, closely associated with class and occupation, persisted (Webster, 2002, p. 221). Individual clinical judgment was privileged over more rational forms of resource use, leading to presumed, though often unmeasurable, divergences in health care provision (Newdick, 2005, p. 52). The Service was heavily dependent on staff directly recruited from former colonial territories, particularly in the Caribbean and South Asia (Doyal, 1979, p. 205).

Notwithstanding the shortcomings just discussed, the national scale remained pre-eminent in this period. Uneven and unequal access could only appear as objects of concern against the ideal of a truly 'national' health service. This is evident in the response of English courts to patients seeking judicial review of health care rationing. Courts uniformly rejected these applications on grounds of justiciability.[61] They held that allocation of resources at the macro-level was solely a matter for government. At the clinical level doctors had to decide. The finitude of resources that produced these cases was defined nationally. Thus Stephen Brown LJ, rejecting an attempt to compel the provision of more specialist nurses in a Birmingham hospital, held that:

> 'This is not the forum in which a court can properly express opinions upon the way in which national resources are allocated or distributed . . . The courts of this country cannot arrange the lists in the hospital.'[62]

Government and NHS planners were best equipped to decide on general allocation, not courts adjudicating on individual disputes.

The NHS and the crisis of national space

The Keynesian system in Britain and through the West went into crisis in the 1970s (Glyn, 2007). That crisis was expressed and resolved spatially through an extended process of rescaling .[63] This process is generally comprehended under the label 'globalisation'. The neoliberal order which has replaced the post-war settlement is characterised by the breakdown of the relatively closed national space economy. But, though the national scale has lost its former predominance, no single scale has replaced it as the 'primary pivot' of economic activity, regulation or sociopolitical struggle (Brenner and Theodore, 2002, p. 363). The local level has gained in prominence through an internal

59 Public health in Britain long predates 1948. But the creation of the NHS can be seen as a radical extension of the work done by from nineteenth-century sanitarians such as Edwin Chadwick; see Porter (1997, p. 215).

60 Webster (2002, p. 29).

61 See Newdick (2005).

62 *R v. Central Birmingham Health Authority, ex parte Collier* (CA) (6 January 1988), reprinted in Kennedy and Grubb (2000, p. 340).

63 See Harvey (1999, p. 373)

CAMBRIDGE JOURNALS

http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

redifferentiation of national social space. The competitive ‘place marketing’ of cities is one example (Harvey, 1990, p. 89). So also is the trend to decentralisation and micro-autonomy in welfare delivery. Supra-state space has also thickened. Production and service provision are articulated across regional and global scales through outsourcing. To an extent this is enabled and contained by emerging regulatory regimes, such as the European Union (van Apeldoorn, 2003). Scalar denationalisation has also been effective in representations of space. The ‘global’ thus underpins a rhetoric of competitiveness aimed at higher productivity and lower wage costs. This does not mean, however, that the nation has lost all salience. On the contrary, competitiveness can only be promoted through the figure of different nations contesting for investment and employment. The state is profoundly implicated in producing the phenomena of globalisation.[64] Privatisation and the ‘opening’ of national economies, along with international and regional trade law, are all unthinkable without the practical and ideological contribution of governments and official institutions.

The relativisation of scales has also been evident in health care. There has been a significant withdrawal of the NHS from its former role in producing British national space. With the spread of autonomous Foundation Trusts and the Private Finance Initiative, the role of the Service in the material construction of space has dwindled.[65] Local innovation and corporate autonomy are used to justify diversity and unevenness. Critics claim that ‘reforms’ are interfering with the collection of population health data, as well as with mechanisms for ensuring equity of resources (Pollock, 2004, p. 223). Capacity to represent national health space declines accordingly. At subnational level new scales are called into being through the devolution of health related powers to assemblies in Scotland, Wales and Northern Ireland. As will be seen in the next section, the institutions of the European Union increasingly intervene to create common entitlements to provide and use health care services across the member states.[66] On the ideological plane the ‘national’ form of the NHS is routinely disparaged. Thus, it is said to be ‘the second largest employer in Europe after the Red Army’.[67] Market space, locally heterogeneous, but unbounded by national frontiers, is the new utopia (Levitas, 2007).

Again it must be noted that national government continues to play a vital role in the production of new health spaces. As with other privatisations it is engaged as the realtor of its own assets (Whitfield, 2001, p. 74). Moreover, some reforms seem to reassert the national scale. For example a dense system of clinical regulation and standard setting has developed since 1997.[68] In England, for example, the Healthcare Commission functions as an inspectorate evaluating and comparing clinical outcomes in NHS facilities across the country.[69] The National Institute for Health and Clinical Excellence produces guidelines on the cost-effectiveness of medicines which determine prescription practice throughout the Service.[70] But, if the national hasn’t gone away, it is also true that it no longer retains the ‘taken-for-grantedness’ that it had in post-war health care (Jessop, 2002, p. 180). The consequences of these developments for rhetoric and ethics have been diagnosed by Nancy Fraser. She says that:

> ‘Although it went unnoticed at the time, [the Keynesian-national] framework lent a distinctive shape to arguments about social justice. Taking for granted the modern territorial state as the

64 See Wood (2002).

65 For an overview of reforms, see Talbot-Smith and Pollock (2006).

66 The latest comprehensive initiative can be found in European Commission (2008).

67 This is usage is especially popular among politicians, see, for example, Blunkett (2008).

68 For an overview, see Pridmore and Gammon (2007).

69 See Healthcare Commission (2007).

70 See further, Syrett (2003).

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

> appropriate unit, and its citizens as the pertinent subjects, such arguments turned on what precisely those citizens owe one another . . . Today however this framework is losing its aura of self-evidence.'[71]

This loss of 'obviousness' is a vital context of the reasoning in *N*. In the next section I explore the contested deployment of the topic of national space in that case. I compare it with a contemporaneous Court of Appeal decision which addressed patient mobility from Britain to other member states of the European Union.

The topic of space in *N*

According to their Lordships, the application in *N* was not primarily a demand to be free from deportation. It was instead an attempt to obtain medical treatment unavailable in her home country.[72] In Lord Hope's words, to allow the appeal:

> 'would risk drawing into the United Kingdom large numbers of people already suffering from HIV in the hope that they too could remain here indefinitely so that they could take the benefit of the medical resources available in this country. This would result in a very great and no doubt unquantifiable commitment of resources which it is, to say the least, highly questionable the state parties to the Convention would ever have agreed to.'[73]

This reasoning clearly starts from a very specific understanding of space rooted in the common sense of the national territory. Lord Brown offered a more detailed outline of the cost to the UK of N's treatment:

> '[a]llowing the patient to remain in the host state to enjoy decades of healthy life at the expense of that state [would constitute] an expense both in terms of the cost of continuing treatment (the medication itself being said . . . to cost some £7,000 per annum) and any associated welfare benefits, and also in terms of immigration control . . . '[74]

Admittedly, as Baroness Hale noted, N was unaware of her HIV status on arriving in Britain. She was not, said her Ladyship:

> 'a would-be immigrant who came here to benefit from our superior services.'[75]

However, though sympathetic, this evaluation is also anchored in a topic of national space delimiting access to 'our' national medical resources; a territorially defined 'we' which produces and is entitled to health care. This concern with eligibility was raised in the well-known case of *Re A (Conjoined Twins: Surgical Separation)*.[76] There Ward LJ felt obliged to reassure his readers and auditors that 'the parents are not Kosovan refugees unjustifiably draining our resources'.[77] It is this Keynesian common sense, rearticulated in the face of a deterritorialised attempt to access care, that

71 Fraser (2005, p. 76).

72 [2005] UKHL 31 per Lord Brown at para [88]. The difficult distinction between positive and negative obligations of states has been considered by the European Court of Human Rights in other medical law contexts; see Millns (2002).

73 [2005] UKHL 31 at para [53].

74 [2005] UKHL 31 at para [92].

75 [2005] UKHL 31 at para [58].

76 [2000] 3 FCR 577 (CA).

77 [2000] 3 FCR 577 (CA at 585).

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

defeats the analogy N had sought to draw between her case and that of *D v. UK*. Lord Nicholls was explicit about this:

> 'The essential difference [between the two cases] is not to be found in humanitarian differences. Rather it lies in recognising that article 3 does not require contracting states to undertake the obligation of providing aliens indefinitely with medical treatment lacking in their home countries.'[78]

Selectively deployed, the national scale remains pertinent even (perhaps especially) under pressure of increasing global mobility.

This anxiety to secure the national frontier was reproduced by the ECtHR in N's case. The majority held that:

> 'a search for a fair balance between the demands of the general interest of the community and the requirements of the protection of the individual's fundamental rights'

was inherent to the whole Convention.[79] Advances in medical science, as well as economic differences between regions of the world, meant that the level of treatment available could differ greatly depending on location. But Article 3 ECHR did not place an obligation on states to alleviate such disparities.[80] Interestingly, the dissenting judges in the Strasbourg court were equally concerned with the 'floodgate' argument. They sought, however, to show that it did not apply in this case. They quoted from UK asylum and immigration statistics to show that a humane decision in N's favour would not lead to Europe becoming 'the sickbay of the world'.[81]

N concerns migration from the global south to the global north. Its assertion of the 'national' can be compared with the response of English courts to the movement of patients within the European Union. In *Secretary of State for Health v. R (on the Application of Watts)*[82] a patient was seeking NHS funding to travel to France for a hip-replacement operation. The European Court of Justice (ECJ) has long held that the freedom to provide services across borders guaranteed by the European law, implies a freedom on the part of the consumer to travel to receive services in another country.[83] Mrs Watts argued that, where such services are funded by welfare agencies at home, there is a duty on governments to fund 'health tourism' in such cases. The ECJ had already found such a duty where a patient could not be offered treatment at home 'within the time normally necessary for obtaining it'.[84] The point at issue in *Watts* was whether national NHS waiting times would exclusively determine 'the time normally necessary for obtaining' treatment. The Court of Appeal suspected that they wouldn't. It referred the case to the ECJ for a clarification of European law under Article 234 of the European treaty. In making the referral, May LJ noted the likely significance of such a finding for the NHS. Its effect would be to:

> 'disrupt NHS budgets and planning and undermine any system of orderly waiting lists . . . [Furthermore] if the NHS were required to pay the costs of some of its patients having treatment

78 [2005] UKHL 31 at para [15].

79 Application No. 26565/05, judgment of 27 May 2008 at para [44] (ECtHR).

80 Application No. 26565/05, judgment of 27 May 2008 at para [44] (ECtHR).

81 Application No. 26565/05, judgment of 27 May 2008 (ECtHR) – Joint Dissenting Opinion of Judges Tulkens, Bonello and Spielmann at para [8].

82 [2004] EWCA Civ 166.

83 *Luisi and Carbone v. Ministero del Tesoro* Cases 286/82 and 26/83 [1984] ECR 377 (ECJ); see further Hervey and McHale (2004).

84 *Inizan v. Caisse Primaire d'Assurance Maladie des Hauts de Seine* Case C-56/01 [2003] ECR I-12403 (ECJ).

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

abroad at a time earlier than they would receive it in the United Kingdom this would require additional resources.'[85]

Since waiting lists were a product of scarce resources this extra funding could only be obtained if:

'those who did not have treatment abroad received their treatment at a later time than they otherwise would or if the NHS ceased to provide some treatments that it currently does provide.'[86]

May LJ's fears were confirmed when the ECJ subsequently upheld Mrs Watts's claim.[87] In the language of political economy used above, we can say that the European market scale triumphed over the Keynesian national scale in Watts, as it was bound to do, given the constitutional priority of European economic law over national law.[88]

The politics of pity

Pathos plays an important role in their Lordships' speeches in *N*. However, it was not deployed directly as a means of gaining the audience's sympathy for N herself. To do so would have undermined the topic of national space reasserted by the House and thus, also, the decision to refuse her application to remain in the UK. Nonetheless, as discussed above, the facts of medical law cases often evoke pity or even anger, for example, at the behaviour of medical professionals or the law's failure to offer relief to the patient. Furthermore, these intense feelings are likely to be widespread, given the high profile of such cases. As a result, pathos figures less as a positive strategy and more as a risk to be contained in judicial rhetoric. The nature of that risk can be explored with reference Hannah Arendt's work on the history of revolutionary politics.

Arendt based her views on certain differences between the American and French revolutions. The aim of the former was to liberate individual men from tyranny; the aim of the latter was to free 'the life process itself from the fetters of scarcity'.[89] She traced the immensely greater level of violence which followed the French revolution to this difference. After 1789, mass poverty was no longer simply a matter of fate and an object of charity. Its elimination became the central moral purpose of political change, taken up by thinkers and revolutionaries over the following two centuries. Arendt offered a trenchant critique of this 'politics of pity'.[90] She argued that the great cruelty unleashed by the 'social' revolutions was precisely due to their instrumentalisation of sentiment for political ends. Boundless misery led first to boundless sympathy and then to boundless coercion in the attempt to eliminate it. 'Pity-inspired virtue . . . played havoc with justice and made light of laws.'[91] The American revolutionaries, by contrast, had ignored social issues and avoided political sentiment.[92] Consequently, 'nothing was permitted' to them 'that would have been outside the range of civil law'.[93]

85 [2004] EWCA Civ 166 per May LJ at para [105].

86 [2004] EWCA Civ 166 per May LJ at para [105].

87 *R v. Bedford Primary Care Trust, ex parte Watts* Case C-372/04 [2006] QB 667 (ECJ).

88 *Factortame v. Secretary of State for Transport (No.2)* Case C-213/89 [1990] ECR I-2433 (ECJ).

89 Arendt (1973, p. 64).

90 This label is taken from Boltanski (1993, p. 15).

91 Arendt (1973, p. 90).

92 She argues that the 'primordial crime' of slavery did not invalidate this aspect of American constitutionalism; see Arendt (1973, p. 71).

93 Arendt (1973, p. 92).

CAMBRIDGE JOURNALS

http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

The risks presented by pathos to the House of Lords in *N* derived from just such a combination of politics and pity. Admittedly these were not of the same magnitude as the conflagration anticipated by Arendt, writing at the height of the Cold War. Rather they can be characterised as threats to the orderly functioning of the court and its sense of itself within the wider constitutional system. Though differing in intensity, they too can be seen to undermine legality and authority. For one thing, the strong feelings associated with pathos are held to be incompatible with objective deliberation. They lead to a 'disproportion' in judgment which favours prominent over more needy cases (Boltanski, 1993, p. 27). For another, such applications offer a rallying point for social causes, whose prosecution would 'politicise' the work of the court, taking it well beyond its official task of adjudication. In the rest of this section I seek to show how the politics of pity were an important feature of *N*.

Luc Boltanski offers an insightful application of Arendt's thought in the context of contemporary humanitarian campaigns. Drawing on this work it is possible to elaborate three key preconditions of a politics of pity.

(1) 'The need for a face.' Generalised presentation of a problem like the global AIDS pandemic is not likely to move audiences in the developed world. Statistics do not speak; they do not evoke feelings of pity (Boltanski, 1993, p. 57). The engagement of spectators requires the visible presence of an identifiable, individual victim.
(2) 'Exemplarity.' There has to be a sufficient connection between the plight of the individual victim and the general problem. Though identified in her uniqueness, the victim must also be seen to be typical of the mass of sufferers (p. 28). Only thus will any subsequent intervention qualify as political.
(3) 'Meaningful action.' The intervention of the spectator to relieve suffering requires a medium of assistance (e.g. money) and an institutional vehicle for action (e.g. the banking system). However, these are abstract and impersonal forms, tending to distance the spectator from the individual victim and 'swallow up' their beneficent intervention. Accordingly, the action taken has to be shown to be effective in specific cases, as well as responding to the broader problem (p. 35).

Charities concerned with development and disaster relief attempt to meet these preconditions in their campaigning. They focus on named locations typical of a region or part of the world. For example, donors are encouraged to 'adopt' a child in an African village who subsequently corresponds with them.[94]

Legal decision-making cannot be straightforwardly equated with charitable campaigning. Nonetheless, it is clear that each of the forgoing preconditions is met in *N* and cases like it.

(1) 'The need for a face.' As Tim Murphy has argued, the common law differs from other social sciences precisely through its reliance on individual disputes, rather than statistics, as a means of generating knowledge about the world.[95] Thus, in *N* a particular victim was brought before the court in person.[96] A detailed recitation of the painful facts of the case preceded and informed the doctrinal analysis.
(2) 'Exemplarity.' For Lord Nicholls, N's:

> 'case as a would-be immigrant is far from unique . . . The prevalence of AIDS worldwide, particularly in Southern Africa, is a present-day human tragedy on an immense scale.'[97]

94 See Action Aid (2008).

95 Murphy (1997, p. 116).

96 Classical writers noted that, as well as words, physical objects and the human body itself could be sources of pathos; see, for example, Cicero (2001, p. 175 [2.196]) and Quintilian (2001, p. 355 [2.15.6]).

97 [2005] UKHL 31 at para [9].

CAMBRIDGE JOURNALS

http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

Moreover, techniques of legal reasoning meant that N was reconfigured in general terms: first as an asylum seeker fleeing persecution in Uganda; and then as an applicant for relief under Article 3 of the European Convention on Human Rights. As such she stood in for a much broader class of victim.

(3) 'Meaningful action.' The process of abstraction just described means that decisions in such cases have (a potentially broad) precedential value. At the same time, however, a positive outcome to adjudication also confers a concrete benefit on a recognisable individual.

Thus, several important features of litigation and the legal form itself mean that a case such as N's has the potential to convert the court into a 'theatre' for the politics of pity, as discussed above. 'Theatre' can be understood here in two senses.[98] First, as a stage for the display of human suffering and the evocation of sympathy in members of the audience (Marshall, 1984). Second, since the spectacle cannot be perceived neutrally, the court becomes a venue for global political struggles. It can be presumed that members of the House of Lords were aware of the broader ongoing politics of pity engaged in by charities and campaigning journalists. The facts of N's case formed part of this wider spectacle of suffering. As such they threatened the court's functioning as an ostensibly depoliticised zone of adjudication. In the next section I seek to show how the court addressed this risk by marginalising the politics of pity.

Beyond pity

There are four main ways in which the House of Lords sought to pre-empt the politics of pity in *N*: (1) they sought the sympathy of the audience for their own plight as decision-makers; (2) they suggested that the broader issues of access to essential medicines represented by the case were better addressed by bureaucratic, than individualised means; (3) they emphasised the capacity of the executive to refrain from exercising its power to deport; and (4) they substituted compassion for pity as an appropriate response to the plight of the applicant.

Ethos: sympathy for the judge

In a straightforward deployment of ethos, Lord Hope offered a negative oratorical definition of the tasks and competence of the court:

> 'The function of a judge in a case of this kind . . . is not to issue decisions based on sympathy . . . [T] hey must not allow their decisions to be influenced by feelings of revulsion or sympathy, judges must examine the law in a way that suppresses emotion of all kinds. The position that they must adopt is an austere one.'[99]

This seeks to bolster the status of the court, by relegating argument in the pathetic mode to the margins of the decision. Similarly, Baroness Hale stated that she could not allow the appeal, 'much though [she] would like to do so'.[100] The question for the court, she said is:

> 'How are we to distinguish between the sad cases where we must harden our hearts and the even sadder cases where to do so would be inhumane?'[101]

An authoritative, reasoned decision would be reached. To reinforce the point, Lord Hope invokes the well-worn image of judges weighing and balancing:

98 I draw here on the reading of Adam Smith set out in Boltanski (1993); see further, Raphael (2007).

99 [2005] UKHL 31 at para [21].

100 [2005] UKHL 31 at para [71].

101 [2005] UKHL 31 at para [59].

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

> '[T]he fact is that there are at least two sides to any argument. The consequences if the decision goes against the appellant cannot sensibly be detached from the consequences if it is in her favour.'[102]

The court, in other words, would not allow itself to be overwhelmed by feeling. As has been mentioned, such obvious rhetorical bids for authority are often made in novel or controversial cases. The judicial speaker is forced to address an audience wider than usual, including sections of the mass public, as well as legal professionals, academics and fellow judges (Goodrich, 1986, p. 199).

The language of feeling is not absent from *N*. On the contrary, it is to be found in all of the judgments. Lord Nicholls accepted that the facts:

> 'encompass much human misery. No one can fail to be touched by the plight of the appellant and of others in a similar position. The prospect facing them if returned to their home country evokes a lasting sense of deep sadness.'[103]

These comments seem at first glance to be aimed at evoking sympathy for the applicant. However, on closer inspection it can be observed that ethos, rather than pathos, is the true mode of persuasion here too. In vivid, figurative terms, Lord Nicholls recounts the facts of the case and the probable consequences of deportation:

> 'The cruel reality is that . . . if she returns to Uganda and cannot obtain the medical assistance she needs to keep her illness under control, her position will be similar to having life support switched off.'[104]

This demonstrates that the judge accepts the very difficult nature of the case, and is not reluctant to convey this difficulty to his audience ('esteem me'). Moreover, a judge who is not afraid to face these facts is one who can be trusted to reach a prudent decision in the case ('follow me'). Lord Hope concluded on a similar note by avowing that he would 'resist the temptation to remit this case for further consideration of the facts'.[105] The final character-based proof is the sympathy evoked for the judge faced with a tragic choice such as this. Like the members of his audience, he is a man of feeling, appropriately troubled by the consequences of his decision ('love me'). In effect the audience's feelings for N are redirected towards the judges here in order to bolster its sense of the court's authority.

A bureaucratic alternative

According to Lord Hope, rather than drawing large number of HIV sufferers into the UK in quest of treatment, the:

> 'better course . . . would be for states to continue to concentrate their efforts on the steps which are currently being taken, with the assistance of drug companies, to make the necessary medical care universally and freely available in the countries of the third world . . . '[106]

This presents a second alternative to an open politics of pity, one addressed briefly by Arendt. She suggests that social issues are not best dealt with by political means. Any attempt to do so will generate all the risks of lawlessness and tyranny discussed above. Rather, insofar as human need

102 [2005] UKHL 31 at para [21].

103 [2005] UKHL 31 at para [10].

104 [2005] UKHL 31 at para [4].

105 [2005] UKHL 31 at para [54].

106 [2005] UKHL 31 at para [53].

CAMBRIDGE JOURNALS

http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

enters the public realm, this must be a matter of administration 'to be put into the hands of experts'.[107] The aggregate problem, and not the individual case, must be the focus of attention. It is in this spirit that Lord Brown prefaces his consideration of the facts of the case with a brief survey of the global scene:

> 'There are an estimated 25 million people living with HIV in Sub-Saharan Africa (July 2004 UNAIDS report), many more million AIDS sufferers the world over. The prospects for the great many are bleak indeed.'[108]

For Arendt, bureaucratic measures focused on statistics, rather than persuasion or revolutionary action, were the most appropriate means of relieving human suffering.[109] The 'social question' should be depoliticised and rhetoric replaced with the neutral and abstract language of science and policy.

Deus ex machina

Lord Brown concluded his judgment with the reflection that, although the Home Secretary could lawfully deport N, he was not obliged to do so:

> 'The likely impact upon immigration control (and, doubtless, National Health Service resources) of an adverse Article 3 ruling would be one thing; the favourable exercise of an administrative discretion in this individual case would be another.' [110]

The possibility of clemency is raised here, though its exercise is solely a matter for government. The conflict of principle and sympathy might be resolved by a ministerial intervention in the individual case. As Raymond Williams argued, such expedient devices were a common feature of early Victorian fiction.[111] Structurally similar conflicts between the egoistic values of a predominantly commercial society and the sufferings of individual characters were often relieved through a kind of magic, in the form of an unexpected legacy or emigration. Of course, while these interventions resolved the immediate conflict, they left the dominant social values unchallenged in substance.

Compassion beyond rhetoric

None of the judges was unmoved by N's plight. All spoke of their sympathy for her and their sadness at reaching the decision they did.[112] However, these feelings are better characterised as compassion rather than pity, to borrow another important distinction from Arendt. By contrast with pity, she argues that:

> 'compassion . . . cannot reach out farther than what is suffered by one person and still remain what it is supposed to be, co-suffering . . . [It] can comprehend only the particular, [having] no notion of the general and no capacity for generalization.'

Unlike the politicised pity of campaigners and revolutionaries and unlike the topical reasoning of the law, compassion is not aimed at achieving agreement, it is not expressed in the form of an argument. It is gestural rather than discursive, even when expressed in words. As Arendt says:

---

107 Arendt (1973, p. 91).

108 [2005] UKHL 31 at para [72].

109 Arendt (1973, p. 91).

110 [2005] UKHL 31 at para [99].

111 Williams (1965, p. 82).

112 [2005] UKHL 31 per Lord Nicholls at para [9]; per Lord Hope at para [20]; per Lord Walker at para [55]; per Baroness Hale at para [71]; per Lord Brown at para [95].

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

> 'Closely connected with this inability to generalize is the curious muteness or, at least, awkwardness with words that . . . is the sign of compassion in contrast to the loquacity of pity.'[113]

The intimacy of compassion abolishes the 'the worldly space between men where political matters are located'.[114] She draws a telling example from Dostoevsky's *The Brothers Karamazov*.[115] In response to the Grand Inquisitor's eloquent pity for suffering humanity, Jesus remains silent. He answers the troubled monologue only with a compassionate kiss.[116]

As was seen earlier, rhetoric presumes a certain distance between speaker and audience. The compassionate gesture abolishes this distance, leaving no room for persuasion. We leave the realm of deliberative speech for the purely demonstrative, the personal and idiosyncratic.[117] By contrast, as we have seen, rhetoric is inherently social. The means of persuasion are collectively produced, so to speak. Topics embody a social common sense, typical of a particular group in a given period. In the present context we have seen the influence of the material and representational construction of space upon the logos of medical law. Pathos depends on shared emotions, imaginations 'nourished from the same source', including pity. The ideal character or ethos of the speaker is equally social.

Conclusion

This essay has used techniques of rhetorical analysis to illuminate the influence of social and economic change on reasoning in health care law. In particular it was seen that different spaces and scales have played an important role in shaping arguments about access to medical treatment. This was true, not only as regards the different topics of space invoked (logos), but also as regards the feelings likely to be evoked among audiences (pathos). The element of distance and its overcoming was a constant theme in this analysis. Obviously the physical fact of migration is likely to lead to 'access litigation', as in N's case. On the level of discourse, it is clear that the common sense of national space has been deployed as a means of holding such migrants at bay. However, the declining persuasiveness of that topic was noted. Scales now multiply and compete. As the constructed nature of national space becomes increasingly evident, distance is relativised. On the one hand, European countries with little in common are to be united in a single community of health care users. On the other hand, a firm barrier is erected between Britain and the former colonies from which it has historically drawn material and human resources on the most favourable terms. These include medical knowledge and health care professionals.

Distance is also central to the deployment of pathos in judicial reasoning in this area. As was noted, the successful evocation of pity presumes a relationship of proximity or identification between sufferer and spectator. A number of factors serve to generate this proximity. Some are intrinsic to the operation of the common law itself. Others are a consequence of modern communications media and the educative campaigns of charities and other non-governmental organisations. With imaginations 'nourished' from a common stock of images and stories, people in the rich countries are capable of sympathising with identifiable victims of poverty and ill-health in poor countries. The overcoming of distance in this way presented risks which the House of Lords in *N* sought to avoid in different ways. On the one hand, the suggested bureaucratic solution would reinstate the gap between developed and developing nations. On the other hand, the demonstration

113 Arendt (1973, p. 86).

114 Arendt (1973, p. 87).

115 Arendt (1973, p. 85).

116 Dostoevsky (1880/1958, p. 308).

117 An equivalent distinction is drawn in Kundera (1985, p. 19).

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

of compassion for N made distance irrelevant by dissolving it in the immediacy of human feeling. Both moves tended to depoliticise and displace the question of access to essential medicines.

It is as well to end on a note of caution. Rhetoric offers a well-developed conceptual repertoire for reading cases in this area and linking them to their broader context. It does not, however, offer a fail-safe means of predicting the result of litigation in a particular conjuncture. Instead it highlights the substantive arguments and forms of presentation which are likely to be persuasive at a given time or place. The outcome is always contingent upon the skill of the individual speaker and the identity of the specific audience. We are always concerned with things that admit of being otherwise.

References

ACTION AID (2008) 'Sponsor a Child Today', http://www.actionaid.org.uk/100044/sponsor_a_child_today.html [site accessed 17 December 2008].

AGINAM, Obijiofor (2000) 'Global Village – Divided World, South North Gap and Global Health Challenges at Century's Dawn', *Indiana Journal of Global Legal Studies* 7: 603.

ARENDT, Hannah (1973) *On Revolution*. Harmondsworth: Penguin.

ARISTOTLE, (1991) *The Art of Rhetoric*. Harmondsworth: Penguin.

ARNOLD, Patricia (2005) 'Disciplining Domestic Regulation: The World Trade Organization and the Market for Professional Services', *Accounting, Organizations and Society* 30: 299.

BALKIN, Jack (1996) 'A Night in the Topics: The Reason of Legal Rhetoric and the Rhetoric of Legal Reason', in Peter Brooks and Paul Gewirtz (eds) *Law's Stories*. New Haven: Yale University Press, 211–24.

BARTHES, Roland (1994) *The Semiotic Challenge*. Berkeley: University of California Press.

BARTHES, Roland (2000) *Mythologies*. London: Vintage.

BERMAN, Marshall (1983) *All that is Solid Melts into Air. The Experience of Modernity*. London: Verso.

BERRIDGE, Virginia (1999) *Health and Society in Britain since 1939*. Cambridge: Cambridge University Press.

BEVAN, Aneurin (1978) *In Place of Fear*. London: Quartet Books.

BLUNKETT, David (2008) 'Time to Slash NHS Red Tape', *The Sun*, 8 July.

BOLTANSKI, Luc (1993) *La souffrance à distance. Morale humanitaire, médias et politique*. Paris: Métailié.

BOURDIEU, Pierre (1977) *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.

BOURDIEU, Pierre (2000) *Pascalian Meditations*. Cambridge: Polity.

BRAITHWAITE, John and DRAHOS, Peter (2000) *Global Business Regulation*. Cambridge: Cambridge University Press.

BRENNER, Neil and THEODORE, Nik (2002) 'Cities and the Geographies of "Actually Existing Neoliberalism"', *Antipode* 34: 349.

BURKE, Kenneth (1969) *A Rhetoric of Motives*. Berkeley: University of California Press.

BURRIS, Scott, DRAHOS, Peter and SHEARING, Clifford (2004) 'Nodal Governance', *Australian Journal of Legal Philosophy* 30: 30.

CHANDA, Rupa (2002), 'Trade in Health Services', *Bulletin of the World Health Organization* 80: 158.

CICERO (2001) *On the Ideal Orator (De Oratore)*. New York: Oxford University Press.

DAVIES, Margaret (1996) *Delimiting the Law. 'Postmodernism' and the Politics of Law*. London: Pluto.

DODGSON, Richard, LEE, Kelley and DRAGER, Nick (2002) *Global Health Governance. A Conceptual Review, Discussion Paper Paper No.1*. Geneva: World Health Organization.

DOSTOEVSKY, Fyodor (1880/1958) *The Brothers Karamazov*. London: Penguin.

DOYAL, Lesley (1979) *The Political Economy of Health*. London: Pluto.

DUPRÉ, Catherine (2006) 'Human Dignity and Withdrawal of Medical Treatment: A Missed Opportunity?' *European Human Rights Law Review* 678.

ELDEN, Stuart (2004) *Understanding Henri Lefebvre. Theory and the Possible*. London: Continuum.

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

EUROPEAN COMMISSION (2008), *Proposal for Directive of the European Parliament and Council on the Application of Patient's Rights in Cross-Border Health Care COM (2008) 414*. Brussels.
FOOT, Michael (1962) *Aneurin Bevan – A Biography. Volume One: 1897–1945*. London: MacGibbon & Kee.
FOUCAULT, Michel (1980) *Power/Knowledge. Selected Interviews and Other Writings 1972–77*. London: Longman.
FRASER, Nancy (2005) 'Reframing Justice in a Globalizing World', *New Left Review* 36: 69.
GLYN, Andrew (2007) *Capitalism Unleashed. Finance, Globalization and Welfare*. Oxford: Oxford University Press.
GOODRICH, Peter (1986) *Reading the Law. A Critical Introduction to Legal Method and Techniques*. Oxford: Blackwell.
HARRINGTON, John (2002) '"Red in Tooth and Claw." The Idea of Progress in Medicine and the Common Law', *Social and Legal Studies* 11: 211.
HARRINGTON, John (2004) '"Elective Affinities." The Art of Medicine and the Common Law', *Northern Ireland Legal Quarterly* 55: 259.
HARRINGTON, John (2007) 'Law, Globalisation and the NHS', *Capital and Class* 92: 81.
HARVEY, David (1990) *The Condition of Postmodernity. An Enquiry into the Origins of Social Change*. Oxford: Blackwell.
HARVEY, David (1999) *The Limits to Capital*, rev. edn. London: Verso.
HARVEY, David (2006) *Spaces of Global Capitalism*. London, Verso.
HEALTHCARE COMMISSION (2007) *Annual Report 2006/2007*. London: The Stationery Office.
HERVEY, Tamara and MCHALE, Jean (2004) *Health Law and the European Union*. Cambridge: Cambridge University Press.
HOLLANDER, John (1996) 'Legal Rhetoric', in Peter Brooks and Paul Gewirtz (eds) *Law's Stories*. New Haven: Yale University Press, 176–86.
HUTCHINSON, Allan (2000) *It's All in the Game. A Non-Foundationalist Account of Law and Adjudication*. Durham, NC: Duke University Press.
JESSOP, Robert (2002) *The Future of the Capitalist State*. Cambridge: Polity.
KENNEDY, Ian (1991) *Treat me Right. Essays in Medical Law and Ethics*. Oxford: Clarendon Press.
KENNEDY, Ian and GRUBB, Andrew (2000) *Medical Law*, 3rd edn. London: Butterworths.
KLINCK, Dennis (1994) '"This Other Eden." Lord Denning's Pastoral Vision', *Oxford Journal of Legal Studies* 14: 25.
KUNDERA, Milan (1985) *The Unbearable Lightness of Being*. London: Faber and Faber.
LEFEBVRE, Henri (1991) *The Production of Space*. Oxford: Blackwell.
LEVITAS, Ruth (2007) 'Looking for the Blue: The Necessity of Utopia', *Journal of Political Ideologies* 12: 289.
MARSHALL, David (1984) 'Adam Smith and the Theatricality of Moral Sentiments', *Critical Inquiry* 10: 592.
MEYER, Michel (1999) *Histoire de la rhétorique. Des Grecs à nos jours*. Paris: Librarie Générale Française.
MILLNS, Susan (2002) 'Death, Dignity and Discrimination: The Case of *Pretty v United Kingdom*', *German Law Journal* 3: 1.
MIOLA, José (2007) *Medical Ethics and Medical Law. A Symbiotic Relationship*. Oxford: Hart Publishing.
MURPHY, William T (1997) *The Oldest Social Science? Configurations of Law and Modernity*. Oxford: Clarendon Press.
NEWDICK, Christopher (2005) *Who Should we Treat? Rights, Rationing and Resources in the NHS*. Oxford: Oxford University Press.
NEWDICK, Christopher (2006) 'Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Social Solidarity', *Common Market Law Review* 43: 1645.

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13

PALMER, Stephanie (2005) 'Case Comment: AIDS, Expulsion and Article 3 of the European Convention on Human Rights', *European Human Rights Law Review* 533.
PIPER, Adrian (1991) 'Impartiality, Compassion and Modal Imagination', *Ethics* 101: 726.
Plato (1974) *The Republic*. London: Penguin.
POLLOCK, Allyson M. (2004) *NHS plc. The Privatisation of Our Health Care* London: Verso.
PORTER, Roy (1997) *The Greatest Benefit to Mankind. A Medical History of Humanity from Antiquity to the Present*. London: Harper Collins.
POULANTZAS, Nicos (1978) *State, Power, Socialism*. London: Verso.
PRIDMORE, Julia Ann and GAMMON, John (2007), 'A Comparative Review of Clinical Governance Arrangements in the UK', *British Journal of Nursing* 16: 720.
QUINTILIAN (2001) *The Orator's Education. Books 1–2*. Cambridge, MA: Harvard University Press.
RAPHAEL, David D. (2007) *The Impartial Spectator. Adam Smith's Moral Philosophy*. Oxford: Oxford University Press.
STONE, Roy (1965) 'Ratiocination not Rationalisation', *Mind* 74: 463.
SUNSTEIN, Cass (1996) *Legal Reasoning and Political Conflict*. New York: Oxford University Press.
SYRETT, Keith (2003) 'A Technocratic Fix to the "Legitimacy Problem"? The Blair Government and Health Care Rationing in the United Kingdom', *Journal of Health Politics, Policy and Law* 28: 715.
TALBOT-SMITH, Alison and POLLOCK, Allyson M. (2006) *The New NHS. A Guide*. London: Routledge.
TEUBNER, Gunther (1997) 'The King's Many Bodies: The Self-Deconstruction of Law's Hierarchy', *Law and Society Review* 31: 763.
'T HOEN, Ellen (2002) 'TRIPS, Pharmaceutical Patents and Access to Essential Medicines', *Chicago Journal of International Law* 3: 27.
TIMMINS, Nicholas (2001) *The Five Giants. A Biography of the Welfare State*, 2nd edn. London: Harper Collins.
VAN APELDOORN, Bastiaan (2003) 'The Struggle over European Order: Transnational Class Agency in the Making of "Embedded Neo-Liberalism"', in Neil Brenner, Robert Jessop, Martin Jones and Gordon Macleod (eds) *State/Space. A Reader*. Oxford: Blackwell, 147–72.
VIEHWEG, Theodor (1974) *Topik und Jurisprudenz. Ein Beitrag zur rechtswissenschaftlichen Grundlagenforschung*, 5th edn. München: CH Beck.
WEBSTER, Charles (2002) *The National Health Service. A Political History*, 2nd edn. Oxford: Oxford University Press.
WHITFIELD, Dexter (2001) *Public Services or Corporate Welfare. Rethinking the Nation State in the Global Economy*. London: Pluto.
WILLIAMS, Raymond (1965) *The Long Revolution*. Harmondsworth: Penguin.
WOOD, Ellen Meiksins (2002) *Empire of Capital*. London: Verso.

CAMBRIDGE JOURNALS
http://journals.cambridge.org Downloaded: 25 Feb 2014 IP address: 131.251.254.13